Share of Cost (SOC): UB-04 for Outpatient Services

Page updated: August 2020

This section explains how to complete claims for services rendered to recipients who paid a Share of Cost (SOC). The procedure codes used in the following examples are for illustration purposes only and may not be reimbursable to all provider types. Refer to the *Share of Cost (SOC)* section in the Part 1 manual for an explanation of SOC and how to determine the following:

- If a recipient must pay an SOC
- The SOC amount a recipient must pay
- If the recipient's SOC is certified for the month

SOC Field on Claim

SOC is entered in the *Value Codes and Amounts* field (Boxes 39 thru 41). Value code "23" in the "code" column of the field designates that the corresponding "amount" column contains the SOC. In the following example, the SOC amount of $50.00 is entered as 5000. Do not enter decimal points or dollar signs. Enter full dollar and cents amounts, even if the amount is even. Use only one claim line for each service billed. Refer to the *UB-04 Completion: Outpatient Services* section in this manual for additional information.

This is a sample only. Please adapt to your billing situation

38

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	5000				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1						180000			1
2									2
3									3
4									4
5									5
6									6
23	001	PAGE ____ OF ____	CREATION DATE		TOTALS	180000			23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789	
A						175000	57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX 67 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

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Figure 1: Share of Cost Amount in *Value Codes and Amounts* Field (Boxes 39, 40 and 41).

Billing Multiple Services Rendered on Different Dates of Service

Case Scenario: Three services are rendered to a recipient on different dates. In this case, an outpatient clinic bills Z7500 (room use codes) for a recipient who requires stitches for his cut hand. The recipient was seen twice on June 2, the first visit to stitch the laceration and the second visit to repair several stitches that came loose. The recipient was seen again on June 30 to remove the stitches.

Date	Service	Amount ‹‹(in dollars)››	SOC Cleared ‹‹(in dollars››››)	Balance ‹‹(in dollars)››
06/02/07	room use	20.00	20.00	0.00
06/02/07	room use	20.00	20.00	0.00
06/30/07	room use	20.00	10.00	10.00
Total	‹‹none››	60.00	50.00	10.00

The recipient pays his entire $50 SOC and the provider performs SOC clearance transactions for each of the three services through the eligibility verification system. The recipient's SOC, therefore, is certified and he is eligible for Medi-Cal.

The provider submits a bill to Medi-Cal. Services rendered cost a total of $60. The first two services are not billed to Medi-Cal because the entire charge is paid as SOC by the recipient. The provider bills Medi-Cal for the last $20 service because the SOC covered only $10 of that charge.

To bill, enter the $20 service fee in the *Total Charges* field (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23). Enter the amount of the patient's SOC already applied toward the service fee ($10) in the *Value Codes and Amounts* field (Boxes 39 thru 41). Enter value code "23" in Box 39A and the difference between Box 47 and Box 39 ($10) in the *Estimated Amount Due* field (Box 55).

This is a sample only. Please adapt to your billing situation.

38

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	1000				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1		USE OF TREATMENT ROOM	Z7500	060307	1	2000			1
2									2
3									3
4									4
5									5
6									6
23	001	PAGE ____ OF ____	CREATION DATE		TOTALS	2000			23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0123456789	
A	O/P MEDI-CAL					1000	57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX 67 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS TOTAL RECIPIENT SOC $10. PREVIOUSLY PAID SOC $10. SOC PORTION APPLIED TO OUTPATIENT CLAIM, $10.

81CC a b c d

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Figure 2: Multiple Services Rendered on Different Dates of Service.

Box 80: Record Keeping

For record keeping purposes only and to help reconcile payment on the *Remittance Advice Details* (RAD), providers may show in the *Remarks* field (Box 80) the SOC amount that the recipient paid or obligated.

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Billing Multiple Services Rendered on Same Date of Service

Case Scenario: Two services are rendered to a recipient on the same date. In this case, a recipient visits the emergency room twice to see a doctor about recurring chest pains. The outpatient clinic bills Z7502 (room use code).

Date	Service	Amount ‹‹(in dollars)››	SOC Cleared ‹‹(in dollars)››	Balance ‹‹(in dollars)››
06/18/07	E.R. and blood tests	95.00	60.00	35.00
06/18/07	Second E.R. and blood tests:	29.50	0.00	29.50
Total	‹‹none››	124.50	60.00	64.50

The recipient pays her entire $60 SOC and the provider performs SOC clearance transactions for each of the services through the eligibility verification system. The recipient's SOC, therefore, is certified and she is eligible for Medi-Cal.

The provider submits a bill to Medi-Cal that includes both same-day services on separate claim lines.

To bill, enter the total services charged in the *Total Charges* (Box 47). Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in *TOTALS* (Box 47, line 23). Enter the amount of patient's SOC applied to this claim in the *Value Codes Amount* field (Boxes 39 thru 41). Enter value code "23" in Box 39A and the difference between Box 47 and Box 39 ($64.50) in the *Estimated Amount Due* field (Box 55).

Page updated: August 2020

This is a sample only. Please adapt to your billing situation.

38

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	6000				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1		USE OF EMERGENCY ROOM	Z7502	061807	1	5000			1
2		PANEL TESTS	80061ZS	061807	1	3000			2
3		AMINO ACID NITROGEN	82127ZS	061807	1	1500			3
4		USE OF EMERGENCY ROOM	Z7502	061807	1	2450			4
5		COLLECTION AND HANDLING	Z5218	061807	1	500			5
6									6
23	001	PAGE ____ OF ____	CREATION DATE		TOTALS	12450			23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789	
A	O/P MEDI-CAL					6450	57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX 67 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS PATIENT SEEN IN ER TWICE SAME DAY: 8:05 AM AND 4:45 PM. (SEE ATTACHED ER CERTS.) SEE ATTACHED ITEMIZATION OF PANEL TESTS.

81CC a b c d

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Figure 3: Multiple Services Rendered on the Same Date of Service.

RAD Payment Summary

SOC claims are reviewed prior to payment. Because the recipient's SOC is applied by the State to pay the $50 service billed on this claim, it may appear as "Denied" on the RAD (code 022), or with a payment amount of $.00. The other services will appear in the "Approved" category as partially paid. The Medi-Cal allowed amount for this service will be reduced by the remaining SOC amount. RAD code 408 indicates payment was reduced because of patient liability.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.