

# Children's Regional Integrated Service System (CRISS) Guidelines for UB-04 Completion for Emergency Medi-Cal Claims

## **Box 14 TYPE OF ADMISSION**

Enter the numeric code indicating the necessity for admission to the hospital.

**Emergency – 1**

Elective – 3

Newborn – 4\* (\*used only for baby born outside the hospital in conjunction with appropriate revenue code and source of admission code "4")

## **Box 18 - 24 CONDITION CODES**

**For Emergency Certification: Enter code "81" if billing for emergency services.**

An Emergency Certification Statement must be attached to the claim or entered in the Remarks area. The attending provider must sign the statement. It is required for all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required prior authorization such as emergency services by allergists, podiatrists, medical transportation providers, portable X-ray providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in *Remarks* field, attach the statement to the claim.

## **Box 80 REMARKS**

Use this area for procedures that require additional information, justification or an **Emergency Certification Statement**. The Emergency Certification Statement is required for all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required prior authorization such as emergency services by allergists, podiatrists, medical transportation providers, portable X-ray providers, psychiatrists and out-of-state providers. These Statements must be signed and dated by the provider, and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in the *Remarks* field (Box 80), attach the statement to the claim.

**NOTE:** The Medi-Cal Provider Manual includes procedures for claims for emergency services. Providers should check and follow all procedures in the Manual for these claims.

References:

- OBRA/IRCA Aid Codes and Definitions  
[http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/obra\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/obra_z01.doc)
- UB04 Completion: Inpatient Services  
[http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/ubcompip\\_i00.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/ubcompip_i00.doc)

# Medi-Cal Definition of Emergency Services (CCR, Section 51056)

## Emergency Medical Conditions Definition

“Emergency medical condition” is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient’s health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction to any bodily organ or part

Eligible individuals are entitled to all inpatient and outpatient services that are necessary for the treatment of an emergency medical condition as certified by the attending physician or other appropriate provider and in the same manner as administered under Section 51056 of Title 22 of the *California Code of Regulations*. Continuation of medically necessary inpatient hospital services and follow up care after the emergency has resolved shall not be authorized or reimbursed for aliens eligible for restricted benefits only.

All acute level inpatient days (except an emergency admission for labor and delivery) continue to require authorization via a *Treatment Authorization Request* (TAR) from the appropriate Medi-Cal field office. Admissions for labor and delivery require authorization after the first two days (for a vaginal delivery) or the first three days (for a cesarean section delivery) of the patient’s stay. For additional information, refer to the contract services section in the appropriate Part 2 manual for more information.

## Documentation Required for Emergency Services

When billing for emergency services, providers must indicate emergency treatment on the claim and submit a statement that describes the nature of the emergency, including relevant clinical information about the patient's condition and why the emergency services rendered were considered to be immediately necessary. It must be comprehensive enough to support a finding that an emergency existed. The statement must be signed by the provider. A mere statement that an emergency existed is not sufficient. Refer to the claim completion section of the appropriate Part 2 manual for specific claim form instructions.