

## **General Guidelines for the SBHI and SLOHI (Medi-Cal) Programs**

CenCal Health's Medi-Cal programs, *Santa Barbara Health Initiative (SBHI)* and *San Luis Obispo Health Initiative (SLOHI)*, follow the same claim submission guidelines as outlined in the specific Provider type sections found on the California State Medi-Cal website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). The guidelines outlined below are designed as an overview; we recommend you consult the State's online Manuals for complete information on Provider-specific billing.

CenCal Health will accept the Standard billing forms (CMS-1500 and UB-04), as well as form 25-1 (Long Term Care), for our Medi-Cal program.

The following are general claim submission guidelines. Claims not submitted in accordance with following requirements cannot be readily adjudicated, and may be denied and returned to the provider for corrective action.

Claims must be received within six months from the date of service on the claim to avoid a reduction in payment. Claims received in the 7<sup>th</sup> to 12<sup>th</sup> months from the date of service on the claim will be subject to a reduction. Claims received over one year from the date of service will be denied. However, there may be exceptions to these deadlines: refer to your State Medi-Cal Billing Manual for these exceptions.

All ***original claims*** should be submitted to:

CenCal Health  
P.O. Box 1818  
Bellflower, CA 90707-1818

All ***corrections and appeals*** should be submitted to:

CenCal Health  
4050 Calle Real  
Santa Barbara, CA 93110  
Attention: Adjudication Department.

**DO NOT SEND INQUIRIES, APPEALS OR CORRECTIONS TO THE BELLFLOWER ADDRESS.**

For ***telephone inquiries***, call [800.421.2560](tel:800.421.2560) ext. 183 or [805.562.1083](tel:805.562.1083) to speak to your Claims Representative.

## **GENERAL BILLING INFORMATION**

1. HCPCS and CPT Codes – National HCPCS, "Medi-Cal only" HCPCS, and approved CPT codes must be used when billing for services. CenCal Health implements any changes in codes (e.g. new codes, deleted codes) for the Medi-Cal program as directed by DHCS. Typically, new CPT and HCPCS codes are not implemented for the current year until November 1 of that year. It is important not to use new CPT or HCPCS codes until Medi-Cal has sent notification that those codes may be billed. This information is conveyed on the monthly Provider Bulletins published by the State of California. These Bulletins can also be viewed on the State of California Medi-Cal website.
2. Modifiers – Modifiers should be used in accordance with the guidelines set forth in the Medi-Cal Billing Manual. Use only the modifiers that are listed in the [Modifiers: Approved List modif](#) chapter of the State Billing Manual. The only exception is that SBHI and SLOHI do allow the use of modifiers -57 and -59 (see ***NCCI EDITS*** section below). ALL surgical, laboratory and radiology services must have a modifier attached, or the service line will be denied. If more than one modifier is necessary to properly describe a service, use modifier -99 with the CPT code and provide an explanation of which modifiers apply to that service in the “remarks” field of the claim. DO NOT use two modifiers on a claim line.
3. Unlisted Procedure or Service – When an unlisted procedure code needs to be utilized because there is not an appropriate CPT or HCPCS code, CenCal Health requires a report of the service(s) attached to the claim form or remarks indicating the supplies or injections provided with a complete description.
4. Multiple Surgery – Multiple surgery claims are priced based on the primary, secondary, and subsequent procedures. When multiple procedures are performed on the same date of service, the primary procedure should be billed using modifier “AG”. Second (or bilateral) and subsequent surgeries should be billed using modifier -50 or -51, whichever is appropriate. Each additional procedure will be paid at 50% of the allowable, with the exception of additional procedures that are “add-on” or “modifier -51 exempt”, which are paid at the full allowable. For this reason, you may use modifier -51 on an add-on code or modifier -51 exempt code and receive full payment.
5. CLEAN CLAIMS: To avoid unnecessary denials, all claims should contain all of the required information as outlined in CenCal Health’s policy on CLEAN CLAIMS. ALL paper claims must contain an original signature.

6. CLAIM INQUIRIES: Submit to the address listed above. If submitting a tracer claim, clearly write "TRACER CLAIM" on your form(s). Corrections to denied services can be made directly on the EOB on which the denial appeared or a CIF may be used. If a new claim is submitted, clearly indicate on the claim form "CORRECTED CLAIM". It is important that these claims are not simply rebilled to the P.O. Box in Bellflower as this may cause the claim to deny as a duplicate claim and delay payment.

Appeals may be submitted using an appeal form or letter and all documentation must be included with the appeal.

***All claim inquires, corrections and appeals must be received within the end of the 6<sup>th</sup> month of the date on which the claim appeared on an EOB.***

### **NCCI EDITS**

CenCal Health implemented the use of the NCCI edits beginning for dates of service on and after January 1, 2006. The current Medi-Cal guidelines will continue to be followed for services that are considered inclusive of each other as well: these may or may not be part of the NCCI edit tables.

**NCCI (National Correct Coding Initiative)** edits are used by Medicare and many other private payors in their claims processing to identify CPT codes that are components of each other, or ordinarily would not be billed together. These edits are updated quarterly and can be viewed on the CMS Website. The direct link is:

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>.

You may then select from the range of codes listed.

There are two sets of National Correct Coding Initiative tables: column one/column two correct coding edits, and mutually exclusive edits. All edits consist of code pairs that are arranged in *column one* and *column two* of the tables. All edits are included in the first table except those meeting the criteria for mutually exclusive code edits. Edits based on the criteria for "Gender-Specific Procedures" are also included in the mutually exclusive code edit tables. **The column two code in both tables is not payable with the column one code unless the edit permits use of a modifier associated with NCCI.** The correct coding

edit table contains many edits where the column two code is a component of the column one comprehensive code. However, this table also contains many edits where there is no comprehensive/component relationship, but the column one code and column two code should not be reported together for other reasons.

**THE ONLY CHANGE** to CenCal Health's policy on the use of Medi-Cal approved modifiers is that Providers may now utilize modifier -57 (Decision for Surgery) on certain Evaluation and Management services, and modifier -59 to identify a "DISTINCT PROCEDURAL SERVICE". For purposes of modifier -59 as it relates to the NCCI edits, it should be primarily used to indicate that two or more procedures are performed at different anatomic sites, or different patient encounters. It should be used if no other modifier more appropriately describes the relationship of the procedure codes being billed. **REMEMBER: This change in the use of modifiers -57 and -59 DOES NOT APPLY to State Medi-Cal; only SBHI and SLOHI Medi-Cal members.**

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