California Children's Services (CCS) Program Billing

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This section provides an overview of the California Children's Services (CCS) program billing guidelines. The CCS Program Billing Guidelines located at the end of this section illustrates the different billing processes for CCS. For claim completion instructions, refer to the CCS Billing Example section in this manual.

Billing Overview

Providers must be enrolled in the Medi-Cal program and use their National Provider Identifier (NPI) on all authorized claims for CCS clients, regardless of the client's CCS program eligibility type. ‹‹An NPI must be used when billing for CCS/Medi-Cal clients and CCS-only clients.››

Service Authorization Request (SAR) Number

The CCS program issues providers unique Service Authorization Request (SAR) numbers beginning with a prefix "91" or "97" for services authorized by CCS. The SAR number must be included on the claim form in the appropriate authorization field. Claims without a SAR number will be denied.

Billing Exception

The following billing exception applies to CCS.

Special Billing Instructions at CCS County Office

Providers billing for services rendered to CCS/Medi-Cal clients in Napa, San Mateo, Santa Barbara, Solano and Yolo counties must contact the local CCS county office for billing instructions.

Claim Submission and Timeliness Requirements

Refer to the *Claim Submission and Timeliness Overview* section of the *Part 1 – Medi-Cal Program and Eligibility* manual. This section details the claim forms used by various providers and the guidelines for submitting those claim forms.

Six-Month Billing Limitation

Original (or initial) claims must be received by the California MMIS Fiscal Intermediary within six months following the month in which services were rendered. Providers submitting claims as an exception to the six- month billing time limit must include a valid delay reason code with each claim. Refer to the *Submission* and *Timeliness Instructions* section of the appropriate Part 2 manual for a list of valid delay reason codes.

Payments to providers who submit claims after the six-month billing time limit without the required delay reason code will be reduced in accordance with Medi-Cal policy.

‹‹ASC X12N 837 v. 5010 Claim Billing

The most efficient method of billing is the ASC X12N 837 v.5010 claim on the Medi-Cal Provider Portal. Unlike paper claims, these claims already exist on a computer medium. As a result, manual processing is eliminated. The 837 claim offers additional efficiency to providers because these claims are submitted faster, entered into the claims processing system faster, and paid faster. For more information, refer to the *Electronic Data Interchange (EDI) 837 Claims Overview* section of the *Part 1 – Medi-Cal Program and Eligibility* manual or call the Telephone Service Center (TSC) at 1-800-541-5555.››

Medi-Cal Dental

CCS/Medi-Cal recipients are eligible for dental services provided by the Medi-Cal Dental program. Providers should refer to the *Medi-Cal Dental Provider Handbook* for billing instructions.

‹‹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.