

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number: CLPM-10</b>			<b>Lead Department: Claims</b>	
<b>Policy/Procedure Title: Claim Attachments, Supplemental Information and Documentation Required by Partnership</b>			<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 9/1/25		<b>Next Review Date:</b> 01/01/2026 <b>Last Review Date:</b>		
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>		<input type="checkbox"/> <b>Employees</b>	
<b>Reviewing Entities:</b>	<input type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input type="checkbox"/> <b>QUAC</b>	
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input checked="" type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>		<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b>
	<input type="checkbox"/> <b>CEO</b>	<input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALING</b>	<input checked="" type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>
<b>Approval Signature:</b> <i>Lisa Malvo</i>			<b>Approval Date:</b> 09/01/2025	

**I. RELATED POLICIES:**

A. N/A

**II. IMPACTED DEPTS:**

A. Claims

**III. DEFINITIONS:**

A. N/A

**IV. ATTACHMENTS:**

A. N/A

**V. PURPOSE:**

To provide guidance to Providers on required claim attachments, supplemental information and documentation.

**VI. POLICY / PROCEDURE:**

A. If Partnership Medi-Cal is the secondary payer, attach a copy of the EOB/EMOB/RA or denial letter from the primary carrier with the Explanation Code Key included.

If the primary code is not a valid Medi-Cal code, cross through the code and hand write in the appropriate Medi-Cal code. Partnership will not pay invalid/non-benefit Medi-Cal codes on paper claims.

B. Invoices for By Report or unlisted procedure codes where no rate is listed on the fee schedule. The exception to this would be for drug codes which are submitted with a valid NDC.

C. Ambulance – Emergency and/or 911 documentation is required in the remarks section of the claim form, electronic form, or on a separate attachment.

D. Blood – An invoice from the blood bank is required for pricing.

E. Unlisted or By Report DME – Catalog and/or invoice attachments are required for pricing.

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F. Anesthesia services:

1. Start and Stop times and time in attendance (hands on) time must be documented in the remark section of the claim form.
2. Claims for more than 40 units or 10 hours of time, require an anesthesia report.
3. Claims for anesthesia code 01967 for more than 40 units or 5 hours of time, require an anesthesia report.

G. Transplant Organ – Attach invoice from the Organ Procurement Center listing the cost of the organ.

H. Implants – A manufacturer or distributor invoice for the surgical implantable device. Claims submitted with a catalog page or a purchase order will be denied.

The following documentation is required on the invoice or on another attachment to the claim:

1. The invoice must be produced by the manufacturer or distributor and contain their name and address.
2. The hospital must add the patient’s full name and Medi-Cal recipient number, name of the physician, name of the facility, the date of the surgical implant procedure to the manufacturer or distributor invoice and/or the attachments to the invoice.

The following will result in denied claims:

1. Failure to submit manufacturer or distributor invoices with claims for surgical implantable devices
2. Claims submitted to a hospital invoice or purchase order
3. Claims submitted with a catalog page.

I. Pathology: Billing specimens from different sites

Two or more surgical pathology specimen examinations (88300 – 88309) from different sites billed by the same provider, for the same recipient and date of service are separately reimbursable only when billed “By Report.” Documentation must identify each specimen (for example, skin lesions, and endoscopic biopsies) and include the diagnosis for each specimen. The examinations must be billed on separate claim lines on the same claim form, and the *Service Units/ Days or Units* field must be “1” for each claim line.

J. Sterilization Procedures – All claims for sterilization procedures require a PM330 Consent form. If the sterilization procedure was performed on an inpatient basis, and the total charges exceed \$50,000 see item N below.

K. Hysterectomy Procedures – All claims for hysterectomy procedures require a Hysterectomy Consent form.

L. Second Trimester Abortions – All claims for second trimester abortions require a copy of the Operative Report.

M. Reports are required on CCS Special Care Center codes Z4303 and Z4304.

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N. Claims paid at the percentage of billed charges with a payable amount of \$50,000 or greater require a copy of the itemized statement to be submitted with the claims.

**VII. REFERENCES:**

A.

**VIII. DISTRIBUTION:**

A. PARTNERSHIP4ME PowerDMS Policies & Procedures

**IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:** Senior Director, Claims Department

**X. REVISION DATES:** 9/1/25