
Medicare/Medi-Cal Crossover Claims: Vision Care

Page updated: September 2020

This section contains billing information, billing tips and Medicare documentation requirements for Medicare/Medi-Cal crossover claims submitted for vision care services on a *CMS-1500* claim. Refer to the *CMS-1500 Completion for Vision Care* section in this manual for instructions to complete claim fields not explained in the following examples.

Note: Claims for Medicare non-covered or denied services, Medicare non-eligible recipients, or Charpentier rebills are not crossovers. Providers must follow the instructions in this section for billing straight Medi-Cal claims on the *CMS-1500* 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: Vision Care Billing Examples* and *Medicare/Medi-Cal Crossover Claims: Vision Care Medi-Cal Pricing Examples* sections in this manual. Information in this section is organized as follows:

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

Hard Copy Submission Requirements For 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

Providers must bill for Medicare approved or covered vision care services on a *CMS-1500* claim.

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
 - Original
 - Clear photocopy of the claim submitted to Medicare
 - Facsimile (same format as *CMS-1500* and background must be visible)
- *CMS-1500* 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): CMS-1500* section in the Part 2 manual, *Medical Services for General Medicine*.) *Insurance Plan Name or Program Name* (Box 11C). Enter your Medicare carrier code.

Note: Providers may refer to their Medicare Remittance Notice (MRN) for the carrier code to enter in this field

- *Signature of Physician or Supplier* field (Box 31). Enter the Medi-Cal provider identification number.

Box 31 is required when an NPI is not used in Box 33A and an identification number other than the NPI is necessary for the receiver to identify the provider.

- *Service Facility Location Information* field (Box 32). A nine-digit ZIP code is encouraged when completing this field. Enter the NPI in Box 32A.
- *Billing Provider Info and Phone Number* field (Box 33). A nine-digit ZIP code is encouraged when completing this field. Enter the NPI in Box 33A.

Note: The nine-digit ZIP code entered in this box must match billing provider’s nine-digit ZIP code on file for claims to be reimbursed correctly.

- Copy of the corresponding *Medicare Remittance Notice* (MRN) for each crossover claim (see *Figures 1a* and *1b* in the *Medicare/Medi-Cal Crossover Claims: Vision Care Billing Examples* section of this manual.)
 - Must be complete, unaltered and legible
 - The following fields on the MRN must match the corresponding fields on the *CMS-1500*:
 - ❖ Date(s) of service (“from-through” dates)
 - ❖ 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 code
 - ❖ 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 (See “Billing Limit Exceptions” in the *CMS-1500 Submission and Timeliness Instructions* section in this manual).

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

The following billing tips will help prevent rejections, delays, erroneous payments and/or denials of crossover claims for Part B services billed to Part B Medicare Administrative Contractors (MACs) on a *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 1-inch of the claim form.
- A separate copy of the *Medicare Remittance Notice* (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 MRN) 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 or Denied Services, or Medicare Non-Eligible Recipients” on a following page in this section.
- If multiple provider numbers are entered in the *Signature of Physician or Supplier* field (Box 31), underline the provider number to which payment should be issued.
- Enter the recipient ID number in the *Other Insured’s Policy or Group Number* field (Box 9A).
- If the recipient has Other Health Coverage (OHC), submit a copy of the Remittance Advice or denial letter from the insurance carrier.
- 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 Vision Care* section of this manual.

Crossover Claims Inquiry Forms (CIFs)

CIF for all Crossover Claims

Refer to the *CIF Special Billing Instructions for Vision Care* 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.

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 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 a *CMS-1500* claim according to the instructions in the *CMS-1500 Completion for Vision Care* section of this manual.
- In addition, complete the following *CMS-1500* fields for Charpentier rebills only:
 - *Is There Another Health Benefit Plan?* field (Box 11D). Enter the sum of previous payments from Medicare, Medi-Cal (crossover claim payment) and any Other Health Coverage (OHC).
 - *Additional Claim Information* field (Box 19). 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”
 - *Resubmission Code/Original Ref. No.* field (Box 22). Select one of the following letters that corresponds to the phrase entered in Box 19:
 - ❖ For Rates, enter the letter “R”
 - ❖ For Benefit Limitation, enter the letter “L”
 - ❖ For Both Rates and Benefit Limitation, enter the letter “T”
 - *Procedures, Services, or Supplies/Modifiers* field (Box 24D)
 - ❖ 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).

- The following attachments are required for Charpentier rebilling:
 - A copy of the *CMS-1500* 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, erroneous payments and/or denials when rebilling Charpentier claims:

- A Charpentier rebill must not be combined with a crossover claim.
- Use of Charpentier indicators (“R,” “L” or “T”) on claims that are not Charpentier claims will result in processing delays.
- Failure to place a Charpentier indicator (“R,” “L” or “T”) 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 (the reimbursement information on the claim does not equal the Medicare coinsurance and deductible amounts indicated on the invoice) or 636 (Medi/Medi-Charpentier claim does not meet submission requirements).
- 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 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 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 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 *CMS-1500 Completion for Vision Care* and *CMS-1500 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/Original Ref. No.* field (Box 22) blank on the *CMS-1500* claim. Refer to the *CMS-1500 Completion for Vision Care* section in this manual for a list of codes entered in Box 22.

Medicare Non-Covered Services

The Department of Health Care 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 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 this manual for additional instructions.

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 (This is a Medicare non-covered benefit), they must be billed on a straight Medi-Cal claim. However, because providers have the denial from Medicare on their MRN, 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 the procedures below:

- Submit an original *CMS-1500* claim.
 - Complete the claim according to instructions in the *CMS-1500 Completion for Vision Care* section of 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 indicating the denial.

- If the Medicare denial description is not printed on the front of the Medicare MRN, include a copy of the description from the back of the MRN or the Medicare manual.
- Attach a copy of any Other Health Coverage EOB or denial letter if the recipient has cost-avoided OHC 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.

Billing Tips: Medicare Non-Covered or Denied Services

The following billing tips will help prevent rejections, delays, erroneous payments and/or denials of claims for Medicare non-covered 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 or denied services appearing on the same MRN.
- Medicare-approved/covered services must be billed as crossover claims according to the instructions in “Hard Copy Submission Requirements for Medicare Approved Services” in this section.
- Medicare non-covered or denied services must be billed as straight Medi-Cal claims. Use the *CMS-1500* and attach a copy of the Medicare MRN for the denied services.

Exception: Refer to the *Medicare Non-Covered Services: CPT® Codes* and *Medicare Non-Covered Services: HCPCS Codes* sections in this manual for services that do not require an MRN.

- If a Medicare denial description(s) is not printed on the front of an MRN that shows a Medicare denied service(s), providers must copy the Medicare denial description(s) from the back of the original MRN 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 or denied services for a recipient who has OHC through any private insurance, the provider must also bill the OHC before billing Medi-Cal (refer to the *Other Health Coverage [OHC]* section in this manual). MRNs/EOBs from Medicare and the OHC must accompany the Medi-Cal claim.

- Because Medicare non-covered or denied services are billed as straight Medi-Cal claims, providers must obtain authorization on the 50-3 *Treatment Authorization Request* (TAR) form for any service that normally requires authorization from Medi-Cal. Refer to the *TAR Completion for Vision Care* section of this manual for instructions about how to obtain authorization.

Note: For timeliness requirements, refer to “Billing Limit Exceptions” in the *CMS-1500 Submission and Timeliness Instructions* section in this manual.

Medicare Non-Eligible Recipients

DHCS requires providers to submit formal documentation indicating a 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

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.

<<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.