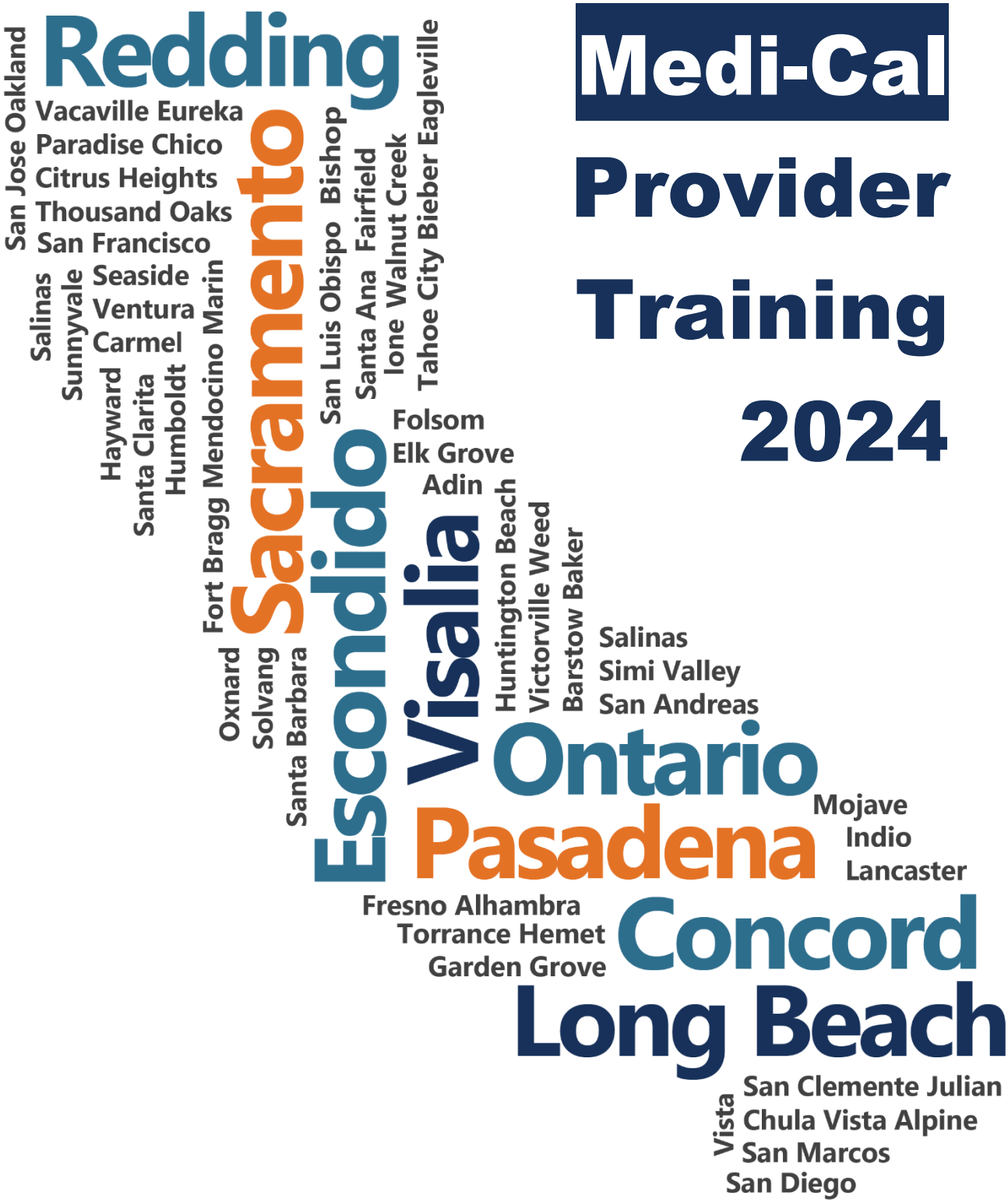


Medi-Cal Provider Training 2024

Inpatient & Outpatient Services

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

The Outreach and Education services is made up of Provider Field Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers self-paced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

How can you get started using the MLP?

- First time users must complete a one-time registration at www.learn.medi-cal.ca.gov
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

Free Services for Providers

Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Provider Field Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on www.medi-cal.ca.gov.

Provider Field Representatives

Receive one-on-one assistance from Provider Field Representatives who live and work in cities throughout California. Provider Field Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the Small Provider Billing Assistance and Training Program, call (916) 636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

Table of Contents

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.

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 not 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:

Part A Services Billed to Part A Contractor Table

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 Table (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

Example: Inpatient *UB-04* Crossover Claim Form

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 08241980

11 SEX F

ADMISSION 12 DATE 100118 13 HR 05 14 TYPE 1 15 SRC

16 DHR 11

17 STAT 01

CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28

29 ACDT STATE

30

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
A	MEDICARE	54321			304952	967250
B	I/P MEDI-CAL					99200
C						

56 NPI 012456789

57 OTHER 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

67 D1D1D1D A B C D E F G H

I J K L M N O P Q

68

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

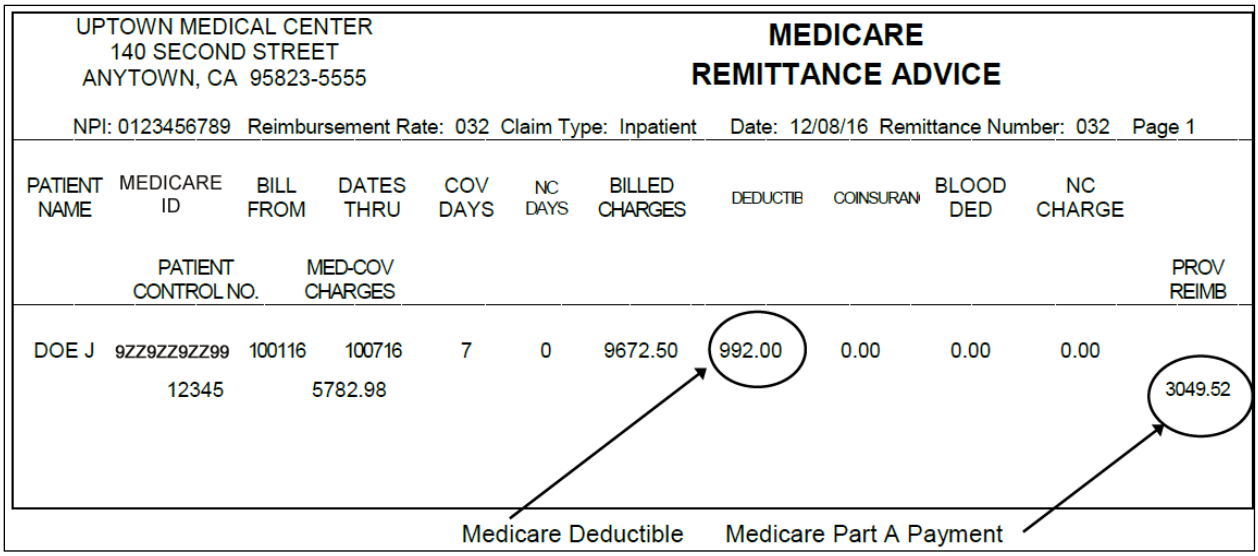
UB-04 CMS-1450 © 2005 NUBC

OMB APPROVAL PENDING

NUBC™ National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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 not 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.

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

Field	Value
1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555 0300
2	
3a PAT. CNTL #	123456789
b. MED. REC. #	
4 TYPE OF BILL	131
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM / THROUGH	1 100119 / ‘100119
7	
8 PATIENT NAME	b DOE, JANE
9 PATIENT ADDRESS	
10 BIRTHDATE	08241980
11 SEX	F
12 ADMISSION DATE / 13 HR	1100119 15
14 TYPE	3
15 SRC	
16 DHR	12
17 STAT	01
18–28 CONDITION CODES	
29 ACDT STATE	
30	
31 OCCURRENCE CODE / DATE	a 50 / 0011519
32–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39 VALUE CODES CODE / AMOUNT	a A1 / 10000
40 VALUE CODES CODE / AMOUNT	a A2 / 12717
41 VALUE CODES CODE / AMOUNT	

	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	0300	DESCRIPTION	36415	1 100119	1	2410		
2	0301	DESCRIPTION	80053	1 100119	1	18575		
3	0301	DESCRIPTION	83880	1 100119	1	21600		
4	0301	DESCRIPTION	84484	1 100119	1	10210		
5	0305	DESCRIPTION	85025	1 100119	1	8055		
6	0305	DESCRIPTION	85379	1 100119	1	10550		
7		DESCRIPTION	71020	1 100119	1	18300		
8	0450	DESCRIPTION	9928325	1 100119	1	131500		
9	0730	DESCRIPTION	93005	1 100119	1	13000		
10	0921	DESCRIPTION	93970	1 100119	1	98700		
23	001	*PAGE ____ OF ____*	*CREATION DATE*		*TOTALS*	TOTAL CHARGE	332900	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	MEDICARE	01001			23017	332900
B	O/P MEDI-CAL					22719
C						

56 NPI: 012456789
57 OTHER 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

66 DX: 0
67: D1D1D1D
67 A–Q:
68:
69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73
74 PRINCIPAL PROCEDURE CODE / DATE | a.–e. OTHER PROCEDURE CODE / DATE | 75
76 ATTENDING NPI 1234567890 QUAL | LAST | FIRST
77 OPERATING NPI QUAL | LAST | FIRST
78 OTHER NPI 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.

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:

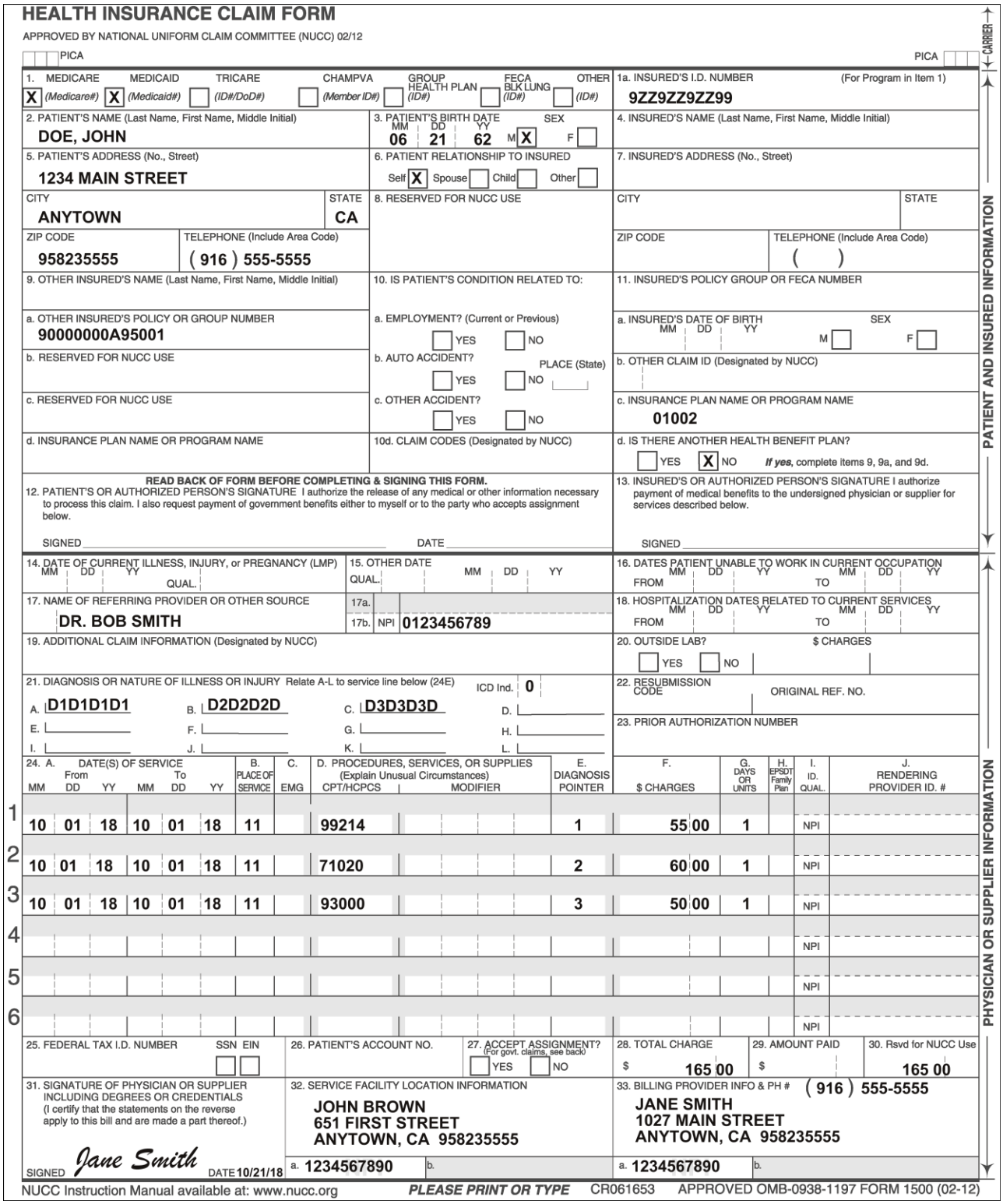
- Original
- Clear photocopy of the claim submitted to Medicare
- Facsimile (same format as *CMS-1500* claim form and background must be visible)

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.

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



HEALTH INSURANCE CLAIM FORM

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

PICA — PICA — CARRIER

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 [ ] NO [X] *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 _____

PATIENT AND INSURED INFORMATION

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 MM DD YY

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 MM DD YY

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	

PHYSICIAN OR SUPPLIER INFORMATION

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)

Example: Simplified *Medicare Remittance Notice*

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

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.

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

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: RAD code 0395

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
012345678	MCARE CROSSOVER	2924026	20000617	12/03/07	

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

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.

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.

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

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: RAD code 0442

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.

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.

Example: Pricing for 0443 Cutback (with deductible)

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: RAD code 0443

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 (MM/DD/YY)	SERVICE DATES TO (MM/DD/YY)	ACCOM/ PROC. CODE	MEDICAL REC NUM/ PATIENT ACCNT#	DAY	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
APPROVES DOE	(RECONCILE TO FINANCIAL SUMMARY) 9ZZ9ZZ9ZZ99	0123825312500	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.

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)

Surgical Modifiers

Introduction

Purpose

The purpose of this module is to provide participants with an understanding of the policies and procedures of surgical modifiers for professional services. This module includes detailed information about correct billing practices and Medi-Cal reimbursement policy.

Module Objectives

- Explain the use of modifiers in the Medi-Cal program
- Demonstrate the correct placement of modifiers on the claim forms
- Examine claim examples
- Review surgical procedure modifiers
- Identify pre-operative and post-operative services policy
- Identify modifiers for Non-Physician Medical Practitioners (NMPs)
- Provide general information regarding anesthesia-related drug and supply modifiers
- Explain “By Report” documentation

Acronyms

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

Description

The use of modifiers is an integral part of billing for health care services. Modifiers give additional information for claims processing. The following modifiers are discussed in this training module:

- Conventional Surgical Modifiers: AG, 50, 51, 80 and 99
- Additional Surgical Modifiers:

Table of Additional Surgical Modifiers

Type of Practice	Surgical Modifier
Anesthesia-related Drugs & Supplies	UA, UB
Evaluation and Management	24, 25, 57
General Use	22, 52, 53, 54, 55, 58, 62, 66, 73, 74, 78, 79, 99
Non-Physician Medical Practitioner	AS, SA, SB, U7, U9

Surgical Procedures Require Modifiers

All surgical procedure codes require a modifier. Failure to submit a modifier with a surgical procedure code will result in the claim being returned to the provider for correction.

The inappropriate use of a modifier, or using a modifier when it is not necessary, will result in a denial or delay in payment. All modifiers and procedure codes must be appropriate for the diagnosis code listed.

Modifier Placement on Claim Form

Modifier placement location appear as **"XX."** See claim form examples below:

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. #
02	01	23				21		Procedure Code	XX					NPI	
														NPI	

Sample: Partial *CMS-1500* Claim Form

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
	DESCRIPTION	Procedure Code XX	020123		

Sample: Partial *UB-04* Claim Form

Primary Surgeon or Podiatrist Modifier AG

The primary surgeon or podiatrist is required to use modifier AG on the only or highest valued surgical procedure code (HCPCS Z1200 thru Z1212 and CPT series 10000 thru 69999) being billed for the date of service.

Multiple Primary Surgeons

Two or more surgeons can use modifier AG for the same patient on the same date of service if the procedures are performed independently and in different specialty areas. This does not include surgical teams or surgeons performing a single procedure requiring different skills. An explanation of the clinical situation and operative reports by all surgeons involved must be included with the claim.

if the procedures are performed independently and in a different anatomical area or compartment. All claims must include:

- Medical justification
- Operative reports by all surgeons involved
- Clearly indicated start and stop times for each procedure

Multiple Surgical Procedure Policy Exceptions

The following medical policies have been established for specific, multiple surgeries when billed for a recipient, by the same provider, for the same date of service.

- Tubal ligations performed at the time of a cesarean section or other intra-abdominal surgery are reimbursable only when billed with CPT code 58611. For more information, refer to the Hysterectomy (hyst) and Sterilization (ster) sections in the appropriate Part 2 manuals
- A salpingectomy or oophorectomy (CPT codes 58700, 58720, 58900 through 58943) billed on the same date of service as a hysterectomy (CPT codes 58150 through 58285) is not separately reimbursable
- A vaginal delivery (CPT codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT codes 59510, 59514, 59618 or 59620) is not reimbursable unless the claim indicates a multiple pregnancy – one child delivered vaginally and one by cesarean section
- Intra-ocular lens with cataract surgery policy is located in the Surgery: Eye and Ocular Adnexa (surg eye) section of the appropriate Part 2 provider manual.
- Insertion of a non-indwelling or temporary indwelling bladder catheter (CPT codes 51701 and 51702) is not separately reimbursable when billed with CPT codes 10021 through 69979
- CPT code 36000 (introduction of needle or intracatheter,vein) is not reimbursable when billed by same provider for the same recipient on the same date of service with any CPT code within the ranges of 00100 through 69999 and 96360 through 96549

Separate Operative Sessions on Same Date of Service Modifier AG

Duplicate billing for surgical services is not reimbursable. Occasionally separate surgical services may be performed during different operative sessions, by the same or a different surgeon, for the same recipient and date of service. Providers must use modifier AG to obtain full reimbursement for both primary procedures and document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim that the procedures were performed at **different times of the day.**

Increased Procedural Services Modifier 22

Modifier 22 may be billed when the work required to provide a service is substantially greater than typically required and. may be identified by adding modifier 22 to the usual procedure code Documentation must support the substantial additional work and the reason for the additional work.

Examples of procedures involving significant increased operative complexity and/or time in a significantly altered surgical field can include:

- Prior surgery
- Distorted anatomy
- Irradiation
- Marked scarring
- Adhesions
- Infections
- Very low weight
- Inflammation

When the service provided is greater than usually required for the listed procedure, requiring the use of modifiers 22 and AG, use modifier 99 with an explanation in the *Remarks* field (Box 80) on *UB-04* claims and Additional Claim Information field (Box 19) on *CMS-1500* claims. Indicate that the procedure performed required the use of both modifiers (99 = AG + 22). Justification is required on the claim.

Assistant Surgeon Modifier 80 and 99

Assistant surgeons must use modifier 80 as a part of each procedure billed. The major surgical procedure is identified by the use of modifier 80 (assistant surgeon) and multiple surgical procedures identified by the use of modifier 99 (multiple modifiers).

Include an explanation in the *Remarks field* (Box 80)/*Additional Claim Information field* (Box 19) of the claim for the modifiers that apply to each procedure. Assistant Surgeons must not bill multiple procedures with modifier 51 or the claim will deny.

Note: Not all surgical procedures are reimbursable to an assistant surgeon. To determine if there are any policy restrictions, refer to the *TAR and Non-Benefit List: Codes* (tar and non cd) section in the appropriate Part 2 provider manual.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **LINE 1: BUIONECTOMY, RT FOOT. LINE 2: BUNIONECTOMY, LT FOOT MODIFIER 99 = MODIFER 80 + 50. LINE 3: EXCISION OF LESION MODIFER 99 = MODIFIERS 80 + 51.**

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. B. C. 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. #
02	01	23				21		28292	80		32 71	1		NPI	
02	01	23				21		28292	99		32 71	1		NPI	
02	01	23				21		28090	99		32 28	1		NPI	

Sample: Partial *CMS-1500* claim form Modifier 80 and 99

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
	BUNIONECTOMY, RT FOOT	2829080	020123	1	
	BUNIONECTOMY, LT FOOT	2829099	020123	1	
	EXCISION OF LESION	2809099	020123	1	

66 DX D1D1D1D D2D2D2D B C D E F G H 66
0 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 2345678901 QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
LINE 1: BUNIONECTOMY, RT FOOT. LINE 2: BUINIONECTOMY, LT FOOT MODIFER 99 = MODIFERS 80 + 50. LINE 3: EXCISION OF LESION MODIFIER 99 = MODIFERS 80 + 51

81CC a b c d

Sample: Partial *UB-04* claim form Modifier 80 and 99

Bilateral Procedure Modifier 50

Providers use modifier 50 when bilateral procedures add significant time or complexity to patient care at a single operative session. To use modifier 50, providers identify the first procedure by its listed procedure code with modifier AG for the primary surgeon. Bilateral procedures requiring a separate incision performed at the same operative session, providers should bill the second procedure on the next billing line with the appropriate CPT code followed by modifier 50, which indicates the procedure was performed bilaterally.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
LINE 1: BUNIONECTOMY, RT FOOT. LINE 2: BUNIONECTOMY, LT FOOT.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. D1D1D1D B. C. 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. #
02	01	23				21		28290	AG		161 71	1		NPI	
02	01	23				21		28290	50		161 71	1		NPI	
														NPI	
														NPI	

Sample: Partial *CMS-1500* Bilateral Modifier 50

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
	BUNIONECTOMY, RT FOOT	28290AG	020123	1	
	BUNIONECTOMY, LT FOOT	2829050	020123	1	

66 DX D1D1D1D
0

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 1234567890 QUAL. LAST FIRST
77 OPERATING NPI 2345678901 QUAL. LAST FIRST
78 OTHER NPI QUAL. LAST FIRST
79 OTHER NPI QUAL. LAST FIRST

80 REMARKS
LINE 1: BUNIONECTOMY, RT FOOT
LINE 2: LT FOOT

81CC a b c d

68

Sample: Partial *UB-04* Bilateral Modifier 50

Multiple Bilateral Procedures

When billing for multiple bilateral procedures performed by the same physician at the same operative session, providers must use modifiers **AG, 50, 51 and 99**. In this example, three bilateral procedures are performed on the patient's eyes and nose by the same physician during the same operative session.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
LINE 4: MODIFIER 99 = MODIFIERS 50 + 51. SEE ATTACHMENT.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

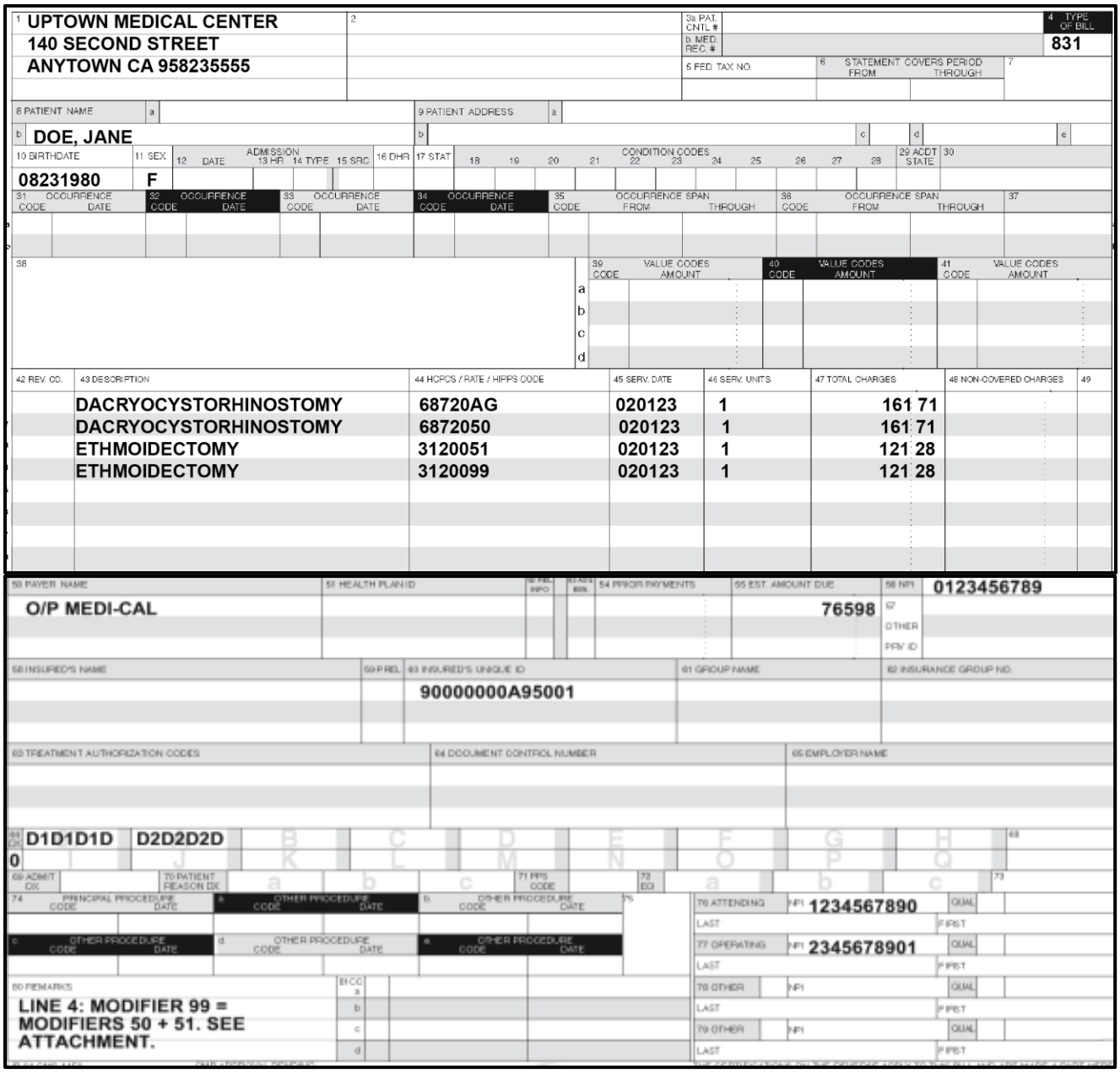
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.

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. #
02	01	23				21		68720	AG		161 71	1		NPI	
02	01	23				21		68720	50		161 71	1		NPI	
02	01	23				21		31200	51		121 28	1		NPI	
02	01	23				21		31200	99		121 28	1		NPI	
														NPI	
														NPI	

Sample: Partial *CMS-1500* Multiple Modifiers AG, 50, 51, and 99



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 831

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 08231980 | 11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	DACRYOCYSTORHINOSTOMY	68720AG	020123	1	161 71	
	DACRYOCYSTORHINOSTOMY	6872050	020123	1	161 71	
	ETHMOIDECTOMY	3120051	020123	1	121 28	
	ETHMOIDECTOMY	3120099	020123	1	121 28	

50 PAYER NAME: O/P MEDI-CAL

55 EST. AMOUNT DUE: 76598

56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D D2D2D2D

76 ATTENDING NPI: 1234567890

77 OPERATING NPI: 2345678901

80 REMARKS: LINE 4: MODIFIER 99 = MODIFIERS 50 + 51. SEE ATTACHMENT.

Sample: Partial *UB-04* Multiple Modifiers AG, 50, 51, and 99

Multiple Procedures Same Operative Session

When multiple procedures are performed at the same operative session, providers should identify the major procedure with modifier-AG, and identify the secondary, additional or lesser procedures by adding modifier -51 to the secondary procedure codes. The procedure code identified with modifier AG is paid at 100 percent of the Medi-Cal reimbursement rate. The procedure code(s) identified with modifier-51 will generally be paid at 50 percent of the Medi-Cal reimbursement rate.

The following example illustrates the standard reimbursement rule for multiple procedures when performed during the same operative session and billed with modifier 51.

Table of Reimbursement Formulas

CPT Code/Modifier	Reimbursement Formula
41150 AG	100 percent of full-fee rate
38720 51	50 percent of full-fee rate
15120 51	50 percent of full-fee rate
31600 51	50 percent of full-fee rate

Billing Multiple Modifiers

When two or more modifiers are necessary to completely delineate a service, use modifier 99 with the appropriate procedure code and explain the applicable modifiers in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim.

For example: when a major surgical procedure is to be performed requiring the use of modifier 22 and modifier AG, use modifier 99 with an explanation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) indicating that the procedure required the use of both modifiers 22 and AG.

National Correct Coding Initiative

A few of surgical procedures are subject to National Correct Coding Initiative (NCCI) edits. To process correctly, claims submitted for multiple surgical procedures on the same day may require addition of an NCCI-associated modifier. For more information, refer to the *Correct Coding Initiative: National* section in the appropriate Part 2 provider manual for instructions regarding the use of NCCI-associated modifiers.

Modifiers Used for Third and Subsequent Procedures

Modifier 99 is used to indicate third and subsequent identical procedures. Modifier 51 is appropriate to indicate a second and third subsequent different procedures. If modifier 51 is used more than once to bill the same procedure code, it will appear to be a duplication

Multiple Surgical Procedures Reimbursed at 100 Percent

Certain procedures billed by the primary surgeon with modifier 51 are exempt from the multiple procedure reduction rule and are paid at 100 percent of the Medi-Cal Maximum Allowable. For a list of exempt procedures refer to the *Surgery: Billing with Modifiers* (surg bil mod) section in the Part 2 provider manual.

Add-on Codes

Codes with “each additional” in the descriptor should **not** be billed with modifier 99 when performed on the same day or at the same operative session as another surgery. Modifier 51 must be used and indicate a “1” in the *Days or Units* field (Box 24G) on the *CMS-1500* claim form or *Serv.Units* field (Box 46) on the *UB-04* claim form. Add-on codes are commonly used to report such things as skin grafts, or multiple lesions performed on the same date of service.

When completing claim form for both the *CMS-1500* and *UB-04*, providers may use (Box 24G) or (Box 46) and indicate the number of times the “each additional” add-on-code was performed. Billing in this format simplifies the claim form completion. The option to bill “1” on each claim line is also an acceptable billing option.

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. #
02	01	23				21		15002	AG		425 00	1		NPI	
02	01	23				21		15003	51		200 00	1		NPI	
02	01	23				21		15003	51		200 00	1		NPI	
02	01	23				21		15003	51		200 00	1		NPI	

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. #
02	01	23				21		15002	AG		425 00	1		NPI	
02	01	23				21		15003	51		600 00	3		NPI	

Sample: Partial *CMS-1500* “Add-On” Codes Billing Options

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
		15002AG	020123	1	425 00
		1500351	020123	1	200 00
		1500351	020123	1	200 00
		1500251	020123	1	200 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
		15002AG	020123	1	425 00
		1500351	020123	1	600 00

Sample: Partial *UB-04* "Add-On" Codes Billing Options

Surgical Team Modifier 66

Although the CPT instructions for modifier 66 (surgical team) permit each physician member of a surgical team to report his/her participation separately from the other physician members for billing Medi-Cal. The services of all physician members of a surgical team, including primary and assistant surgeons, must be billed on a single line of one claim for using the appropriate CPT code with modifier 66.

Exception: Anesthesiologist should submit a separate claim using the appropriate five-digit anesthesia procedure code and modifier.

Two Surgeons Modifier 62

Identifies a surgical procedure that requires two surgeons that perform on distinct parts of a procedure.

Note: Each surgeon would bill with modifier 62.

Operative and Postoperative Modifiers and Descriptions

Reduced Services Modifier 52

For use with surgery codes: 66820, 66821, 66830, 66840, 66850, 66920, 66930, 66940 and 66982 through 66985. Requires “By Report” documentation.

Operative Postoperative Management Modifier 54

Surgical care only

Operative Postoperative Management Modifier 55

Postoperative management only

Staged or Related Procedure Postoperative Period Modifier 58

May be used with CPT codes 15002 through 15429 and 52601 to address subsequent part(s) of a staged procedure.

Return to Operating Room Modifier 78

Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period.

Return to Operating Room Modifier 79

Unrelated procedure or service by the same physician during the postoperative period.

Knowledge Review

9. A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on December 10, 2022. The cone biopsy was performed on December 17, 2022. What modifier should be used for the cone biopsy? _____.

10. An exploratory laparotomy was performed due to a gunshot wound. A few hours later the patient's blood pressure drops, and the patient is urgently taken back to the operating room to reopen and explore for possible leakage from the surgical site. What modifier should be used for the reopen/explorative procedure? _____.

See the Appendix for the Answer Key

Discontinued Procedure Modifiers and Descriptions

If a procedure requires to be discontinued prior to the surgery and administration of anesthesia, it will require "By Report" documentation.

Table of Discontinued Procedure Modifiers and Descriptions

Modifier	Description
53	Discontinued procedure; requires "By Report" documentation
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia; to be reported by hospital outpatient department or surgical clinic only. Requires "By Report" documentation
74	Discontinued outpatient hospital/ambulatory surgery center (ASC) after administration of anesthesia; to be reported by hospital outpatient department or surgical clinic only. Requires "By Report" documentation

Transgender and Gender Diverse Services

Treatment for gender dysphoria is a covered Medi-Cal benefit when medically necessary. Requests for services should be from specialists experienced in providing care to transgender individuals and should use nationally recognized guidelines.

Medically necessary covered services are those services that "are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness or injury" (Title 22, *California Code of Regulations* [CCR], Section 51303).

Note: A service or the frequency of services available to a transgender beneficiary cannot be categorically limited. All medically necessary services must be provided timely. Limitations and exclusions, medical necessity determinations and/or appropriate utilization management criteria that are non-discriminatory may be applied.

For additional billing guidelines, refer to the *Transgender and Gender Diverse Services* (transgender) section of the appropriate Part 2 provider manual.

Evaluation and Management (E&M) Modifiers

Policy for Preoperative Visits Before or on the Day of Surgery

Under most circumstances, including ordinary referrals, the preoperative examination by the operating surgeon or assistant surgeon in the emergency room, hospital or elsewhere on the day of surgery, or one day prior to the day of surgery, is considered a part of the surgical procedure and is not separately reimbursable by Medi-Cal.

Billing exceptions to this policy may be made when the preoperative visit is an initial emergency visit requiring extended evaluation or detention (for example, to prepare the patient or establish the need for the surgery).

Procedures (for example, bronchoscopy prior to thoracic surgery) that are not normally an integral part of the basic surgical procedure may be reimbursed separately.

Policy for Postoperative Visits

Office visits, hospital visits, consultations and ophthalmological exams related to a surgery and billed during a follow-up period of the surgery, are not separately reimbursable if billed by the surgeon or assistant surgeon. These claims will be denied with RAD code 0074 because this service is included in the surgical fee.

Overriding Justification Modifiers

Billing CPT codes 99091 and 99202 thru 99499 (E&M services) with modifier 24, 25, or 57 overrides the requirement of documenting medical justification when billed in conjunction with a surgical procedure as follows:

Modifier	Description
24	Unrelated E&M service by the same physician or other qualified health care professional during a postoperative period
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day of the procedure or other service
57	Decision for surgery (major surgery only, day before or day of procedure)

Non-Physician Medical Practitioner (NMP)

Non-Physician Medical Practitioners (NMPs) include:

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)
- Licensed Midwife (LM)

Modifier and Description for Non-Physician Medical Practitioners

Modifier	Description
AS	Physician assistant, nurse practitioner or clinical nurse specialist services for assistant at surgery. Certified nurse midwives (CNM) may be reimbursed as an "assistant at surgery" during cesarean section deliveries performed by a licensed physician and surgeon
SA	Nurse practitioner rendering service in collaboration with a physician
SB	Nurse midwife. Used when Certified Nurse Midwife service is billed by a physician, hospital outpatient department or organized outpatient clinic (not by CNM billing under his or her own provider number)
U7	Used to denote services rendered by Physician Assistant (PA)
U9	Used to denote services rendered by Licensed Midwife (LM)

Billing Information

Reimbursement for services rendered by an NMP can only be made to the employing physician, organized outpatient clinic or hospital outpatient department. Separate reimbursement is not made for physician supervision of an NMP.

Note: Exceptions to this policy would be for a Certified Nurse Practitioner (CNP) or Certified Nurse Midwife (CNM) enrolled as an independent Medi-Cal provider or a Licensed Midwife.

The following items need to be included on claim forms for reimbursement:

- The NMP's NPI must be noted in the *Remarks* field (Box 80) on *UB-04* claims or *Additional Claim Information field* (Box 19) on *CMS-1500* claims.
- When billing for assistant surgeon services performed by the PA, services must be billed with modifier 99 (multiple modifiers). (99 = 80 + U7).

Note: Surgical codes that are reimbursable for NMP services can be found in the *Non-Physician Medical Practitioners* (NMP) section (non ph) of the Part 2 provider manual.

Non-Physician Medical Practitioner Claim Examples

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
JANE SMITH, CNM, NPI 1234567890

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. D1D1D1D B. C. 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. #
02	01	23				11		57452	SB		275 00	1		NPI	1098765432
														NPI	
														NPI	
														NPI	

Sample: Partial *CMS-1500* Claim Form

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	COLPOSCOPY	57452SA	021122	1	275 00		
	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
						57 OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX D1D1D1D
0

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 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

80 REMARKS
JANE SMITH, NP, NPI 1234567890

81 CC a b c d

76 ATTENDING NPI 0123456789 QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

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.

Sample: Partial *UB-04* Claim Form

Page updated: September 2020

Anesthesia-Related Drugs and Supplies Modifiers

Table of Anesthesia-Related Drugs and Supplies Modifiers

Modifier	Description
UA	Used for surgical or **non-general anesthesia-related** supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code.
UB	Used for surgical or **general anesthesia-related** supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code.

Billing Reminders

- Modifiers UA and UB are mutually exclusive; therefore, only one modifier is allowed for each surgical procedure.
- Modifiers UA and UB do not conflict with the use of other required modifiers. Modifiers AG or 80 may be used on separate lines with UA or UB on the same claim form.
- Do not attach an itemized list of supplies to the claim.
- Surgical procedures with modifier UA or UB performed more than once on the same day to the same recipient by the same or different provider(s) require additional documentation.

By Report Documentation

The following is a list of Medi-Cal services that require attachments:

- Anesthesia time
- “By Report” procedures/modifiers
- Delay Reason Code used on claim
- Denials from Other Health Coverage (OHC) carriers
- Emergency Statement required
- Medicare Non-Covered or Denied services
- Multiple modifiers
- No price is listed
- Specific surgical procedures
- Sterilization or hysterectomy
- Unlisted injections
- Unlisted services (for example, CPT 36299)
  - No specific CPT description of service
  - Requires a TAR
  - Time involved
  - Nature and purpose of procedure
  - Relation to diagnosis
- Unusual/Complicated procedures

“By Report” Documentation Requirements

The Medical Review Unit is unable to process “By Report” claims without the following information on the attachment:

- Patient’s name
- Date of service
- Procedure code
- Operative report and operating time, or procedure report. Each report must include a description of the actual procedure performed and the results of the procedure. *Pro forma* or “canned” reports are unacceptable.
- Estimated follow-up days required
- Size, number and location of lesions (if applicable)
- When billing unlisted “By Report” procedures (no specific description of service), also state the time involved, the nature and purpose of the procedure or service and how it relates to diagnosis.

Note: “By Report” claim submissions do not always require an attachment. For some procedures, entering information in the *Remarks* field (Box 80) for *UB-04* claims and *Additional Claim Information* field (Box 19) for *CMS-1500* claims may be sufficient.

Learning Activity

Modifier Review

1. An assistant surgeon was involved in performing the procedure. What modifier should be used to bill for the assistant's services?
    1. 99
    2. 80
    3. U7
2. Surgical procedures that require two surgeons who perform on distinct anatomical regions on the same recipient, same date of service, may each bill with modifier AG on separate claims.
    1. True
    2. False
3. Procedures billed with modifier 51 are reimbursed at what percentage of the Medi-Cal maximum allowable?
    1. 50%
    2. 100%
4. Is it possible to bill with more than one primary surgical procedure with modifier AG on the same date of service?
    1. Yes
    2. No
5. When billing for Physician Assistant (PA), what modifier should be used?
    1. U7
    2. 80
    3. 99 = (U7 + 80)
    4. None

See the Appendix for the Answer Key.

Resource Information

References

The following reference materials provide Medi-Cal billing and policy information.

Provider Manual References

Part 2

Anesthesia (anest)

CMS-1500 Special Billing Instructions (cms spec)

Correct Coding Initiative: National (correct)

Correct Coding Initiative: National – Claim Preparation (correct cod)

Hysterectomy (hyst)

Modifiers: Approved List (modif app)

Non-Physician Medical Practitioners (NMP) (non ph)

Non-Physician Medical Practitioner (NMP) Billing Example: CMS-1500 (non ph cms)

Non-Physician Medical Practitioner (NMP) Billing Example: UB-04 (non ph ub)

Sterilization (ster)

Supplies and Drugs (supp drug)

Surgery (surg)

Surgery Billing Examples: CMS 1500 (surg bil cms)

Surgery Billing Examples: UB-04 (surg bil ub)

Surgery: Billing with Modifiers (surg bil mod)

UB-04 Special Billing Instructions for Inpatient Services (ub spec ip)

UB-04 Special Billing Instructions for Outpatient Services (ub spec op)

Appendix

Acronyms

Acronym	Description
APR DRG	All Patient Refined Diagnosed Related Groups
BIC	Benefits Identification Card
CA-MMIS	California Medicaid Management Information System
CCN	Claim Control Number
CCS/GHPP	California Children's Services and Genetically Handicapped Persons Program
CSU	Correspondence Specialist Unit
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
MCP	Managed Care Plan
NPI	National Provider Identifier
SOC	Share of Cost
LM	Licensed Midwife
MCP	Managed Care Plan
NCCI	National Correct Coding Initiative
NDC	National Drug Code
NMPs	Non-Physician Medical Practitioners
NP	Nurse Practitioner
NPI	National Provider Identifier
OHC	Other Health Coverage
POS	Point of Service

Acronym	Description
RA	Remittance Advice
RAD	Remittance Advice Details
SOC	Share of Cost
TAR	*Treatment Authorization Request*
TSC	Telephone Service Center
UPN	Universal Product Number

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

Module B Answer Key

Knowledge Review 1

Question 1: A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 1, 2023. The cone biopsy was performed on February 17, 2023. What modifier should be used for the cone biopsy? _____

Answer 1: **79**

Question 2: An exploratory laparotomy was performed due to a gunshot wound. A few hours later the patient's blood pressure drops, and the patient is urgently taken back to the operating room to reopen and explore for possible leakage from the surgical site. What modifier should be used for the reopen/explorative procedure? _____

Answer 2: **78**

Modifier Review

Question 1: An assistant surgeon was involved in performing the procedure. What modifier should be used to bill for the assistant's services?

Answer 1:

b. **80**

Question 2: Surgical procedures that require two surgeons who perform on distinct anatomical regions on the same recipient, same date of service, may each bill with modifier AG on separate claims.

Answer 2:

a. **True**

Question 3: At what percentage of the Medi-Cal maximum allowable do multiple procedures billed with modifier 51 get reimbursed?

Answer 3:

c. **50 percent**

Question 4: Is it possible to bill with more than one primary surgical procedure with modifier AG on the same date of service?

Answer 4:

a. **Yes**

Question 5: When billing for Physician Assistant (PA), what modifier should be used?

Answer 5:

a. **U7**

Enter Notes Here