Crossover Claims

Introduction

Purpose

The purpose of this module is to familiarize participants with the Medi-Cal claim process for recipients who are eligible for both Medicare and Medi-Cal.

Module Objectives

- Identify the components of Medicare/Medi-Cal crossover claims
- Identify the different types of Medicare eligibility (Scope of Coverage)
- Define Qualified Medicare Beneficiary (QMB), aid code 80
- Discuss crossover claim reimbursement and “zero pay” crossovers
- Understand billing for Medicare non-covered services, exhausted services and non-eligible recipients
- Discuss automatic crossover billing procedures and billing tips for specific claim types
- Review crossover completion requirements for inpatient, outpatient, medical and allied health claims
- Discuss crossover claims follow-up and *Claims Inquiry Form* (CIF)
- Review common remittance advice details (RAD) codes and payment examples of Medicare/Medi-Cal claims
- Provide an overview of Charpentier claims

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Page updated: September 2020

Crossover Claim Description

Some Medi-Cal recipients are eligible for services under the federal Medicare program. For most services rendered, Medicare requires a deductible and/or coinsurance that, in some instances, is paid by Medi-Cal. A claim billed to Medi-Cal for the Medicare deductible and/or coinsurance is called a crossover claim. This type of claim has been approved or paid by Medicare.

Medi-Cal recipients may be Medicare-eligible if they are 65 years or older, blind, disabled have end stage renal disease or if the Medi-Cal eligibility verification system indicates Medicare coverage.

Medicare/Medi-Cal Crossover Claim Terminology

- **Crossover:** A claim billed to Medi-Cal for the Medicare deductible and/or coinsurance is called a crossover claim. This type of claim has been approved or paid by Medicare.
- **Deductible:** The dollar amount Medicare recipients must pay for Part A or Part B services prior to receiving Medicare benefits.
- **Coinsurance:** The remaining balance of the Medicare Allowed Amount after a Medicare payment.
- **Co-payments:** The amount required by Medicare Part C or D when services are rendered or drugs are purchased. (Providers may choose to waive these co-payments or may deny service if a recipient cannot pay this amount. Medi-Cal does not generally pay for co-payments.)
- **Medicare Beneficiary Identifier (MBI):** The Medicare recipient’s identification number.

Medicare Health Care Benefits

Scope of Coverage

Medicare divides its services into specific classifications: Part A, Part B, Part C and Part D. Recipients may be covered for Part A only, Part B only, Part D only or a combination of services.

Service Type	Description
Part A	Inpatient Hospital Services, Skilled Nursing Facility Services, Hospice, and Home Health Care
Part B	Outpatient Hospital Services, Physician Services, and Home Health (if recipient is Part B eligible only)
Part C	Medicare Advantage Plans (MSA/PFFS/SNP/HMO/PPO – not crossover claims)
Part D	Prescription drugs not covered by Parts A, B or C (not crossover claims)

For a more extensive and current list of Medicare-covered services, refer to the annual *Medicare & You* publication available online at (*www.medicare.gov*).

Part A – Inpatient Services

Medicare provides coverage for inpatient hospital services, skilled nursing facility services, hospice and home health care services under Part A. These services are reflected on the Medicare *Remittance Advice* (RA).

Note: If a recipient does not have Part A coverage, the Medicare Part A contractor will pay for the services otherwise covered by Part B from funds held in trust for this purpose.

Providers must bill straight Medi-Cal for inpatient Part B-only type of claims because Medi-Cal does not process these as crossover claims. For inpatient Part B-only services, bill as straight Medi-Cal on the *UB-04* claim form showing the Medicare Part B payment as Other Health Coverage (OHC). Refer to the appropriate Part 2 provider manual for billing instructions.

Part B – Outpatient and Professional Services

Medicare provides coverage for medically necessary, professional services and some preventive outpatient services under Part B eligibility. Outpatient claims (Part B services billed to Part A contractors) are reflected on the *Medicare National Standard Intermediary Remittance Advice* (MNSIRA). Providers are required to submit hard copy outpatient crossover claims with the Medicare electronic *Remittance Advice* (RA) information formatted in the MNSIRA. PC-Print Software is used to access and print the Medicare electronic RA in this format. The software is free and available through the Medicare Part A contractors. Part B (outpatient services) billed to Part B (contractors) medical claims are reflected on the *Medicare Remittance Notice* (MRN).

Part C – Medicare Advantage Plans

A Medicare recipient may choose to join a Medicare Advantage Plan (MSA/PFFS/SNP/HMO/PPO) rather than receive Medicare benefits under Part A or Part B fee-for-service Medicare. These claims do not cross over and must be billed as OHC. Refer to the appropriate Part 2 provider manual for billing instructions.

Part D – Prescription Drugs

Medicare Part D provides coverage for prescription drug benefits that would otherwise not be covered by Part A, B or C. Providers supplying drugs to Medicare Part D-eligible recipients should file claims with the Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug (MAPD) plan in which the recipient is enrolled.

Six categories of drugs and supplies will continue to be covered by Medi-Cal:

Category	Description
1 - Weight control	Anorexia, weight loss or weight gain
4 - Coughs and colds	Symptomatic relief
5 - Prescription vitamins and minerals	Select single vitamins and minerals pursuant to *Treatment Authorization Request* (TAR) or utilization restrictions. Combination vitamin and mineral products are not a benefit. Vitamins or minerals used for dietary supplementation are not a benefit.
6 - Non-prescription drugs	Part D, not Medi-Cal; covers insulin, syringes and smoking cessation products
11 - Line Flushes	Clearing of IV lines and tubes, premixed solutions
12 - Less-than-effective Drug Efficacy Study Implementation (LTE DESI) drugs	Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.

Medical Supplies

Most medical supplies are not covered by Medicare and can be billed directly to

Medi-Cal. However, medical supplies listed under the “Medicare Covered Services” heading in the *Medical Supplies* (mc sup) section of the Part 2 provider manual are covered by Medicare. These supplies must be billed to Medicare prior to billing Medi-Cal.

Medicare/Medi-Cal Crossover Claim Policies

Recipient Coverage

Eligibility

The Medi-Cal eligibility verification system indicates a recipient's Medicare coverage. Recipients may be covered for Part A only, Part B only, Part D only or any combination of coverage. One of the following messages will be returned if a recipient has Medicare coverage:

Type of Coverage	Medicare Coverage Message
Part A	Subscriber has Part A Medicare coverage with Medicare Beneficiary Identifier (MBI) _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Part B	Subscriber has Part B Medicare coverage with MBI Number _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Parts A and B	Subscriber has Parts A and Part B Medicare coverage with MBI Number _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Parts A and D	Subscriber has Parts A and D Medicare coverage with MBI Number _____. Medicare Part A-covered services must be billed to Medicare before billing Medi-Cal.
Parts B and D	Subscriber has Parts B and D Medicare coverage with MBI Number _____. Medicare Part B-covered services must be billed to Medicare before billing Medi-Cal.
Parts A, B and D	Subscriber has Parts A, B and D Medicare coverage with MBI
Part D	Subscriber has Part D Medicare coverage with MBI number _____. Medicare Part D covered drugs need to be billed to Medicare carrier before billing Medi-Cal. Carrier name: _____, Cov: R.

Limited Income Recipient – QMB

A Qualified Medicare Beneficiary (QMB), identified with Medi-Cal aid code 80 only, is a Medicare recipient who has limited income and resources. Under this program, Medi-Cal pays only for Medicare premiums, deductibles and coinsurance, within Medi-Cal guidelines.

The following message is returned from the Medi-Cal eligibility verification system when inquiring about eligibility for a QMB with aid code 80 only:

> Medi-Cal Eligibility Limited to Medicare Coinsurance, Deductibles.
> Part A, B Medicare Coverage With MBI #_____.
> Bill Medicare Before Medi-Cal.

As with other crossover claims, Medi-Cal pays coinsurance and/or deductibles for both Medicare Part A and Part B services on crossover claims for aid code 80 only QMBs. Medi-Cal payment, combined with the Medicare payment, will not exceed the lower of either the Medicare or Medi-Cal allowed amount. Straight Medi-Cal claims submitted for Medicare denied and non-covered services for aid code 80 only QMBs will be denied.

Medi-Cal Crossover Claim Reimbursement

Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare Administrative Contractor (MAC) for processing of Medicare benefits. If Medicare approves the claim, it must then be billed to Medi-Cal as a crossover claim. California law limits Medi-Cal's reimbursement of coinsurance and deductibles billed on a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum-allowed amount for similar services.

Zero Pay Crossovers

If a Part B claim is submitted to a Medicare Part B contractor and payment is made by Medicare, the claim automatically crosses over to Medi-Cal. If, within three weeks from the *Medicare Remittance Notice* (MRN) date, the automatic crossover claim does not appear on the Medi-Cal RAD, it may be a "zero pay" claim. Zero pay claims occur when Medicare has already paid more than the Medi-Cal maximum allowance. A zero pay claim will not appear on RADs or EOBs.

Part B claims submitted to a Medicare Part A contractor that are subsequently received and zero paid by Medi-Cal will appear on RADs.

If an automatic crossover claim results in a zero pay (no Medi-Cal payment), but the provider needs the claim to appear on the RAD, the provider must rebill Medi-Cal. Providers must also rebill Medi-Cal if they cannot locate the claim.

Note: Crossover claims do not require a *Treatment Authorization Request* (TAR). Straight Medi-Cal claims for Medicare denied or non-covered services may require a TAR.

Share of Cost

Providers should bill recipients for Medi-Cal Share of Cost (SOC) when applicable. Providers are strongly advised to wait until they receive the Medicare payment before collecting SOC to avoid collecting amounts greater than the Medicare deductible and/or coinsurance. Automatic crossover claims for Medi-Cal recipients with an unmet Share of Cost will deny on the Medi-Cal *Remittance Advice Details* (RAD) with RAD code **0314: Recipient is not eligible for the month of service billed.** Providers should re-bill these claims to Medi-Cal showing the amount of the SOC collected. This amount may not be more than the coinsurance and/or deductible billed on the claim.

Medicare/Medi-Cal Crossover Claim Billing

Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare Administrative Contractor (MAC). If Medicare approves the claim, it must then be billed to Medi-Cal as a crossover claim. However, providers must bill a straight Medi-Cal claim if the services are not covered by Medicare, Medicare benefits have been exhausted, or the claim has been denied.

Crossover Claim Procedures

Automatically Billed Crossover Claims

Medicare providers bill Medicare for crossover claims in one of the following ways:

- Part A services billed to Part A contractors
- Part B services billed to Part A contractors
- Part B services billed to Part B contractors

Medicare Contractors

Most Medicare-approved Part A and Part B services billed to Medicare contractors can cross over to Medi-Cal automatically. Medicare uses a consolidated Coordination of Benefits Contractor (COBC) automatically transmit claims to Medi-Cal that were billed to Part A and Part B contractors for Medicare/Medi-Cal-eligible recipients.

The Medicare COBC uses eligibility information to identify Medi-Cal crossover claims. DHCS updates this information monthly. It is not necessary to include Medi-Cal provider or recipient identification numbers on claims sent to Medicare.

Make sure the National Provider Identifier (NPI) used on your Medicare claims is registered with Medi-Cal.

Direct Billed Claims

Most Medicare-approved Part A and Part B services billed to the Medicare Administrative Contractor (MAC) will cross over to Medi-Cal automatically. Claims that do not automatically cross over to Medi-Cal may be submitted as crossover claims.

The following claims may not cross over electronically and must be billed directly to Medi-Cal:

- Claims for recipients with Other Health Coverage (OHC), particular Health Care Plans or Managed Care coverage (may be submitted as straight Medi-Cal claims only)
- Unassigned claims
- Medicare 100 percent paid or 100 percent denied claims (denied claims may be submitted as straight Medi-Cal claims only)
- Claims for which Medi-Cal does not have a provider record for the NPI used on the original Medicare claim. (This can happen if the NPI used for Medicare claims is not the same as the NPI registered with Medi-Cal.)
- Claims that Medicare indicates were automatically crossed over to Medi-Cal but do not appear on a Medi-Cal *Remittance Advice Details* (RAD) within four to six weeks from the MNSIRA or MRN date, or that cannot be located in the system (Part B “zero pay” claims)

Note: 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. Refer to *Medicare/Medi-Cal Crossover Claims* in the appropriate Part 2 provider manual for specific billing instructions.

Non-Crossover Claim Procedures

Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare Administrative Contractor for processing of Medicare benefits.

The following situations are not crossovers and must be billed as straight Medi-Cal:

- Medicare non-covered service
- Medicare denied services
- Medicare exhausted services
- Medicare non-eligible recipient
- Medicare Health Maintenance Organization (HMO) recipient
- Inpatient claims for recipients not covered by Part A (inpatient services for recipients with Part B-only eligibility)

Medicare Non-Covered Service

DHCS maintains a list of Medicare non-covered services that may be billed directly to the California MMIS Fiscal Intermediary (FI) 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 to Medi-Cal without any Medicare payment or denial documentation. If a service or supply is not included in the chart, but was not covered by Medicare, submit the claim with the corresponding MNSIRA or MRN showing the non-covered services or supplies.

Note: Medicare non-covered services are available in the following sections of the Part 2 provider manual: *Medicare Non-Covered Services: CPT-4 Codes* (medi non cpt) and *Medicare Non-Covered Services: HCPCS Codes* (medi non hcp).

Medicare Denied Service

Medicare-denied services may only be billed as straight Medi-Cal claims with the MNSIRA attached showing the denial. When billed on a crossover claim, Medicare denied services will not be paid by Medi-Cal and may be reflected on the Medi-Cal RAD with a RAD code **0395: This is a Medicare non-covered benefit.**

Note: Providers do not need to see the crossover claim rejected on the Medi-Cal RAD with RAD denial 0395, before billing the denied Medicare denied services to Medi-Cal.

Part 2 provider manual: *Medicare/Medi-Cal Crossover Claims: Outpatient Services* (medi crr op)

Medicare Exhausted Service

If a service or supply exceeds Medicare's limitations, supporting documentation must be included with the straight Medi-Cal claim. Physical therapy and occupational therapy for Medi-Cal patients with Medicare coverage must be billed to Medicare first. After Medicare benefits for physical and occupational therapy have been exhausted, providers may bill Medi-Cal directly (claim must include a copy of the MNSIRA or MRN that shows the benefits are exhausted).

Medicare Non-Eligible Recipients

Providers must submit formal documentation that indicates a recipient is <u>not</u> eligible for Medicare when billing straight Medi-Cal for the following recipients:

- Recipients who are 65 years or older
- Recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage

Claims submitted without documentation, or with insufficient Medicare documentation for recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage, will be denied.

Acceptable documentation for Medicare non-eligible recipients includes the following:

Document Type	Conditions
Medicare Card	Showing eligibility start date after date of service (DOS)
Document signed, dated and stamped by Social Security Administration (SSA) or any documentation on SSA or Department of Health and Human Services (HHS) letterhead	• The document is valid only for dates of service up to the end of the month of the date on the document, or the date of entitlement. • Handwritten statements are acceptable if they bear an SSA stamp and contain the specific date criteria mentioned above.
Common Working File (CWF) printout or 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.

Other Health Coverage – HMO

Medi-Cal recipients who receive benefits from a Medicare-contracted Health Maintenance Organization (HMO) are identified with Other Health Coverage (OHC) code "F." Medi-Cal recipients who also have Medicare HMO coverage must seek medical treatment through the HMO. Neither the HMO nor Medi-Cal pays for services rendered by non-HMO providers.

Exception: HMO plans often cover required emergency care until the patient's condition permits transfer to the HMO's facilities. Providers should contact the HMO for emergency treatment authorization and billing instructions.

Straight Medi-Cal claims may be submitted for services not covered by the Medicare HMO plan. Claims must be accompanied by an HMO denial letter or *Explanation of Benefits* (EOB) documenting that the Medicare HMO does not cover the service.

Billing Tips – Medicare Non-covered, Denied and Exhausted Services

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

- Bill as straight Medi-Cal claims. Use the *CMS 1500* or *UB-04* claim forms.
- Attach a copy of the MNSIRA or MRN.
- Obtain a TAR if the service normally requires authorization.
- For a Medicare recipient who also has OHC, bill the OHC before billing Medi-Cal.
- Ensure the MNSIRA/MRN shows the reason for denial. If a Medicare denial description is not printed on the front of an MNSIRA/MRN that shows a Medicare-denied service, copy the Medicare denial description from the back of the original MNSIRA/MRN, or from the Medicare manual, and submit it to Medi-Cal with the claim. This applies to any service denied by Medicare for any reason.
- For MNSIRAs/MRNs showing both Medicare approved and non-approved services, only include non-approved services on the straight Medi-Cal claim.

Notes:

Crossover Claim Submission

Timeliness

Providers have 12 months from the month of service and 60 days from the Medicare Remittance Advice (RA) date to submit a crossover claim to Medi-Cal.

Note: Claims received beyond the timeliness guidelines will require a delay reason code in order to receive full reimbursement

Mailing Instructions

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 and are rejected, may be billed directly to Medi-Cal (electronically or by hard copy). Providers must submit hard copy crossover claims to the FI:

Inpatient Only
California MMIS Fiscal Intermediary
P.O. Box 15500
Sacramento, CA 95852-1500

All Other Provider Types
California MMIS Fiscal Intermediary
P.O. Box 15700
Sacramento, CA 95852-1700

Hard Copy Submission Requirements

Inpatient Services

Part A Services Billed to Part A Contractor

For detailed hard copy billing instructions, refer to the Part 2 provider manual *UB-04 Completion: Inpatient Services* section (ub comp ip) and Part 2: *Medicare/Medi-Cal Crossover Claims: Inpatient Services* section (medi cr ip)

Follow these instructions to bill for services rendered:

Box Number	Form Fields	Instructions
4	Type of Bill	First two digits must be 11 or 18 and values must match the Medicare RA. If first two digits are 12, bill as straight Medi-Cal with other health coverage.
6	From-Through Dates of Service	From-through dates of service must match the Medicare RA.
8b	Patient Name	Patient name must match the Medicare RA.
31	Occurrence Codes & Dates	List the date of the MNSIRA (MMDDYY) with code 50.
39 thru 41 A thru D	Value Codes and Amounts	• Blood Deductible: Enter code 06 and the Medicare blood deductible amount. Leave blank if not applicable. • Patient's SOC: Enter code 23 and the patients' SOC 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.
42	Revenue Code	The Revenue Code must display "001" in column 42, line 23.

Part A Services Billed to Part A Contractor (continued)

Box Number	Form Fields	Instructions
47	Total Charges Amount	The Total Charges and amount must match the Medicare RA in column 42, line 23.
50	Payer Name	Payers must be listed in the following order of payment: • OHC, if applicable, except Medicare supplemental insurance • Medicare • Medicare supplemental insurance (if applicable) • Medi-Cal Inpatient Services (IP)
51	Health Plan ID	Enter the Medicare contractor ID.
54 A thru C	Prior Payments	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 must match the MNSIRA ALLOW/REIMB amount not the NET REIMB AMT.
55	Est. Amount Due	On the corresponding Medicare line, enter the same total charges amount as in Box 47, line 23.
56	NPI	Submit an original *UB-04* claim form using the provider NPI in effect appropriate for the date of service on the claim
57 A thru C	Other Billing Provider ID	This field is not required, but can be used for legacy provider ID numbers and atypical providers who do not have an NPI to report (Box 56).
60 A thru C	Insured's Unique ID	Enter the beneficiaries MBI number on the line that corresponds to the Medicare payer line in Box 50. Enter the Medi-Cal BIC ID number on the line that corresponds to the Medi-Cal IP payer line in Box 50.
76, 77, 78, 79	Attending, Operating, & Other	Enter appropriate provider NPI.

Note: In Box 55, on the corresponding Medi-Cal IP line, list the *Amount Due* by calculating the difference between these items:

Calculation

SUM (Blood deductible + Medicare deductible + Medicare coinsurance)

– SUM (SOC, OHC, Medicare supplemental insurance payments)

= Amount Due

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL # 12345

b. MED. REC. #

4 TYPE OF BILL 111

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 100118 THROUGH 100718

7

8 PATIENT NAME a

b DOE, JANE

9 PATIENT ADDRESS a b c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
08241980	F	100118	05	1		11	01													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a 50	120818													
b														

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	A1	99200				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	PAGE ____ OF ____	CREATION DATE		TOTALS	TOTAL CHARGE	967250	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 012456789
A	MEDICARE	54321			304952	967250	57
B	I/P MEDI-CAL					99200	OTHER
C							PRV ID

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	JANE DOE		9ZZ9ZZ9ZZ99		
B			90000000A95001		
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX 0 — D1D1D1D A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX — 70 PATIENT REASON DX a b c — 71 PPS CODE — 72 ECI a b c — 73

74 PRINCIPAL PROCEDURE CODE DATE — a. OTHER PROCEDURE CODE DATE — b. OTHER PROCEDURE CODE DATE — 75

c. OTHER PROCEDURE CODE DATE — d. OTHER PROCEDURE CODE DATE — e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1234567890 QUAL
LAST FIRST

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI 2345678901 QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

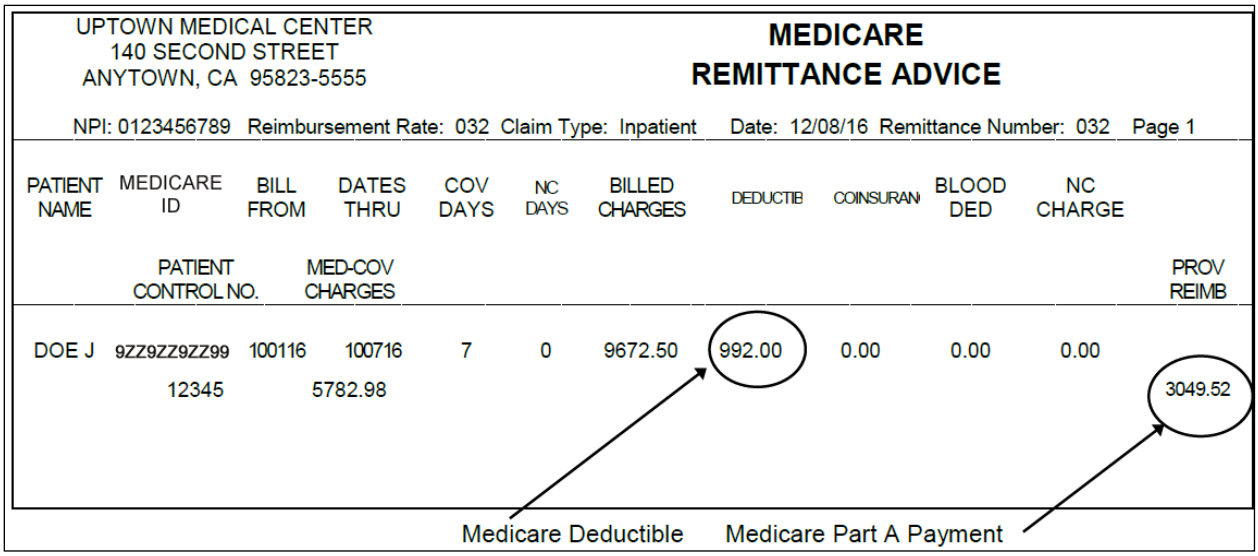
80 REMARKS

81CC a b c d

UB-04 CMS-1450 © 2005 NUBC — OMB APPROVAL PENDING — NUBC National Uniform Billing Committee LIC9213257 — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Example: Inpatient *UB-04* Crossover Claim Form

Attach a copy of the MNSIRA showing the Part A payment. The single claim detail level MNSIRA printed with Medicare's free PCPrint software is required for outpatient claims. For providers who receive an electronic RA, this version is preferred and may also be required in the future for inpatient claims.



UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN, CA 95823-5555

MEDICARE
REMITTANCE ADVICE

NPI: 0123456789 Reimbursement Rate: 032 Claim Type: Inpatient Date: 12/08/16 Remittance Number: 032 Page 1

PATIENT NAME	MEDICARE ID	BILL FROM	DATES THRU	COV DAYS	NC DAYS	BILLED CHARGES	DEDUCTIB	COINSURAN	BLOOD DED	NC CHARGE	
	PATIENT CONTROL NO.		MED-COV CHARGES								PROV REIMB
DOE J	9ZZ9ZZ9ZZ99	100116	100716	7	0	9672.50	992.00	0.00	0.00	0.00	
	12345		5782.98								3049.52

Medicare Deductible Medicare Part A Payment

Simplified Medicare RA with Part A Payment

Outpatient and Professional Services

Part B Services Billed to Part A Contractor

For detailed hard copy billing instructions, refer to the Part 2 provider manual, *UB-04 Completion: Outpatient Services* section (ub comp op) and Part 2: *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section (medi cr op).

UB-04 Claim Form (applicable fields):

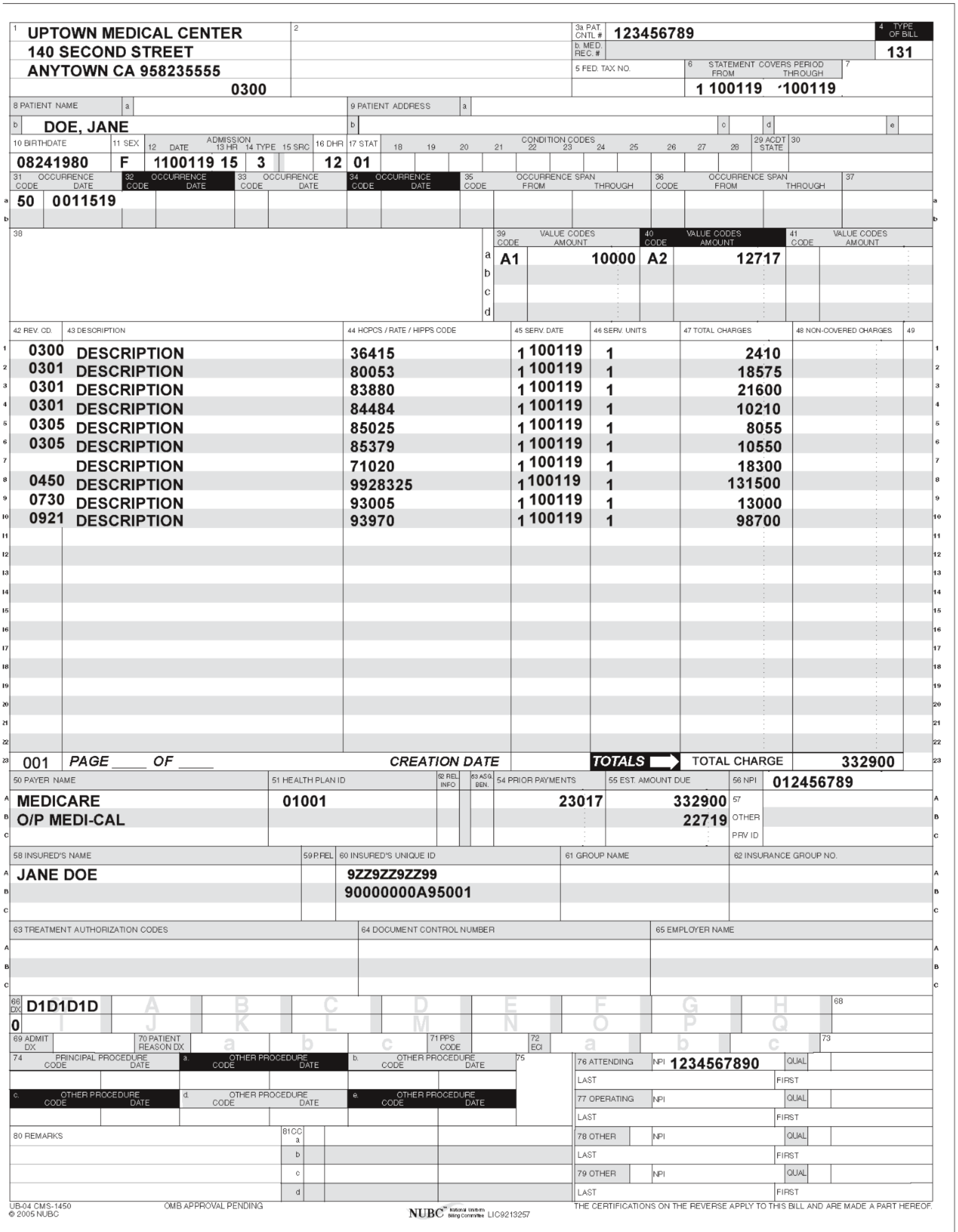
Box Number	Field Name	Instructions
4	Type of Bill	First two digits will be 13, 14, 72, 74, 75, 76, or 85 and values must match the *Medicare National Standard Intermediary Remittance Advice* (MNSIRA).
8B	Patient Name	Patient name must match the MNSIRA.
31	Occurrence Codes & Dates	Enter code 50 and the date (MMDDYY) of the MNSIRA.
39 thru 41 A thru D	Value Codes and Amounts	Enter code 23 and the patient's SOC for the claim. Leave blank, if not applicable. • Enter code 06 and the blood deductible amount. • Enter code 38 and the number of pints of blood. • Enter code A1 and the Medicare deductible amount if Medicare is the primary payer. Enter code B1 if Medicare is a secondary payer. Leave blank, if not applicable. • Enter code A2 and the Medicare coinsurance amount if Medicare is the primary payer. Enter code B2 if Medicare is a secondary payer. Leave blank, if not applicable.

UB-04 Claim Form (applicable fields) (continued):

Box Number	Field Name	Instructions
42	Revenue Code	Enter the revenue codes that were billed to Medicare on the claim in the same order as they appear on the MNSIRA in column 42, lines 1-22. Crossover claims in excess of 15 claim lines must follow special billing instructions and be split-billed on two or more claim forms. • The Revenue Code must display “001” in column 42, line 23. • Dates of service on or after January 1, 2019, a four-digit revenue code must be included on outpatient claims billed on paper *UB-04* claim forms or electronic billing.
43	Description	Enter all claim detail lines (services) that were billed to Medicare on the claim in the same order as they appear on the MNSIRA in lines 1-22. Crossover claims in excess of 15 claim lines must follow special billing instructions and be split-billed on two or more claim forms.
44	HCPCS/Rate	Enter the same procedure codes billed to Medicare.
45	Service Date	Enter the actual date of service on each detail line.
47	Total Charges	Enter the total charge for each service billed to Medicare in lines 1-22. Enter the sum of the line item charges on line 23.

_UB-04_ Claim Form (applicable fields) (continued):

Box Number	Field Name	Instructions
50	Payer Name	Payers must be listed in the following order of payment: • OHC, if applicable, except Medicare supplemental insurance • Medicare • Medicare supplemental insurance (if applicable) • Medi-Cal Outpatient Services
51	Health Plan Id	Enter the Medicare contractor ID.
54 A thru C	Prior Payments	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 must match the MNSIRA ALLOW/REIMB amount <u>not</u> the NET REIMB AMT.
55	Estimated Amount Due	• On the corresponding Medicare line, enter the total charges from Box 47, line 23. • On the corresponding Medi-Cal line, enter the difference of: Blood deductible + Medicare deductible + Medicare coinsurance amounts less SOC, OHC and Medicare supplemental insurance payments.
56	NPI	Submit an original _UB-04_ claim form using the provider NPI in effect appropriate for the date of service on the claim
76, 77, 78, 79	Attending, Operating, & Other	Enter appropriate provider NPI.



1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555 0300
3a PAT. CNTL #	123456789
4 TYPE OF BILL	131
6 STATEMENT COVERS PERIOD FROM / THROUGH	1 100119 / ʼ100119
8 PATIENT NAME	DOE, JANE
10 BIRTHDATE	08241980
11 SEX	F
12 ADMISSION DATE / 13 HR	1100119 / 15
14 TYPE	3
16 DHR	12
17 STAT	01
31 OCCURRENCE CODE / DATE	50 / 0011519
39 VALUE CODES CODE / AMOUNT	A1 / 10000
40 VALUE CODES CODE / AMOUNT	A2 / 12717

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0300	DESCRIPTION	36415	1100119	1	2410	
0301	DESCRIPTION	80053	1100119	1	18575	
0301	DESCRIPTION	83880	1100119	1	21600	
0301	DESCRIPTION	84484	1100119	1	10210	
0305	DESCRIPTION	85025	1100119	1	8055	
0305	DESCRIPTION	85379	1100119	1	10550	
	DESCRIPTION	71020	1100119	1	18300	
0450	DESCRIPTION	9928325	1100119	1	131500	
0730	DESCRIPTION	93005	1100119	1	13000	
0921	DESCRIPTION	93970	1100119	1	98700	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	TOTAL CHARGE	332900

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MEDICARE	01001	23017	332900	012456789
O/P MEDI-CAL			22719	

58 INSURED'S NAME	60 INSURED'S UNIQUE ID
JANE DOE	9ZZ9ZZ9ZZ99
	90000000A95001

66 DX	D1D1D1D
0	
76 ATTENDING NPI	1234567890

UB-04 CMS-1450 © 2005 NUBC · OMB APPROVAL PENDING · NUBC National Uniform Billing Committee LIC9213257 · THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Example: Outpatient *UB-04* Crossover Claim, Part B to Part A Contractor Services

Include a complete, unaltered and legible copy of the corresponding MNSIRA for each crossover claim.

Medicare National Standard Intermediary Remittance Advice

Uptown Medical Center
140 Second Street
Anytown, CA 95823-5555
0123456789

FPE: 02/01/17
PAID: 11/15/16
CLM#: 166
TOB: 131

Medicare Contractor
1234 B Street
Anytown, CA 98765-5555
555-555-5555

PATIENT: DOE, JANE
MEDICARE ID: 9ZZ9ZZ9ZZ99
PAT STAT: CLAIM STAT: 19

SVC FROM: 10/01/2016
THRU: 10/01/2016

PCN: 123456789
MRN: 000193638
ICN: 12345678901234

CHARGES:		PAYMENT DATA: =DRG		0.370	=REIM RATE
3329.00	=REPORTED	0.00	=DRG AMOUNT	0.00	=MSP PRIM PAYER
0.00	=NCVD/DENIED	0.00	=DRG/OPER/CAP	0.00	=PROF COMPONENT
0.00	=CLAIM ADJS	2871.64	=LINE ADJ AMT	0.00	=ESRD AMOUNT
3329.00	=COVERED	0.00	=OUTLIER (C)	104.03	=PROC CD AMOUNT
DAYS/VISITS:		0.00	=CAP OUTLIER	230.17	=ALLOW/REIM
0	=COST REPT	100.0	=CASH DEDUCT	0.00	=G/R AMOUNT
0	=COVD/UTIL	0.00	=BLOOD DEDUCT	0.00	=INTEREST
0	=NON-COVERED	127.19	=COINSURANCE	0.00	=CONTRACT ADJ
0	=COVD VISITS	0.00	=PAT REFUND	0.37	=PER DIEM AMT
0	=NCOV VISITS	0.00	=MSP LIAB MET	230.17	=NET REIM AMT

REMARK CODES: MA01

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOW/REIM	GC	RSN	AMOUNT	REMARK CODES
0300	10/01	36415			1	24.10	3.00	CO	42	21.10	
0301	10/01	80053			1	185.75	14.77	CO	42	170.98	
0301	10/01	83880			1	216.00	47.43	CO	42	168.57	
0301	10/01	84484			1	102.10	13.75	CO	42	88.35	
0305	10/01	85025			1	80.55	10.86	CO	42	69.69	
0305	10/01	85379			1	105.50	14.22	CO	42	91.28	
0324	10/01	71020	00260		1	183.00	25.07	CO	45	137.42	
								PR	2	20.51	
0450	10/01	99283	00611	25	1	1315.00	4.07	CO	45	1173.36	
								PR	1	100.00	
								PR	2	37.57	
0730	10/01	93005	00099		1	130.00	18.05	CO	45	107.44	
								PR	2	4.51	
0921	10/01	93970	00267		1	987.00	78.95	CO	45	843.45	
								PR	2	64.60	

Example: Medicare Remittance Advice Details Form

Note: For Outpatient Part B claims billed to Part A contractors only: The PC-Print single claim detail version of the MNSIRA will be accepted as an attachment to both original and CIF or appeal hard copy crossover claims. Refer to the appropriate Part 2 provider manual for specific program requirements.

Outpatient and Professional Services, Part B

Part B Services Billed to Part B Carriers

Hard copy submission requirements for Part B services billed to Part B carriers are listed below.

CMS-1500 claim forms should be submitted in one of the following formats:

- Original
- Clear photocopy of the claim submitted to Medicare
- Facsimile (same format as *CMS-1500* claim form and background must be visible)

Notes:

CMS-1500 claim form fields for Crossovers only:

Box Number	Field Name	Instructions
1	Medicare/Medicaid/TRICARE/ CHAMPVA/Group Health Plan (SSN or ID)/FECA Blk Lung (SSN)/ Other (ID)	Enter an "X" in both the *Medicare* and *Medicaid* boxes.
1A	Insured's ID Number	Enter the recipient's MBI number.
9A	Other Insured's Policy or Group Number	Enter the 14-character Medi-Cal recipient identification number from the Beneficiary Identification Card.
10D	Claim Codes (Designated by NUCC)	Enter the patient's SOC for the service (leave blank if not applicable).
11C	Insurance Plan Name or Program Name	Enter the Medicare Contractor ID.
31	Signature of Physician or Supplier	The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only. An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. (The legacy Medi-Cal ID was previously required in this field for crossovers.)
32	Service Facility Location Info.	Enter the full address where services were provided, including the nine-digit ZIP code.
32A	Service Facility NPI	Enter the NPI of the Service Facility.
33	Billing Provider Information	Enter the full billing address, including the nine-digit ZIP code.
33A	Billing Provider NPI	Enter the NPI of the Billing Provider.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9ZZ9ZZ9ZZ99

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 90000000A95001

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: 01002

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D1 B. D2D2D2D C. D3D3D3D D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	18	10	01	18	11		99214		1	55 00	1		NPI	
2	10	01	18	10	01	18	11		71020		2	60 00	1		NPI	
3	10	01	18	10	01	18	11		93000		3	50 00	1		NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 165 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use 165 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Smith DATE 10/21/18

32. SERVICE FACILITY LOCATION INFORMATION

JOHN BROWN
651 FIRST STREET
ANYTOWN, CA 958235555

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN, CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Example: Billing Medi-Cal for Part B Services Billed to a Part B Contractor

Jane Smith, M.D.
1027 Main Street
Anytown, CA 95823

10/01/16

Medicare Remittance Notice
Medicare Contractor (12345)

BENEFICIARY NAME / MBI/EX NO. CONTROL NUMBER	SERVICE FROM MO-DAY	SERVICE TO DAY-YR	PLACE TYPE	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
JOHN DOE 9ZZ9ZZ9ZZ99	10-01-16 10-01-16 10-01-16	10-01-16 10-01-16 10-01-16	11 11	99214 71020 93000	55.00 60.00 50.00	40.00 50.00 45.00		0.00 0.00 0.00 0.00	08.00 10.00 09.00	32.00 40.00 36.00	
CLAIM TOTALS					165.00	133.00		0.00	27.00	108.00	0.00

Example: Simplified *Medicare Remittance Notice*

Inpatient Part B-Only Services

Part B-Only Services Billed to a Part A Contractor

For detailed straight Medi-Cal hard copy billing instructions, refer to the Part 2 provider manual, *Medicare/Medi-Cal Crossover Claims: Inpatient Services* section (medi cr ip).

Reminders:

- Submit the *UB-04* claim form, including each of the appropriate accommodation and ancillary services.
- Enter the payment amount in the appropriate *Prior Payment* field (Box 54) when Part B payment appears on a MNSIRA.
- Attach the MNSIRA labeled “ancillary” or “Part B” to the straight Medi-Cal claim. For providers who receive an ERA, the single claim detail level MNSIRA printed with Medicare’s free PC-Print Software is preferred and may be required in the future for inpatient claims.
- A TAR is required for hard copy billing of Part B-only services.

Billing Tips: Inpatient Part B to Part A Only

Follow these billing tips to help prevent rejections, delays, misapplied payments and/or denials of crossover claims:

- Do not highlight information on the claim or attachments.
- Do not write in undesignated white space or the top one-inch of the claim form.
- MNSIRA/MRNs must be complete, legible and unaltered. For example, make sure the date in the upper right-hand corner is legible. For providers who receive an electronic remittance, the single claim detail level MRN printed with the free Medicare Remit Easy Print (MREP) or MNSIRA printed with the free Medicare PC-Print Software is preferred and may be required in the future.
- Crossover claims must not be combined. Examples of common errors include:
  - Multiple recipients on one *UB-04* or *CMS-1500* claim form
  - One MNSIRA/MRN for multiple *UB-04* or *CMS-1500* claim forms
  - Multiple claims (one or more MNSIRAs/MRNs) for the same recipient on one *UB-04* or *CMS-1500* claim form
  - Multiple claim lines from more than one MNSIRA/MRN for the same recipient on one *UB-04* or *CMS-1500* claim form
- All Medicare-allowed claim lines must be included on the crossover claim and must match each corresponding MNSIRA/MRN provided by Medicare.
- Medicare-denied claim lines that appear on the same crossover claim, or on the MNSIRA/MRN with Medicare-allowed claim lines, cannot be paid with the crossover claim.

Notes:

Crossover Claim Follow-Up

Tracing Claims

A *Claims Inquiry Form* (CIF) cannot be submitted to trace an automatic crossover claim. However, a CIF must be submitted to trace a direct-billed crossover claim. Submit a crossover claim (*CMS-1500/UB-04* with an MRN or Medicare RA) to trace an automatic crossover claim.

Claims Inquiry Form (CIF)

A CIF is used to initiate an adjustment or correction on a claim. The four ways to use a CIF for a crossover claim are:

- Reconsideration of a denied claim
- Trace a claim (direct billed claims only)
- Adjustment for an overpayment or underpayment
- Adjustment related to a Medicare adjustment

Crossover CIF Billing Tips

Follow these billing tips to help prevent rejections, delays, misapplied payments and/or denials of crossover CIFs:

- Submit only one crossover claim (that is, only one Claim Control Number [CCN]) for each CIF.
- Enter the 13-digit CCN of the most recently denied crossover claim from the RAD in Box 9.
- Mark *Attachment* field (Box 10) and include appropriate documentation that is clear, concise and complete.
- Mark *Underpayment* field (Box 11) or *Overpayment* field (Box 12), if applicable.
- If requesting an adjustment, use the approved CCN that is being requested for adjustment.
- In the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19), indicate the reason for the adjustment or the denial, the type of action desired, and corrected information.
- Failure to complete the *Remarks* field of the CIF may cause claim denial or delayed processing.
- Make sure timeliness requirements are met.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) is completed.

Crossover Pricing Examples

This section has examples of Medicare/Medi-Cal claims for medical and outpatient services billed on the *CMS-1500* and *UB-04* claim forms.

Welfare and Institutions Code (W&I Code), Section 14109.5 limits Medi-Cal's payment of the deductible and coinsurance to an amount that, when combined with the Medicare payment, should not exceed the amount paid by Medi-Cal for similar services. This limit is applied to the total sum of the claim. Therefore, the combined Medicare/Medi-Cal payment for all services of a claim may not exceed the amount allowed by Medi-Cal for all services of a claim.

Note: Medicare deductible and coinsurance amounts that are hard copy billed are reimbursed as if they were automatically transferred from the Part B carrier.

Remittance Advice Details

The Medi-Cal RAD form shows each crossover service that was processed. For each procedure listed on the RAD form, the Medicare Allowed, Medi-Cal Allowed, Computed MCR AMT (Medicare payment) and Medi-Cal Paid amounts are shown. If Medi-Cal reduces or denies payment consideration for total claim services, the corresponding RAD code is included.

Part 1 Medicare/Medi-Cal Crossover Claims Overview (medicare)

Notes:

Payment Examples

The following payment examples are for illustration only and do not necessarily represent Medi-Cal or Medicare allowed amounts. Crossover services payments are made in accordance with W&I Code, Section 14109.5.

0395 Medicare Non-Covered Benefit

Line 2 of the following *RAD* form example lists “0395” (This is a Medicare non-covered benefit. Rebill Medi-Cal on an original claim form except for aid code “80”, QMB [Qualified Medicare Beneficiary Program] recipients) in the *RAD CODE* field. To be reimbursed for this service, this claim line must be billed separately as a straight Medi-Cal claim.

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT "Medicare Allowed" minus "Deduct" X 80%	COINSUR "Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	BILLED TO MEDI-CAL "Deduct" plus "Coinsur"	MEDI-CAL ALLOWED Medi-Cal price on file or "Medicare Allowed", whichever is less. ("Medicare Allowed" is adopted and shown on the RAD if no Medi-Cal price is on file.)	COMPUTED MEDI-CAL AMOUNT "Medi-Cal Allowed" minus "Computed Medicare Amount"	DEDUCT PLUS COINSUR "Deduct" plus "Coinsur"	PAID AMOUNT The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	RAD CODE
99214	50.00	45.20	0.00	36.16	9.04	9.04	45.20				
93000	50.00	0.00	0.00	0.00	0.00	0.00	0.00		-		0395
Claim Totals	100.00	45.20	0.00	36.16	9.04	9.04	45.20	9.04	9.04	9.04	

Example: Sample pricing for RAD code 0395 (Medicare Non-Covered Benefit)

CA MEDI-CAL
Remittance Advice Details

TO: JOHN DOE, M.D.
400 CALIFORNIA STREET
ANYTOWN, CA 95344

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE	PAGE: 1 OF 1 PAGES
012346789	MCARE CROSSOVER	3949026	20000617	12/03/07	

RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	ACCOM PROC. CODE	PATIENT ACCOUNT NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
APPROVES (RECONCILE TO FINANCIAL SUMMARY)													
DOE	9ZZ9ZZ9ZZ99	4069652123000	073107 073107	073107 073107	99214 93000		0001 0001	45.20	45.20				0395
	TOTAL	4069652123000	073107	073107				45.20	45.20	36.16-		9.04	
BLOOD DEDUCT	0.00	0.00	COINS	9.04-	CUTBACK	0.00	SOC	0.00	-				

EXPLANATION OF DENIAL/ADJUSTMENT CODES

0395 THIS IS A MEDICARE NON-COVERED BENEFIT. REBILL MEDI-CAL ON AN ORIGINAL CLAIM FORM, EXCEPT AID CODE 80 – QMB RECIPIENTS.

Example: RAD code 0395

0442 Cutback (Zero Pay)

In the following example, the amount paid by Medicare exceeded the Medi-Cal maximum reimbursement, which resulted in a zero Medi-Cal payment.

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT "Medicare Allowed" minus "Deduct" X 80%	COINSUR "Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	BILLED TO MEDI-CAL "Deduct" plus "Coinsur"	MEDI-CAL ALLOWED Medi-Cal price on file or "Medicare Allowed", whichever is less. ("Medicare Allowed" is adopted and shown on the RAD if no Medi-Cal price is on file.)	COMPUTED MEDI-CAL AMOUNT "Medi-Cal Allowed" minus "Computed Medicare Amount"	DEDUCT PLUS COINSUR "Deduct" plus "Coinsur"	PAID AMOUNT The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	RAD CODE
99214	300.00	280.44	0.00	224.35	56.09	56.09	117.60				
71020	15.00	14.57	0.00	11.66	2.91	2.91	11.88				
93000	75.00	72.04	0.00	57.63	14.41	14.41	47.16				
Claim Totals	390.00	367.05	0.00	293.64	73.41	73.41	176.64	-117.00	73.41	0.00	442

Example: Sample pricing for RAD code 0442 (Zero Pay)

CA MEDI-CAL
Remittance Advice
Details

TO: ST. JOE'S HOSPITAL
1000 OAK STREET
ANYTOWN, CA 93332-6720

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE	PAGE: 1 OF 1 PAGES
1234567890	MCARE CROSSOVER	39248026	20000617	08/29/07	

RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM MMDDYY	SERVICE DATES TO MMDDYY	ACCOM/ PROC. CODE	PATIENT CONTROL NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
APPROVES (RECONCILE TO FINANCIAL SUMMARY)													
DOE	9ZZ9ZZ9ZZ99	0213820410700	071907 071907	071907 071907	73030TC 73060TC	4006300	0001 0001	130.10 115.30	22.92 18.34				
	TOTAL	0213820410700	071907	071907				245.40	41.26	196.32-			0442
BLOOD DEDUCT	0.00 DEDUCT	0 00	COINS	49 08	CUTBACK	49 08	SOC	0 00					

EXPLANATION OF DENIAL/ADJUSTMENT CODES

442 MEDICARE PAYMENT MEETS OR EXCEEDS MEDI-CAL MAXIMUM REIMBURSEMENT.

Example: RAD code 0442

An automatic crossover claim resulting in a zero Medi-Cal payment will not be shown on the RAD form. However, if at least one procedure processes as a 0444 cutback, the automatic zero Medi-Cal payment crossover claim will appear on the RAD form. This indicates to providers that they may rebill the 0444 cutback procedures (excluding physician services). Refer to “Charpentier Rebilling” in the *Medicare/Medi-Cal Crossover Claims: CMS-1500* (medi cr cms) section of the Part 2 provider manual for more information.

0443 Cutback with Deductible

In this example, the deductible and coinsurance amount ($101.60) exceeds the Medi-Cal maximum allowable amount ($70.87), resulting in a cutback.

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT From RA	MEDICARE PAYMENT From RA	COINSUR From RA	BILLED TO MEDI-CAL "Deduct" plus Coinsur"	MEDI-CAL ALLOWED Medi-Cal price on file or "Medicare Allowed", whichever is less. ("Medicare Allowed" is adopted and shown on the RAD if no Medi-Cal price is on file.)	COMPUTED MEDI-CAL AMOUNT "Medi-Cal Allowed" minus "Medicare Payment"	DEDUCT PLUS COINSUR "Deduct" plus "Coinsur"	PAID AMOUNT The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	RAD CODE
77057	108.01	108.01					70.87				
Claim Totals	108.01	108.01	100.00	6.41	1.60	101.60	70.87	64.46	101.60	64.46	443

Example: Pricing for 0443 Cutback (with deductible)

CA MEDI-CAL
Remittance Advice Details

TO: VALLEY HOSPITAL
1000 SMITH STREET
ANYTOWN, CA 98888-4444

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE	PAGE: 1 OF 1 PAGES
0123456789	MCARE CROSSOVER	39248026	20000617	09/29/07	

RECIPI NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM (MMDDYY)	SERVICE DATES TO (MMDDYY)	ACCOM/ PROC. CODE	MEDICAL REC NUM/ PATIENT ACCNT#	DAY	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
APPROVES (RECONCILE TO FINANCIAL SUMMARY)													
DOE	9ZZ9ZZ9ZZ99	012382531250	082707	082707	77057	M847585914	0001	108.01	70.87	6.41-		64.46	0443
BLOOD DEDUCT	0.00	DEDUCT 100.00	COINS	1.60	CUTBACK	37.14	SOC	0 00					

EXPLANATION OF DENIAL/ADJUSTMENT CODES

443 MEDI-CAL PAYMENT MAY NOT EXCEED THE MAXIMUM AMOUNT ALLOWED BY MEDI-CAL.

Example: RAD code 0443

Notes:

Charpentier Claims

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.

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

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.
- Rates and Benefit Limitations: 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 cut back by Medicare due to a benefit limitation.

Pricing Information

Cutback

If there is a price on file, crossover claims will be cut back with RAD code 0444: **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 0444 cutback is not reflected on the RAD.

Exceeds Medicare Rate

If Medi-Cal's rates and/or limitations are greater than the Medicare-allowed amount, 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.

Knowledge Review

1. A crossover claim is a claim billed to Medi-Cal for the Medicare _____ and _____.
2. What types of services does Medicare Part A cover? _____
3. What types of services does Medicare Part B cover? _____ and _____
4. Recipients with aid code 80 have coverage that is _____ to _____ _____ _____.
5. List two reasons why a crossover claim may not automatically cross over to Medi-Cal:
   a) _____
   b) _____
6. Which OHC code is used to identify a Medicare HMO?_____
7. Combined Medicare/Medi-Cal payment for all services of a claim may not exceed the _____ _____ by Medi-Cal for all services.
8. A Charpentier claim may be billed for?
   a) _____
   b) _____
   c) _____

See the Appendix for the Answer Key.

Resource Information

References

The following reference materials provide Medi-Cal program, claims and eligibility information.

Provider Manual References

Part 1

M*edicare/Medi-Cal Crossover Claims Overview* (medicare)

Part 2

CMS-1500 Completion (cms comp)
Medicare/Medi-Cal Crossover Claims: CMS-1500 (medi cr cms)
Medicare/Medi-Cal Crossover Claims: CMS-1500 Billing Examples for Allied Health (medi cr cms exa)
Medicare/Medi-Cal Crossover Claims: CMS-1500 Billing Examples for Medical Services (medi cr cms exm)
Medicare/Medi-Cal Crossover Claims: CMS-1500 Pricing Examples for Medical Services (medi cr cms prm)
Medicare/Medi-Cal Crossover Claims: Inpatient Services (medi cr ip)
Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples (medi cr ip ex)
Medicare/Medi-Cal Crossover Claims: Outpatient Services (medi cr op)
Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples (medi cr op ex)
Medicare/Medi-Cal Crossover Claims: Outpatient Services Medi-Cal Pricing Examples (medi cr op pr)
Medicare/Medi-Cal Crossover Claims: UB-04 (medi cr ub)
Medicare Non-Covered Services: Charts Introduction (medi non cha)
Medicare Non-Covered Services: CPT-4 Codes (medi non cpt)
Medicare Non-Covered Services: HCPCS Codes (medi non hcp)
UB-04 Completion: Inpatient Services (ub comp ip)
UB-04 Completion: Outpatient Services (ub comp op)

Module A Answer Key

Knowledge Review 1

Question 1: A crossover claim is a claim billed to Medi-Cal for the Medicare _____ and _____.

Answer 1 coinsurance, deductible

Question 2: What types of services does Medicare Part A cover? _____

Answer 2: Inpatient

Question 3: What types of services does Medicare Part B cover? _____ and _____

Answer 3: Outpatient, professional

Question 4: Recipients with aid code 80 have coverage that is _____ to _____ _____ _____.

Answer 4: restricted, Medicare services only

Question 5: List two reasons why a crossover claim may not automatically cross over to Medi-Cal:

Answer 5:

a) Claim is unassigned
b) Medicare denied 100% of the claim

Question 6: Which OHC code is used to identify a Medicare HMO?_____

Answer 6: F

Question 7: Combined Medicare/Medi-Cal payment for all services of a claim may not exceed the _____ _____ by Medi-Cal for all services.

Answer 7: amount allowed

Question 8: A Charpentier claim may be billed for?

Answer 8:

a) rates
b) limitations
c) rates and limitations