Medicare/Medi-Cal Crossover Claims: Outpatient Services

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This section contains billing information, billing tips and Medicare documentation requirements for Medicare/Medi-Cal crossover claims submitted on a *CMS-1500* or *UB-04* claim. Refer to the *Medicare/Medi-Cal Crossover Claims Overview* section in the Part 1 manual for eligibility information and general guidelines. Refer also to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* and *Medicare/Medi-Cal Crossover Claims: Outpatient Services Medi-Cal Pricing Examples* sections in this manual. Information in this section is organized as follows:

- Hard copy Submission Requirements of Medicare Approved Services
- Crossover *Claims Inquiry Forms* (CIFs)
- Charpentier Rebilling
- Billing for Medicare Non-Covered, Exhausted or Denied Services, or Medicare Non-Eligible Recipients

All outpatient services are Part B services. Medicare providers bill the following:

- Outpatient physician component services to Part B carriers, and
- All other outpatient services to Part A intermediaries

Hard Copy Submission Requirements of Medicare Approved Services

Where to Submit Hard Copy Crossover Claims

Medicare/Medi-Cal crossover claims for Medicare approved or covered services that do not automatically cross over or that cross over but cannot be processed must be hard copy billed directly to Medi-Cal. Providers must submit crossover claims to the California MMIS Fiscal Intermediary at the following address:

Attn: Crossover Unit
California MMIS Fiscal Intermediary
P.O. Box 15700
Sacramento, CA 95852-1700

Part B Services Billed to Part B Carriers

Hard copy submission requirements for Part B services billed to Part B carriers are as follows:

- One of the following formats of the *CMS-1500* claim (8/05 version only)
  - Original
  - Clear photocopy of the claim submitted to Medicare
  - Facsimile (same format as *CMS-1500* and background must be visible)
- *CMS-1500* claim fields for crossovers only
  - *Medicaid/Medicare/Other ID* field (Box 1). Enter an "X" in both the Medicare and Medicaid boxes.
  - *Other Insured's Policy or Group Number* field (Box 9A). Enter the Medi-Cal recipient identification number in one of the following formats:
    - ❖ 14-digit Medi-Cal recipient ID number
    - ❖ Nine-digit Client Index Number
  - *Claim Codes* field (Box 10D). Enter the patient's Share of Cost for the service (leave blank if not applicable). (Refer to the *Share of Cost [SOC]* section in the appropriate Part 2 manual.)
  - *Insurance Plan Name or Program Name* (Box 11C). Enter the Medicare carrier code.
  - *Rendering Provider Number* field (Box 24J). Enter the National Provider Identifier (NPI) number.
- Copy of the corresponding *Medicare Remittance Notice* (MRN) for each crossover claim (see *Figures 1a and 1b* in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* section in this manual.)
  - Must be complete, unaltered and legible
  - The following fields on the MRN must match the corresponding fields on the *CMS-1500* claim:

❖ Date(s) of service (“from-through” dates)

Note: When billing Medicare for Medi-Cal medical supply crossover claims, providers should not include the Universal Product Number (UPN), qualifier, unit of measurement qualifier and UPN units. Crossover claims for Medi-Cal medical supply items that require hard copy crossover claims to be submitted to Medi-Cal must contain the UPN and appropriate qualifier listed in the shaded area of Box 24A (*Date of Service*). Claims for contracted medical supplies that do not have the appropriate UPN will be denied. The unit of measure qualifier and quantity may be listed in the shaded area of Box 24D (*Procedure Code*); however, hard copy crossover claims without this information will not be denied.

❖ Patient last name or Medicare ID number

❖ Provider name

❖ Billed charge(s)

❖ Procedure code(s)

– Originals, photocopies or electronic printouts of MRNs are acceptable in any format as long as the following critical fields can be identified:

❖ Date of MRN

❖ Carrier name (this field may be handwritten or typed) and five-digit contractor ID code for the carrier that processed the payment for Medicare

❖ Provider name

❖ Patient last name or Medicare ID number

❖ Service dates

❖ Billed/charged/submitted

❖ Procedure code(s)

❖ Allowed

❖ Deductible

❖ Coinsurance

❖ Provider paid/pay provider

- Timeliness (refer to “Delay Reasons” in the *UB-04 Submission and Timeliness Instructions* section in this manual.)

Psychiatric Services for HCP-Enrolled Recipients

Medicare/Medi-Cal crossover claims for psychiatric services must be hard copy billed if the recipient is enrolled in a Health Care Plan (HCP) that is not capitated for psychiatric services. To facilitate prompt and appropriate payment, the rendering provider's NPI number must be entered in the *Rendering Provider Number* field (Box 24J) of the *CMS-1500* claim.

Billing Tips: Part B Services Billed to Part B Medicare Administrative Contractors

The following billing tips will help prevent rejections, delays, mispayments and/or denials of crossover claims for Part B services billed to Part B Medicare Administrative Contractors (MACs):

- Submit the (8/05) version of the *CMS-1500* claim form.
- If submitting a *CMS-1500* facsimile, the background must be visible.
- Do not highlight any information on the claim or attachments. Highlighting renders the data unreadable by the system and causes a delay in processing the claim.
- Do not write in undesignated white space or the top one inch of the claim form.
- A separate copy of the MRN must be submitted with each *CMS-1500* claim form.
- MRNs must be complete, legible and unaltered. For example, make sure the date in the upper right-hand corner is legible.
- Crossover claims must not be combined. Examples of common errors that will result in rejections, delays, mispayments and/or denials include:
  - Multiple recipients on one *CMS-1500* claim form
  - One MRN for multiple *CMS-1500* claim forms
  - Multiple claims (on one or more MRNs) for the same recipient on one *CMS-1500* claim form
  - Multiple claim lines from more than one MRN for the same recipient on one *CMS-1500* claim form
- All Medicare-allowed claim lines must be included on the crossover claim and must match each corresponding MRN provided by Medicare.
- Medicare-denied claim lines that appear on the same crossover claim MRN with Medicare-allowed claim lines cannot be paid with the crossover claim. Refer to "Billing for Medicare Non-Covered, Exhausted or Denied Services, or Medicare Non-Eligible Recipients" on a following page in this section.

- Enter the Medi-Cal recipient identification number in the *Other Insured's Policy or Group Number* field (Box 9A) in one of the following formats:
  - 14-digit Medi-Cal recipient ID number
  - Nine-digit Client Index Number
- If the recipient has Other Health Coverage (OHC), submit a copy of *the Remittance Advice* (RA) or denial letter from the insurance carrier.
- If a provider billed Part B services to a Medicare Part A intermediary and received a Medicare RA, follow the billing instructions in "Part B Services Billed to Part A Intermediaries" on a following page in this section.
- Submit Medicare adjustment crossovers on a *Claims Inquiry Form* (CIF). Follow the Medicare/Medi-Cal crossover claims billing instructions in the *CIF Special Billing Instructions for Outpatient Services* section in this manual.

Part B Services Billed to Part A Intermediaries

Hard copy submission requirements for Part B services billed to Part A intermediaries are as follows:

- Original *UB-04* claim (current version only)
  - Complete according to instructions in the *UB-04 Special Billing Instructions for Outpatient Services* section in this manual.

  Note: *Type of Bill* field (Box 4) must match what is shown on the Medicare RA
- Additional *UB-04* claim fields for crossovers only:

  Occurrence Codes and Dates (Boxes 31 thru 34).

  DATE OF RA.
  - Enter code 50 and the date (MMDDYY) of the Medicare RA.

  Value Codes and Amount (Boxes 39 thru 41 A thru D).

  BLOOD DEDUCTIBLE.
  - Enter code 06 and the Medicare blood deductible amount.
  - Leave blank if not applicable.

  PATIENTS' SHARE OF COST.
  - Enter code 23 and the patients' Share of Cost for the claim.
  - Leave blank if not applicable.

PINTS OF BLOOD.

- Enter code 38 and the number of pints of blood billed.
- Leave blank if not applicable.

MEDICARE DEDUCTIBLE.

- Enter code A1 if Medicare is the primary payer, or B1 if Medicare is a secondary payer.
- Enter the deductible amount.
- Leave blank if not applicable.

MEDICARE COINSURANCE.

- Enter A2 if Medicare is the primary payer, or B2 if Medicare is a secondary payer.
- Enter coinsurance amount.
- Leave blank if not applicable.

Description (Box 43).

Enter all claim detail lines (services) that were billed to Medicare on this claim. Crossover claims in excess of 15 claim lines must be billed on two or more claim forms. Refer to “Split Billing: More Than 15 Line Items for Part B Services Billed to Part A Intermediaries” in this section.

HCPCS/Rate (Box 44).

Enter the procedure code as billed to Medicare.

Service Date (Box 45).

Enter the actual date of service on each detail line.

Total Charges (Box 47).

Enter the total charge for each service billed to Medicare in the *Total Charges* field.

Revenue Code (Box 42), Description (Box 43), and Total Charges (Box 47).

Box 42, Line 23: Enter “001” to indicate that this is the total charge line.

Note: The crossover claim to Medi-Cal should include the revenue codes present on the accompanying Medicare RA.

Box 47, Line 23: Enter the total amount of all charges billed to Medicare.

Payer Name (Boxes 50 A thru C).

The payers must be listed in the following order of payment:

1. Other Health Coverage (OHC) (if applicable) except Medicare Supplemental Insurance
2. Medicare
3. Medicare Supplemental Insurance (if applicable)
4. Medi-Cal

<u>Medicare/Medi-Cal Payers</u>

If only Medicare and Medi-Cal are involved, enter "MEDICARE" on line A and "O/P MEDI-CAL" on line B. Enter the facility type as the first two digits in the *Type of Bill* field (Box 4). (Refer to the *UB-04 Completion: Outpatient Services* section in this manual.)

<u>OHC Payers</u>

If OHC is involved and is primary, enter the name of the OHC on line A, enter "MEDICARE" on line B, and enter "O/P MEDI-CAL" on line C. Enter the facility type code as the first two digits in the *Type of Bill* field (Box 4).

<u>Medicare Supplemental Insurance Payers</u>

If Medicare supplemental insurance is involved, it is secondary to Medicare. Enter "MEDICARE" on line A, enter the name of the Medicare supplemental insurance on line B, and enter "O/P MEDI-CAL" on line C. Enter the facility type code as the first two digits in the *Type of Bill* field (Box 4).

Health Plan ID (Box 51).

Enter the Medicare carrier code.

PRIOR PAYMENTS (Boxes 54 A thru C).

Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50.

Note: The Medicare payment amount entered in Box 54 must match the *Medicare National Standard Intermediary Remittance Advice* (Medicare RA) Allowable Reimbursement Amount (Allow/Reim), <u>not</u> the Net Reimbursement Amount (Net Reim Amt).

Estimated Amount Due (Boxes 55 A thru C).

Note: Do not enter a decimal point (.) or dollar sign ($).

On the corresponding Medicare line, enter the total charges from Box 47, line 23.

On the corresponding Medi-Cal line, follow the instructions below:

Add the blood deductible (value code 06), Medicare deductible (value code A1 or B1), and Medicare coinsurance (value code A2 or B2). (See Boxes 39 thru 41 and example on the following page.)

‹‹Estimated Amount Due Example Table 1››

For example:	
Blood Deductible	40 00
Medicare Deductible	60 00
Medicare Coinsurance	+ 20 00
Total	120 00

Add the SOC (Boxes 39 thru 41 [value code 23]), the OHC (Box 54) and the Medicare supplemental insurance (Box 54).

‹‹Estimated Amount Due Example Table 2››

For example:	
SOC	50 00
OHC	25 00
Supplemental insurance	+ 25 00
Total	100 00

Then subtract that total (100 00) from the deductible(s) and coinsurance total (120 00). The difference equals the Estimated Amount Due. Enter this amount in Box 55 on the Medi-Cal line.

‹‹Estimated Amount Due Example Table 3››

For example:	
Sum of Deductible + Coinsurance	120 00
Sum of SOC/OHC/Supplemental	– 100 00
Estimated Amount Due 20 00	

NPI (Box 56).

Enter the NPI.

Other Provider ID (Box 57).

Box 57 is required when an NPI is not used in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.

- Copy of the corresponding *Medicare National Standard Intermediary Remittance Advice* (Medicare RA) for <u>each</u> crossover claim (see Figures 2a and 2b in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* section of this manual).
  - Must be complete, unaltered and legible
  - The following fields on the RA must match the corresponding fields on the *UB-04* claim:
    - ❖ Date(s) of service (“from-through” dates)
    - ❖ Patient last name or Medicare ID number
    - ❖ Provider name
    - ❖ Billed/Total/Submitted charge(s)

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- Printouts of electronic RAs are acceptable only in the PC Print single claim detail version of the *Medicare National Standard Intermediary Remittance Advice* format (see examples in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* section in this manual). The following critical fields must be present:
  - Date of RA
  - Intermediary name (this field may be handwritten or typed) and Medicare contractor ID code
  - Provider name
  - Patient last name or Medicare ID number
  - "From-through" dates
  - Billed/total/submitted charges
  - Deductible and/or coinsurance amount(s)
  - Non-covered/non-allowed charges (if applicable)
  - Denial reason/reason code (Medicare-denied claims only, not crossovers.)
  - Type of Bill (TOB)/type of claim/claim type/bill type (such as inpatient, outpatient or Nursing Facilities Level B [NF-Bs])
  - At the claim line level:
    - Medicare Billed
    - Medicare Paid
    - Adjustment Group Code
    - Adjustment Reason Code
    - Adjustment Amount

- Timeliness (refer to "Delay Reasons" in the *UB-04 Submission and Timeliness Instructions* section of this manual).

Billing Tips: Part B Services Billed to Part A Medicare Administrative Contractors

The following billing tips will help prevent rejections, delays, mispayments and/or denials of crossover claims for Part B services billed to Part A Medicare Administrative Contractors (MACs):

- Submit an original *UB-04* claim form, not a facsimile.
- Do not highlight any information on the claim or attachments. Highlighting renders the data unreadable by the system. This causes a delay in processing the claim.

- Include all services billed to Medicare on the crossover claim.
- Each crossover claim must match the corresponding Medicare RA.
- A separate copy of the Medicare RA must be submitted with each *UB-04* claim form.
- All copies of Medicare RAs must be complete, legible and unaltered and in the correct format.
- Crossover claims must not be combined. Examples of common errors that will result in rejections, delays, mispayments and/or denials include:
  - Multiple recipients on one *UB-04* claim form
  - One Medicare RA for multiple *UB-04* claim forms
  - Multiple claims (on one or more RAs) for the same recipient on one *UB-04* claim form
  - Multiple claim lines from more than one RA for the same recipient on one *UB-04* claim form
  - Summary level rather than detail level RA
  - Non-PC Print version of RA
- Electronic outpatient crossover claims in excess of 15 lines billed automatically by Medicare to Medi-Cal will be split by Medi-Cal into separate claims. Separate *Medi-Cal Remittance Advice Details* (RADs) will also be prepared. Any crossover claims in excess of 15 lines that do not cross over automatically may either be billed electronically via Computer Media Claims (CMC) or must be billed on two or more *UB-04* paper claim forms. Refer to “Split Billing: More than 15 Line Items for Part B Services Billed to Part A Intermediaries” on a following page. Also refer to the appropriate example in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* section.
- If the recipient has Other Health Coverage (OHC), submit a copy of the EOB/RA or denial letter from the insurance carrier.
- Submit Medicare adjustment crossovers on the *Claims Inquiry Form* (CIF). Follow the Medicare/Medi-Cal crossover claims billing instructions in the *CIF Special Billing Instructions for Outpatient Services* section in this manual.

Special Billing Instructions

Rural Health Clinics, Federally Qualified Health Centers and Indian Health Services Memorandum of Agreement (IHS/MOA) Clinics

Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) and Indian Health Services Memorandum of Agreement (IHS/MOA) crossover claims are not reimbursed based on the Medicare deductible and coinsurance reflected on the Medicare RA. Instead, Medi-Cal reimburses RHC/FQHC crossover claims at a rate set by the Department of Health Care Services (DHCS) that equals the difference between the Medicare payment rate and the Prospective Payment System (PPS) rate. Medi-Cal reimburses IHS/MOA crossover claims at a rate set by DHCS that equals the difference between the Medicare payment rate and the federally calculated IHS/MOA visit rate.

RHC, FQHC and IHS/MOA crossover claims do not automatically cross over to Medi-Cal and must be hard copy billed on the *UB-04* claim according to the billing instructions in the *UB-04 Completion: Outpatient Services* section in this manual. In addition, these claims require special crossover billing procedures, as follows:

- Do not complete the Condition Codes fields (Boxes 18 thru 24).
- Enter "CROSSOVER CLAIM" in the Description field (Box 43).
- Enter procedure code 02 (crossover claim) in the HCPCS/Rate field (Box 44).
- Do not enter "MEDICARE" in the Payer Name field (Box 50) or any amount in the *Prior Payments* field (Box 54).
- Attach the Medicare RA to the claim.
- If Medicare does not cover the service, the service is exhausted, or Medicare denies the service, use the appropriate Medicare status code. (Refer to "Billing for Medicare Non-Covered, Exhausted or Denied Services, or Medicare Non-Eligible Recipients" on a following page in this section.)

A sample crossover claim for RHC, FQHC and IHS/MOA crossover claims may be found in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* section in this manual.

For RHC and FQHC policy information, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health* Centers (FQHCs). For important RHC/FQHC billing instructions refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes and Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Example* sections in this manual.

For IHS policy information, refer to the *Indian Health Services/Memorandum of Agreement (IHS/MOA)* sections in this manual.

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Dialysis: Part B Services

Dialysis includes all routine and non-routine dialysis services, lab tests, drugs, injections and blood products. Crossover claims for dialysis services may automatically cross over to Medi-Cal. Otherwise, they may be hard copy billed according to the billing instructions in the *UB-04 Completion: Outpatient Services* section in this manual, and under "Part B Services Billed to Part A Intermediaries" on a previous page in this section. Approved providers may bill these claims to Medi-Cal electronically using the Computer Media Claims (MS) system according to the instructions in the *CMC* section in the Part 1 Medi-Cal provider manual. In addition, these claims require special crossover billing procedures, as follows:

- Use the same procedure codes, descriptions and quantities billed to Medicare.
- Attach a copy of the single claim PC Print version of the *Medicare National Standard Intermediary Remittance Advice* and any other previously required documentation.

Note: To avoid duplicate billing, providers are strongly advised to wait until the end of each month to bill Medicare and Medi-Cal for dialysis services.

A sample crossover claim for dialysis services may be found in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* section in this manual.

For complete policy information, refer to the *Dialysis: End Stage Renal Disease Services* section in the appropriate Part 2 manual.

Split Billing: More Than15 Line Items for Part B Services Billed to Part A Intermediaries

Medi-Cal cannot process more than 15 lines per claim form for outpatient crossover claims. Therefore, electronic outpatient crossover claims billed for more than 15 line items for Part B services billed to Part A intermediaries will be split into separate claims for processing. Separate *Medi-Cal Remittance Advice Details* (RADs) will also be prepared. Any crossover claims in excess of 15 lines that do not cross over automatically may either be billed electronically via Computer Media Claims (CMC) or must be billed on two or more *UB-04* paper claim forms.

Submit paper split-billed crossover claims according to the billing instructions in the *UB-04 Completion: Outpatient Services* section in this manual and under "Part B Services Billed to Part A Intermediaries" on a previous page in this section. In addition, these claims require special crossover billing procedures, as follows:

- Enter the sum of the deductible amounts (reason code PR 1) from the Medicare RA that correspond to the lines billed on the claim using code A1 in the *Value Codes and Amounts* field (Boxes 39 thru 41) of each claim.
- Enter the sum of the coinsurance amounts (reason codes PR 2 and PR 122) from the Medicare RA that correspond to the lines billed on the claim using code A2 in the *Value Codes and Amounts* field (Boxes 39 thru 41) of each claim.
- Enter "001" on line 23 in the *Revenue Code* field (Box 42), and the sum of the charges amounts from the Medicare RA that correspond to the lines billed on the claim in the *Total Charges* field (Box 47) of each claim.
- Enter the sum of the Medicare payment amounts from the Medicare RA that correspond to the lines billed on the claim in the *Prior Payments* field (Box 54) of the Medicare line of each claim.

Note: The amount entered on each split-billed claim is determined by the provider, but the sum of the amounts on each split-billed claim must equal the summary data on the Medicare RA.

- The following information must be entered in the *Remarks* field (Box 80) on each split-billed claim form:
  - On line A:
    - ❖ Enter "SPLIT-BILLED."
    - ❖ Enter the number of the claim (for example, "CLAIM 1 OF 2").
    - ❖ Enter "DEDUCTIBLE." Then enter the total deductible amount from value code A1 (Boxes 39 thru 41) from all claims or from the summary data on the Medicare RA.
  - On line B, enter the total amount from all claims in the following categories:
    - ❖ Enter "TOTAL CHARGE =." Then enter the total Medicare billed amount from line 23 of the *Total Charges* field (Box 47) or from the summary data on the Medicare RA.
    - ❖ Enter "MCARE PAID." Then enter the total amount from the "MEDICARE" line in the *Prior Payments* field (Box 54) from all claims or from the summary data on the Medicare RA.
    - ❖ Enter "COINS." Then enter the total coinsurance of value code A2 (Boxes 39 thru 41) <u>from all claims</u> or from the summary data on the Medicare RA.

- On lines C and D, enter the breakdown for each claim in the same categories as above:
  - ❖ Line C. Enter "CLAIM 1." Then enter the claim 1 amounts for total charges, total Medicare paid and coinsurance. Align the amounts under the corresponding amounts on line B.
  - ❖ Line D. Enter "CLAIM 2." Then enter the amounts only for total charges, total Medicare paid and coinsurance. Align the amounts under the corresponding amounts on lines B and C.
  - ❖ Use an attachment if additional space is required.

- A separate copy of the entire Medicare RA must be submitted with each *UB-04* claim. Indicate which detail lines of each Medicare RA correspond to the claims. (For example, bracket the appropriate detail lines and write "CLAIM 1 of 2" in the margin.) To simplify the process, detail lines with no patient responsibility (no deductible or coinsurance due) need not be included on the split bill to Medi-Cal.

Crossover Claims Inquiry Forms (CIFs)

CIF for All Crossover Claims

Refer to the *CIF Special Billing Instructions for Outpatient Services* section in this manual to complete a CIF for a Medicare/Medi-Cal crossover claim.

Note: Do not use a CIF to rebill a Charpentier claim. Refer to "Charpentier Rebilling" on a following page in this section.

Reimbursement for Beds and Mattresses

Claims for rentals of low air-loss/air-fluidized bed, nonpowered advanced pressure-reducing overlays or mattresses, or powered air overlays are paid by Medicare on a monthly basis. When claims for these cross over automatically to Medi-Cal, the crossover claim and *Explanation of Medicare Benefits* (EOMB)*/Medicare Remittance Notice* (MRN) reflect only one date of service and a quantity of one. Because Medi-Cal reimburses rental of these items on a daily basis, the crossover claims are processed for only one date of service, instead of one month. To request full reimbursement for these claims, providers must submit a CIF stating the actual "from-through" dates of service and the actual quantity in the *Remarks* area of the CIF.

‹‹**Reimbursement Codes for Beds and Mattresses Table**››

Durable Medical Equipment	HCPCS Code
Low air-loss/air-fluidized bed	E0193, E0194
Powered pressure-reducing air mattress	E0277
Powered air overlay	E0372
Nonpowered advanced pressure-reducing overlay or mattress	E0371, E0373

Charpentier Rebilling

Medi-Cal Reimbursement

A permanent injunction (Charpentier v. Belshé [Coye/Kizer]) filed December 29, 1994, allows providers to rebill Medi-Cal for supplemental payment for Medicare/Medi-Cal Part B services, excluding physician and laboratory services. This supplemental payment applies to crossover claims when Medi-Cal's allowed rates or quantity limitations exceed the Medicare allowed amount. Part A intermediaries do not use a fee schedule to determine allowed amounts for each service; therefore, this only applies to Part B services billed to Part B carriers. The following definitions apply to Charpentier rebills:

- Rates – The Medi-Cal allowed amount for the item or service exceeds the Medicare allowed amount.
- Benefit Limitation – The quantity of the item or service is cutback by Medicare due to a benefit limitation.
- Both Rates and Benefit Limitation – Both the Medi-Cal allowed amount for the item or service exceeds the Medicare allowed amount and the quantity of the item or service is cutback by Medicare due to a benefit limitation.

All Charpentier rebilled claims must have been first processed as Medicare/Medi-Cal crossover claims.

Cutback

If there is a price on file, claims will be cut back with Remittance Advice Details (RAD) code 444. The message for RAD code 444 reads, "For non-physician claims, see Charpentier billing instructions in the provider manual. Medi-Cal automated system payment does not exceed the Medicare allowed amount."

Medicare Allowed Amount

If there is no price on file, Medi-Cal adopts the Medicare allowed amount and a 444 cutback is not reflected on the RAD.

Exceeds Medicare's Allowed Amount

If Medi-Cal's rates and/or limitations are greater than that of Medicare, rebill the claim by following Charpentier billing instructions and attaching appropriate pricing documentation.

Note: A Charpentier rebill must not be combined with a crossover claim.

Where to Submit Charpentier Rebills

All Charpentier rebills must be mailed to the CA-MMIS FI at the following address:

California MMIS Fiscal Intermediary
P.O. Box 15700
Sacramento, CA 95852-1700

Submission Requirements

Providers must use the following submission requirements to be considered for supplemental payment under the Charpentier injunction.

- Providers must first bill Medicare and any Other Health Coverage (OHC) to which the recipient is entitled.
- The claim must then be billed as a crossover and approved by Medi-Cal.
  - The claim may cross over automatically from the Part B carrier, or
  - The crossover claim may be hard copy billed to Medi-Cal by the provider.
- After Medi-Cal processes the crossover claim, complete the *UB-04* claim according to the instructions in the *UB-04 Completion: Outpatient Services* section in this manual.
- In addition, complete the following *UB-04* fields for Charpentier rebills only.
  - *Condition Codes* (Boxes 18 thru 24). Select one of the following alpha-numeric characters that corresponds to the phrase entered in Box 80:
    - ❖ For Rates, enter "Z2"
    - ❖ For Benefit Limitation, enter "Z1"
    - ❖ For Both Rates and Benefit Limitation, enter "Z3"

- *Description* (Box 43).
  - ❖ If multiple claim lines were originally processed by Medicare and fewer claim lines are now being rebilled to Medi-Cal, indicate with an asterisk on the Medicare MRN the items or services that are being rebilled to Medi-Cal for Charpentier processing. Also indicate the claim line number that corresponds to the asterisk(s).
  - ❖ If a Medi-Cal HCPCS Level III code is used, indicate on the Medicare MRN (beside the line being rebilled) the Medi-Cal *UB-04* claim line number that corresponds to the Medicare procedure code.

    Note: Complete the claim using the HCPCS code that most closely reflects the items or services rendered and that most closely equates to the Medicare code originally billed to Medicare and to the code shown on the MRN. This certifies that the Medi-Cal code on the claim best reflects the item or service actually rendered to the recipient.
- *Prior Payments* (Box 54). Enter the sum of previous payments from Medicare, any other health insurance carriers and Medi-Cal (crossover claim payment).
- *Remarks* field (Box 80) or on an attachment to the claim. Select one of the following phrases, as previously defined:
  - ❖ For Rates, enter the words "Medi/Medi Charpentier: Rates"
  - ❖ For Benefit Limitation, enter the words "Medi/Medi Charpentier: Benefit Limitation"
  - ❖ For Both Rates and Benefit Limitation, enter the words "Medi/Medi Charpentier: Both Rates and Benefit Limitation"

- The following attachments are required for Charpentier rebilling:
  - A copy of the *CMS-1500* claim submitted to Medicare (An original or facsimile is acceptable.)
  - A copy of the corresponding Medicare MRN (printouts of electronic MRNs are acceptable.)
  - The Medi-Cal RAD showing the crossover payment
  - Proof of payment or denial from any other health insurance carriers, if applicable
  - *Treatment Authorization Request* (TAR), if applicable
  - Copy of manufacturer catalog page or invoice or any other required pricing documentation, if applicable

Billing Tips: Charpentier Rebills

The following billing tips will help prevent rejections, delays, mispayments and/or denials when rebilling Charpentier claims

- A Charpentier rebill must not be combined with a crossover claim.
- Use of Charpentier indicators ("Z1," "Z2" or "Z3") on claims that are not Charpentier claims will result in processing delays.
- Failure to place a Charpentier indicator ("Z1," "Z2" or "Z3") on a legitimate Charpentier claim prevents the system from recognizing the claim as a Charpentier rebill. This may result in processing delays or denial of the claim.
- Claims with incorrectly marked MRNs will be denied with RAD code 066 or 636.
- Obtain an approved *Treatment Authorization Request* (TAR) if a TAR would be required when billed as a Medi-Cal-only claim.
  - Providers are strongly advised to obtain an approved TAR prior to billing Medicare for all high-dollar Durable Medical Equipment (DME) items.
  - Enter the 11-digit TAR Control Number from the approved TAR in the *Treatment Authorization Codes* field (Box 63) on the claim.
  - See the *TAR Overview* section in the Part 1 manual for additional information.
- Providers are not required to submit a copy of the *Medicare Appeal and Decision* form when billing Medi-Cal for the difference between Medicare and Medi-Cal's allowed amount.

Billing for Medicare Non-Covered, Exhausted or Denied Services, or Medicare Non-Eligible Recipients

Medicare Reimbursement

Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare carrier or intermediary for processing of Medicare benefits. Medi-Cal recipients are considered Medicare-eligible if they are aged 65 years or older, blind or disabled, or if the Medi-Cal eligibility verification system indicates Medicare coverage. If Medicare approves the claim, it must then be billed to Medi-Cal as a crossover claim.

Straight Medi-Cal Claims

Providers must bill as a straight Medi-Cal claim if any of the following apply: the services are not covered by Medicare, Medicare benefits have been exhausted, Medicare has denied the claim, or the recipient is not eligible for Medicare. These are not crossover claims. For billing and timeliness instructions, refer to the *UB-04 Completion: Outpatient Services* and *UB-04 Submission and Timeliness Instructions* sections in this manual.

Note: Charpentier claims require Medicare status codes. However, in all other circumstances, these codes are optional; therefore, providers may leave the *Resubmission Code* field (Box 22) blank on the *CMS-1500* claim. Refer to the *CMS-1500 Completion* section in the appropriate Part 2 manual for a list of codes entered in Box 22.

Medicare Non-Covered Services

DHCS maintains a list of Medi-Cal codes that may be billed directly to the California MMIS Fiscal Intermediary as straight Medi-Cal claims for Medicare/Medi-Cal recipients. Do not send these claims to the Crossover Unit.

All services or supplies on a straight Medi-Cal claim must be included in the *Medicare Non-Covered/Covered Services Charts* for direct billing. If a service or supply is not included in the chart, submit the corresponding Medicare MRN showing the services or supplies that are not allowed by Medicare when billing Medi-Cal. Refer to the *Medicare Non-Covered Services: CPT® Codes* and *Medicare Non-Covered Services: HCPCS Codes* sections in the appropriate Part 2 manual for additional instructions.

Claim Completion

To bill such claims, enter a “Y8” in the *Condition Codes* field (Boxes 18 thru 24) of the claim, and attach the appropriate documentation.

Medicare Exhausted Services

Physical therapy and occupational therapy for Medi-Cal patients with Medicare coverage must be billed to the appropriate Medicare carrier or intermediary. After Medicare benefits for physical and occupational therapy have been exhausted, providers may bill Medi-Cal directly and must include a copy of the Medicare MRN/RA that shows the benefits are exhausted.

Adjustment for Underpaid Claim: Benefits Exhausted Prior to Completion of Services

When a patient's physical or occupational therapy Medicare benefits end in the middle of a service, a provider may be underpaid by Medi-Cal. To request adjustment on a claim payment for this reason only, follow these steps:

- Complete an *Appeal Form* (90-1) requesting adjustment of the Medi-Cal claim that included the exhausted Medicare physical or occupational therapy benefits. Refer to the *Appeal Form Completion* section in this manual.
- Attach the following documentation:
  - Copy of the Medicare claim
  - Medicare MRN/RA for the claim on which benefits became exhausted
  - Medi-Cal RAD showing warrant number, warrant date and the underpayment for the exhausted service (if any)
  - A completed *UB-04* claim listing all procedure codes of the claim on which benefits became exhausted, with the usual and customary charge for these services and any other required information such as quantity, facility type and diagnosis
- To bill such claims, enter a "Y1" in the *Condition Codes* field (Boxes 18 thru 24) of the claim, and attach the appropriate documentation.

Where to Submit Documentation

Send the above documentation to the CA-MMIS FI at the following address:

Attn: Appeals Unit
California MMIS Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

Adjustment for Underpaid Claim: Services Rendered After Benefits Exhausted

The instructions for filing these special adjustments do not affect instructions for services rendered after the Medicare benefits have been exhausted. These claims must be billed directly to Medi-Cal on a *UB-04* claim, including a copy of the Medicare MRN/RA, that shows the benefits that are exhausted.

If a service or supply exceeds Medicare's limitations, supporting documentation must be included with the claim. Refer to "Charpentier Rebilling" in this section.

Medicare Denied Services

Medicare denied services should be billed as straight Medi-Cal claims.

Note: If a claim has been adjudicated as a crossover and any of the service lines reflected on the RAD have a RAD code 395, they must be billed on a straight Medi-Cal claim. However, because providers have the denial from Medicare on their MRN/RA, they do not have to see the crossover claim reflected on the RAD with RAD code 395 before billing the Medicare denied services to Medi-Cal.

To bill for Medicare denied services, follow these steps:

- Submit an original *UB-04* claim
  - Complete the claim according to instructions in the *UB-04 Completion: Outpatient Services* section in this manual.
  - Do not include any Medicare approved services on the claim. The Medicare approved services must be billed separately as a crossover claim.
- Attach a copy of the Medicare MRN/RA indicating the denial.
  - If the Medicare denial description is not printed on the front of the Medicare MRN/RA, include a copy of the description from the back of the MRN/RA or the Medicare manual.
- Attach a copy of any Other Health Coverage EOB/RA or denial letter if the recipient has cost-avoided Other Health Coverage through any private insurance (refer to the *Other Health Coverage (OHC) Guidelines for Billing* section in the Part 1 manual).
- Do not send these claims to the Crossover Unit.
- To bill such claims, enter a "Y7" in the *Condition Codes* field (Boxes 18 thru 24) of the claim and attach the appropriate documentation.

<u>Services Denied When Included in Medicare's Surgical Fee, or Not Separately Payable</u>

Medi-Cal does not pay for an office visit when Medicare has denied payment because the visit was included in the surgical fee. The surgical fee covers reimbursement of office visits on the same day that surgery is performed and during the follow-up period of the surgical procedure. In addition, Medi-Cal does not pay for services denied by Medicare because the procedure is a component part of a group of services. Medi-Cal will deny these claims with RAD code 027: "Services denied by Medicare (included in surgical fee, incidental, or not separately payable) are not payable by Medi-Cal."

Billing Tips: Medicare Non-Covered, Exhausted or Denied Services

The following billing tips will help prevent rejections, delays, mispayments and/or denials of claims for Medicare non-covered, exhausted or denied services:

- A single claim form cannot be used when billing for the combination of Medicare-approved or covered services and Medicare non-covered, exhausted or denied services appearing on the same MRN/RA.
- Medicare-approved/covered services must be billed as crossover claims according to the instructions in "Hard Copy Submission Requirements of Medicare Approved Services" in this section.
- Medicare non-covered, exhausted or denied services must be billed as straight Medi-Cal claims. Use the *UB-04* claim and attach a copy of the Medicare MRN/RA for the exhausted or denied services.

  Exception: Refer to the *Medicare Non-Covered Services: CPT® Codes* and *Medicare Non-Covered Services: HCPCS Codes* sections in the appropriate Part 2 manual for services that do not require an MRN/RA.
- If a Medicare denial description(s) is not printed on the front of an MRN/RA that shows a Medicare denied service(s), providers must copy the Medicare denial description(s) from the back of the original MRN/RA or from the Medicare manual and submit it to Medi-Cal along with their bill for the Medicare denied service(s). This applies to any service(s) denied by Medicare for any reason.
- When billing Medicare non-covered, exhausted or denied services for a recipient who has Other Health Coverage (OHC) through any private insurance, the provider must also bill the OHC before billing Medi-Cal (refer to the *Other Health Coverage (OHC)* and *Other Health Coverage (OHC): CPT® and HCPCS Codes* sections in this manual). MRN/EOB/RAs from both must accompany the Medi-Cal claim.
- Since Medicare non-covered, exhausted or denied services are billed as straight Medi-Cal claims, the provider must obtain a *Treatment Authorization Request* (TAR) if the service normally requires prior authorization.

Note: For timeliness requirements, refer to "Delay Reasons" in the *UB-04 Submission and Timeliness Instructions* section of this manual.

Medicare Non-Eligible Recipients

DHCS requires that providers submit formal documentation indicating the recipient is not eligible for Medicare when billing Medi-Cal for the following recipients:

- ‹‹Recipients who are 65 years or older (for example, those with non-citizen status)››
- Recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage

To bill such claims, enter a "Y6" in the *Condition Codes* field (Boxes 18 thru 24) of the claim, and attach the appropriate documentation. Official documentation from the Social Security Administration (SSA) is acceptable as proof that a recipient is not eligible for Medicare. A statement or certification by the provider or the recipient is not acceptable. (See "Medicare Documentation Requirements" in this section for examples of acceptable/non-acceptable Medicare documentation.)

Medicare Documentation Requirements

Providers must submit Medicare payment or denial documentation with their claims for all Medi-Cal recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage.

Claims either with no documentation or with insufficient or unacceptable Medicare documentation will be denied.

Acceptable Medicare Documentation

Examples of acceptable Medicare documentation include:

- Health insurance (Medicare) card indicating Part A or Part B benefits after the date of service billed
- Any document signed, dated and stamped by an SSA District Office, or any documentation on SSA or Department of Health and Human Services letterhead:
  - Valid for dates of service up to the end of the month of the date on the document, or the date of entitlement

    Note: Handwritten statements are acceptable if they bear an SSA stamp and contain the specific date criteria mentioned above.
- "Third-Party Query Confidential" computer printouts:
  - If the printout says "Not in File as of XX/XX/XX," it can be accepted for dates of service up to the date printed
  - Common Working File (CWF) printout
- Screen printout of electronic *Medicare Remittance Notice* (MRN):
  - Date of MRN
  - Carrier name (this field may be handwritten or typed)
  - Provider name
  - Patient last name or Medicare ID number
  - Service date

- Billed/charge/submitted
- Procedure code
- Allowed
- Deductible
- Coinsurance
- Provider paid/pay provider

- Screen printout of electronic *Medicare Remittance Advice* (RA):
  - Date of RA
  - Intermediary name (this field may be handwritten or typed)
  - Provider name
  - Patient last name or Medicare ID number
  - "From-through" dates
  - Billed/total/submitted charges
  - Deductible and/or coinsurance amount(s)
  - Non-covered/non-allowed charges (if applicable)
  - Denial reason/reason code (Medicare denied claims only, not crossovers.
  - Type of Bill (TOB)/Type claim/Claim type/Bill type (such as inpatient, outpatient and Nursing Facilities Level B [NF-Bs])

Note: For all RAs showing a Medicare denial, if the Medicare denial description is not printed on the front of the RA, providers must include a separate copy of the Medicare denial description (from the back of the original RA or from the Medicare manual) when billing for a Medicare denied claim.

Non-Acceptable Medicare Documentation

Examples of non-acceptable Medicare documentation include:

- Medicare Eligibility Certification Forms completed by the recipient or any statement from the recipient
- Forms indicating that the recipient's name and SSN do not match or are incorrect
- ‹‹Permanent Resident or "Green" Cards››
- Statements from the provider and/or recipient regarding the recipient's Medicare eligibility
- Documents not dated
- Medicare claim denials due to incomplete, unacceptable or inappropriate information from the provider or recipient
- Medicare denials stating that the claim should be resubmitted to Medicare

‹‹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.