CenCal HEALTH
Local. Quality. Healthcare.

4050 Calle Real Santa Barbara, CA 93110
1-800-421-2560

Modifiers / Helpful Hints for Billing "Medi-Cal" (SBHI & SLOHI)

Radiology / Pathology Services

70000 - 79999 & 80000 - 89999

Modifier	To be used when:
26	Only the professional component (reading and report by physician) was performed by the billing provider.
90	Performed by an outside laboratory but billed by another provider. Include name and address of outside lab on the claim form.
99	Two or more modifiers are necessary to completely describe a service; the multiple modifiers used must be explained in the *remarks* **field (Box 80)**/*Reserved for Local Use* field (Box 19) of the claim **or on an attachment**. (i.e. modifier 99 = 80 + 51)
TC	Only the technical component (equipment and supplies for Facility) was performed by the billing provider.

Surgical Services - All surgical procedure codes require a modifier (this isn't true anymore)

Surgical Services: 10000 - 69999

Modifier	To be used when:
22	Modifier -22 may be billed when the work required to provide a service is substantially greater than typically required. Documentation **must be attached to claim** and support the "substantial additional work" and the reason for the additional work, such as increased intensity, time, technical difficulty of procedure, or severity of patient's condition where increased effort is required.
25	**This modifier CANNOT be used on a surgical procedure code.** Modifier -25 is used to indicate the day a procedure was performed, the patient required a significant, separately identifiable E&M service above and beyond the other service(s) provided.
50	Bilateral procedures must be billed on two claim lines in order to receive proper reimbursement. Use the surgical code with modifier "AG" on the first claim line to identify one anatomical side, and the surgical code with modifier "50" on the second claim line to identify the opposite anatomical side. NOTE: **You must also request (submit) the *Treatment Authorization Request* (TAR) for bilateral surgical procedures using this same methodology.**
51	Multiple procedures are performed at the same operative session. Provider should identify the major procedure with modifier "AG", and identify the secondary, additional or lesser procedures by adding modifier "51" to the secondary procedure codes. Use modifier "51" on add-on or modifier "51" exempt codes as well. These codes will still be paid at full value.
53	Any additional information or explanation of what percentage of the procedure was completed. **Documentation is required** to determine final reimbursement of the procedure. Without documentation, the claim line will be denied.
59	Identifying procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same physician.
62	Two surgeons work together as primary surgeons performing distinct part(s) of a procedure. Each surgeon should report his/her distinct operative work by adding modifier -62 to the primary procedure code. For subsequent surgical procedures that require modifier -62, use modifier -99 and in Box 19 note, 99 = 62 + 51.
66	Highly complex procedures are carried out under the "surgical team" concept. The services of all physician members of a surgical team, including primary and assistant surgeons, must be billed on a single line of one claim form using the appropriate CPT-4 code(s). Include rendering provider NPI # and any supporting documentation necessary.
76	Used when a procedure or service is repeated on the same date of service by the **same physician.** On a surgical claim, this modifier should be listed secondary to -AG, -50 or -51.
77	Repeat procedure by **a different** physician on the same date of service. On a surgical claim, this modifier should be listed secondary to -AG, -50 or -51.
79	Indicates that the performance of the procedure was unrelated to the original or previous service. Can be used on a surgical or medicine code.
99	Two or more modifiers are necessary to completely describe a service. Use modifier "99" with the appropriate procedure code and explain the applicable modifiers in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim. For example, when a major surgical procedure is to be performed requiring the use of modifier "22" and modifier "AG", use modifier "99" with an explanation in the *Remarks* area/*Reserved For Local Use* field (Box 19) indicating that the procedure required the use of both modifiers "22" and "AG" (99 = AG + 22).

	80 & 99	The assistant surgeon must use modifier “80” as a part of each procedure billed. The major surgical procedure is identified by the use of modifier “80” (assistant surgeon) and multiple surgical procedures identified by the use of modifier “99” (multiple modifiers, i.e. 99 = 80 + 51).
	AG	To be used on the highest valued surgical procedure code (CPT-4 series 10000 - 69999), and should only be applied to one CPT for each surgical session.
	SA	Used to identify Nurse Practitioner's (NP) services. The supervising physician’s provider number must be entered as the rendering physician’s on each applicable claim line. The NP's name, provider number, and type of NMP-NP must be included in the Remarks field(Box 80)/Reserved for Local Use field (Box 19) on the claim form. If modifier “99” is used, modifier “99” remarks are also listed in Box 80 or Box 19 on the claim form (i.e. 99 = SA + ZL).
	SB	Primary care services rendered by a Certified Nurse Midwife (CNM) must be performed under the general supervision of a physician. CNM's who bill services using their own provider number must NOT enter modifier -SB on the claim. **Modifier -SB is reserved for physicians, hospital outpatient departments or organized outpatient clinics that bill CNM services.**
	U7	Used to identify Physician Assistant (PA) services. Services rendered by a PA must be performed under the general supervision of a physician, and the supervising physician’s provider number must be entered as the rendering physician’s on each applicable claim line. The PA’s name, provider number and type of NMP-PA must be included in the Remarks field(Box 80)/Reserved for Local Use field (Box 19) on the claim form. If modifier “99” is used, modifier “99” remarks are also listed in Box 80 or Box 19 on the claim form (i.e. 99 = U7 + 80).
	ASC & Outpatient Surgery Centers - SBHI and SLOHI Programs Only	
	Modifier	**To be used for:**
	UA	Medi-Cal only - used on surgical code(s) to report supplies and drugs related to anesthesia for surgical encounters performed under any type of anesthesia except general anesthesia.
	UB	Medi-Cal only - used on surgical code(s) to report supplies and drugs related to anesthesia for surgical encounters where general anesthesia is used.
	Transportation Modifiers Non-Emergency/Emergency	
	D	Diagnostic or therapeutic site other than “P” or “H”
	E	Residential, domiciliary, custodial facility (Nursing Home, not Skilled Nursing Facility)
	G	Hospital-based dialysis facility (hospital or hospital-related)
	H	Hospital
	I	Site of transfer (for example, airport or helicopter pad) between types of ambulance
	J	Non-hospital-based dialysis facility
	M	Psychiatric Inpatient Hospital
	N	Skilled Nursing Facility (SNF)
	P	Physician’s office (includes HMO non-hospital facility, clinic, etc.)
	R	Residence
	S	Scene of accident or acute event
	X	Intermediate stop at physician’s office en route to the hospital (includes HMO non-hospital facility, clinic, etc.) NOTE: Modifier X can only be used in the second position of the modifiers
	Vision care Modifiers	
	22	Modifier -22 may be billed when the work required to provide a service is substantially greater than typically required. Documentation must support the "substantial additional work" and the reason for the additional work, such as increased intensity, time, technical difficulty of procedure, or severity of patient's condition where increased effort is required.
	LT	Procedures performed on the left side of the body
	RT	Procedures performed on the right side of the body
	E1	Upper left eyelid
	E2	Lower left eyelid
	E3	Upper right eyelid
	E4	Lower right eyelid
*	**SC**	Medically Necessary service or supply ***(use modifier with CPT 68731 to indicate use of temporary collagen punctal plugs) Use modifiers E1-E4 for permanent silicone punctal plugs.**
	50	Bilateral procedures must be billed on two claim lines in order to receive proper reimbursement. Use the surgical code with modifier "AG" on the first claim line to identify one anatomical side, and the surgical code with modifier "50" on the second claim line to identify the opposite anatomical side. NOTE: **You must also submit the *Treatment Authorization Request* (TAR) for bilateral surgical procedures using this same methodology.**
	RA	Replacement of a DME item
	NU	Purchase of new equipment
	54	Surgical care only
	99	Two or more modifiers are necessary to completely delineate a service; the multiple modifiers used must be explained in the *remarks* **field (Box 80)**/*Reserved for Local Use* field (Box 19) of the claim **or on an attachment**.

CenCal HEALTH
Local. Quality. Healthcare.

Reference Guide

Explain Codes:	Explain Reasons:	Suggested Resolution:
32	Recipient Not Eligible on Date of Service	Verify that the members 9 digit ID # is correct (look for transposed #'s, make sure all digits are correct). Verify that the member is eligible and be sure to bill the correct program (SBHI/SLOHI, AIM). If necessary, check eligibility on our website at www.cencalhealth.org or contact our Member Services Department at 877-814-1861
33	Member# invalid or does not match Name and DOB on Claim	Verify that the member ID # is correct (look for transposed #'s, make sure all digits are correct).Verify that the member is eligible and be sure to bill the correct program (SBHI / SLOHI). Be sure that the DOB, member name and gender matches that which is on file with CenCal health. If the claim is for the baby using mom's ID #, make sure that the relationship code is 19 on the UB-04 claim form and that the Child checkbox is checked under the *Patient Relationship To Insured* field (box # 6) on the CMS 1500 claim form. If necessary, contact our Member Services Department at 877-814-1861 for additional eligibility information.
34	This is a Duplication of a Previously Submitted Claim	The most common reason for this explain code is due to providers *resubmitting corrections* on a currently processing claim. First time claims are sent to CenCal Health, P.O. Box 948 Goleta, CA 93116. Claim corrections can be resubmitted but please allow 30 business days for claims processing prior to submitting an additional claim for review.
8U	Authorization is missing or does not match service billed	Verify that the authorization number on your claim is correct and that there are no transposed numbers. Verify that the code that is being billed on your claim matches that which has been approved on your authorization. If a code needs to be corrected or included on your authorization contact Health Services for further instruction at 805-562-1082.
K6	Procedure code requires a modifier	Add the appropriate modifier to the claim line and resubmit the claim for review. For additional information on approved modifiers, please visit www.Medi-Cal.ca.gov. Type "modifiers approved list" in the search bar.
3G	Service cannot be reimbursed without matching Medicare EOB	Please resubmit your claim with a copy of the Medicare EOMB. Please be sure to **include the explain code reasons** that came with your Medicare EOMB.
8W	Authorization limit reached	The units that have been approved on your TAR have been exhausted. Request a new TAR with the new number of units requested. Make sure that the DOS on your effected claim is included on your TAR request. If you have additional questions please contact Health Services at 805-562-1082
4K	Claims received after 1 year from the date of service	Claims submitted 1 year after the DOS should be sent to the state FI department. Please see the Delay reason instructions for additional information. www.Medi-Cal.ca.gov.
6U	Missing completed Referral Form	Check eligibility to obtain the telephone number of the members PCP. Contact the PCP's office for a retro RAF. Once obtained, resubmit your claim with the RAF number enterd in box 23 on your claim form and in box 63 on the UB-04 claim form.
TA	Service limit exceeded; denial may be reconsidered with documentation	Procedure code billed has benefit restrictions; please verify quantity billed and submit documentation for further review of benefits. **When submitting a TAR for a limited procedures that require further authorization, place the remark "TAR FOR OVERAGES " on your TAR request.**
JC	TAR required for the Proc/Drug/Diag	Obtain a TAR by using our provider portal at www.cencalhealth.org. For additional questions regarding your TAR request, contact Health services at 805-562-1082 or fax 805-681-3071. If you have a TAR; place your authorization number in box 23 for the CMS 1500, or box 80 on the UB04.
Claim Correction, Provider Dispute or Appeal?		
	Corrections	Corrections are made by resubmitting the claim with the appropriate correction or documentation needed. **Remember - corrections must be received within 6 months from the original EOB denial.**
	Disputes	Provider/Dispute: A Dispute is used when questioning or disputing the amount paid, disagreement regarding denials. **Please note that disputes need to be received within the 6 month follow up period for both contracted and non-contracted. Send Disputes to CenCal Health, 4050 Calle Real, Santa Barbara, CA 93110.**
	Appeals	An Appeal is used if you disagree with the resolution of a previously disputed claim. An Appeal request must be received in writing within 90 days of the action/inaction causing the complaint. Send Appeals to CenCal Health, 4050 Calle Real, Santa Barbara, CA 93110.
REMINDERS: * All claim Disputes and Appeals **MUST** be sent to CenCal Health, 4050 Calle Real, Santa Barbara, CA 93110. * Claim corrections should be electronically resubmitted with the appropriate correction(s) for reconsideration. All corrections **MUST be received** in our office within 6 months from the date of the original EOB.		
Timeliness Guidelines		
	A claim submitted in the 7th to 9th month after the DOS	Payment will be reduced by 25% if submitted without an appropriate delay reason code. For delay reason code information log on to the Medi-Cal website at www.Medi-Cal.ca.gov and in the search box search "delay reason codes."
	A claim submitted in the 10th to 12th months after the DOS	Final payment will be reduced by 50% if submitted without an appropriate delay reason code. For delay reason code information log on to the Medi-Cal website at www.Medi-Cal.ca.gov and in the search box search "delay reason codes."

	A claim received after 1 year from the DOS	No reimbursement from CenCal Health is warranted for a claim billed over one year from the date of service. Claims must be submitted to **FI at the State EDS level**. For delay reason code information log on to the Medi-Cal website at www.Medi-Cal.ca.gov and in the search box search "delay reason codes."
Claims Customer Service Representatives are available M-F 8:00-4:00 (PST)		
Claims Customer Service Representatives		Toll Free: 800-421-2560 ext. 1083 or Local: 805-562-1083
Claims Department e-mail		cencalclaims@cencalhealth.org
Claims department fax number		805-681-8261
Claim Submission and Corrections mailing adddress		CenCal Health, P.O. Box 948, Goleta, CA 93116
Disputes/Appeals and DOS Correction Form mailing address		CenCal Health, 4050 Calle Real, Santa Barbara, CA 93110

NCCI EDITS

CenCal Health implemented NCCI (National Correct Coding Initiative) edits for our claims processing system beginning on January 1, 2006. These edits apply to all of our programs (SBHI, SLOHI, PP2, Healthy Families, Healthy Kids and IHSS) and can be accessed at: http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage.

Providers must submit appropriate national modifiers to indicate a separately identifiable service or E&M visit to avoid possible denials. The NCCI tables indicate if a modifier is allowed for each CPT or HCPCS code listed on the table. Below are the definitions of the explain codes that indicate a claim service line was denied due to NCCI edits.

- **MY** - Payment for this service is already included in another service
- **MZ** - OFFICE VISIT W/I SURGICAL FOLLOW-UP DAYS. Payment for visit included w/ surgical code
- **MW** - Mutually exclusive procedure performed during same session

If your claim is denied with one of the above denial codes, correct with an NCCI edit modifier, IF APPROPRIATE, for the service performed. Please do not submit written medical justification, medical records, or any other comments when sending your claim for reconsideration: these will be returned for an appropriate modifier.

If your claim *remains* denied once an appropriate modifier has been submitted, you may then dispute with medical records or other written documentation.

CenCal HEALTH
Local. Quality. Healthcare.

PROVIDER *DISPUTE/APPEAL* RESOLUTION REQUEST

*CONTACT FULL NAME/ADDRESS/PHONE NUMBER	*PROVIDER NPI NO.

***CLAIM TYPE:**

(1) PHARMACY	☐
(2) PHYSICIAN	☐
(3) HOSPITAL INPATIENT	☐
(4) HOSPITAL OUTPATIENT	☐
(5) LTC	☐
(6) VISION	☐
(7) ALLIED/DME	☐

*RESOLUTION REQUEST TYPE ☐ DISPUTE ☐ APPEAL

INSTRUCTIONS:
- Please complete this form if you are seeking reconsideration of a previous claims determination.
- **Dispute** request is for reconsideration of the original claim that has been previously denied and underpaid.
- **Appeal** request is for reconsideration of previously disputed claim(s) that was rejected , denied or underpaid.
- Fields with an asterisk (*) are required. Please provide the Contacts full information or the resolution letter will be mailed to the address on file.
- Multiple "LIKE" Claims are for Disputes ONLY, and to be used for same provider but different members and dates of service.
- Be specific when completing the Description of Dispute/Appeal and Expected Outcome.

*CLAIM INFORMATION ☐ SINGLE ☐ MULTIPLE "LIKE" CLAIMS

*REASON FOR DISPUTE/APPEAL (ENCLOSE ALL SUPPORTING DOCUMENTS. INCLUDING CLAIM COPY.)

*EXPECTED OUTCOME:

*PATIENT NAME:	*ID NUMBER:	*CCN NUMBER:	*DATE OF SERVICE:

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE AND COMPLETE.

SIGNATURE _____ DATE _____

Proposition 56 Supplemental Payment

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) increased the excise tax on cigarettes and tobacco products for purposes of funding specified expenditures, including programs administered by the Department of Health Care Services (DHCS).

DHCS has indicated that supplemental payments for physician services in both the Medi-Cal fee-for-service (FFS) and Medi-Cal managed care delivery systems for the 2018-2019 fiscal year will be made available to the managed care plans in April of 2019. CenCal Health's requirement is to reimburse applicable providers *(FQHC, RHC and non-contracted providers are excluded from the eligible providers list)*, the procedure codes listed below inclusive of the supplemental payment rate for dates of service **July 1, 2018 through June 30, 2019** to CenCal Health eligible members, *excluding members with Medicare primary.*

CPT Code	Supplemental Payment Amount	CPT Code	Supplemental Payment Amount
90863	$5.00	99214	$62.00
99211	$10.00	99393, 99394	$72.00
99201	$18.00	99391	$75.00
99212	$23.00	99215	$76.00
99395	$27.00	99381, 99383	$77.00
99385	$30.00	99392	$79.00
99202	$35.00	99382	$80.00
99203	$43.00	99204, 99384	$83.00
99213	$44.00	99205	$107.00

What can you expect to see on your claims paid in March of 2019 and on?

- CenCal Health will begin making supplemental payments on applicable claims beginning March 1, 2018
- Explain code **G9** *(Payment has been increased due to Prop 56 Supplemental Payment Methodology)* will be applied to current claims due for supplemental payment
- Explain code **H3** *(Additional payment made due to Prop 56 Supplement Payment Methodology)* will be applied starting in March, for all retroactive dates of service claims due for supplemental payment
- Late filing reductions and share of cost (SOC) will not apply to these supplemental payments; full supplemental amount will be paid for dates of service July 1, 2018 through June 30, 2019 to CenCal Health eligible members, *excluding members with Other Health Care coverage or Medicare primary*

Please visit the DHCS Medi-cal website to learn more about this payment or contact the Provider Services Department with any questions at (805) 562-1676 or email psrgroup@cencalhealth.org.

Important Addresses

Paper Claims are mailed to:

CenCal Health

P.O. Box 948

Goleta, CA 93116-0948

Claim Disputes and Appeals are mailed to:

CenCal Health

Attn: Claims Department

4050 Calle Real

Santa Barbara, CA 93110

- **Please Note:** Corrected claims should be resubmitted electronically. If attachments are required, print your claim and mail it to PO Box 948, Goleta, CA 93116-0948

Email Address

Claims inquiries can be emailed to:

cencalclaims@cencalhealth.org

- A Claims Service Representative (CSR) will respond within 24 hours of receipt of the email
- It can be addressed and sent directly to CSR by indicating their name in the Subject field of the email
- Please include the pertinent information in the email in order for us to promptly respond (CCN, member information, date of service, required attachments etc.)

Claims Service Representative Specialty List

Claims Service Representative	Claim Specialty
Anita Cordero	Physician, Vision, DME/Allied & Transportation
Conor Finfrock	Outpatient, Inpatient & Long Term Care
Nancy Martinez-Garcia	Outpatient, Inpatient & Long Term Care
Roxanne Euglow	Outpatient, Hearing Aid & Transportation
Stephanie Snowden	Physician & Vision
Will Rebero	Physician & Vision

Claims Service – Call Greeting Options

Claims Direct Line: 805-562-1083 or 800-421-2560 ext 1083

Option 1 – Billing Address and FAX #

Option 2 – Claims Status for Claims 30 business days and older

Option 3 – Same and Similar Calls

Option 4 – Check Tracers & EOP Issues

Option 5 – Claim Denial and/or Billing Questions

- **Option 1** – Physician & Physician Specialty Services
- **Option 2** – Inpatient & Long Term Care
- **Option 3** – Outpatient, Surgery Centers & Hospice Care
- **Option 4** – Allied & DME (durable medical equipment, hearing aids, transportation, PT, OT and Acupuncture

Claims Service Representative's

- Contact us to schedule a personal Webinar or in-office meeting. We can assist your office with:
  - Better understanding your top denials
  - Getting your denied claims paid
  - Conducting a CenCal Claims Portal training
  - Training your new office staff on billing CenCal Health
  - Answering common questions