

Medi-Cal Provider Training 2016

Advanced Billing: Allied Health & Medical Services





The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP's easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at <http://www.medi-cal.ca.gov/education.asp>.

Free Services for Providers

Provider Seminars and Webinars

Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives

The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit

The four SPBU Specialists are dedicated to providing 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 SPBU 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!

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Allied Health Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages when billing on the *CMS-1500* claim form, provide billing advice and appropriate follow-up procedures for these denials. The module lists *Remittance Advice Details* (RAD) codes and messages that are used to reconcile accounts. RAD codes appear on the Medi-Cal RAD for claims that are approved, denied, suspended or adjusted, as well as for Accounts Receivable (A/R) and payable transactions.

Module Objectives

- Identify the 10 most common claim denial messages for allied health services
- Provide the appropriate follow-up procedures for listed claim denials
- Offer billing tips to prevent claim denials
- Show common billing errors that cause denials
- Highlight the correct provider manual section for each denial

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

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

Provider Manual References

Part 1

Aid Codes Master Chart (aid codes)

Appeal Process Overview (appeal)

CIF Overview (cif)

Eligibility: Recipient Identification (elig rec)

Eligibility: Recipient Identification Cards (elig rec crd)

Remittance Advice Details (RAD) Codes and Messages: 001 – 099 (remit cd001)

Remittance Advice Details (RAD) Codes and Messages: 300 – 399 (remit cd300)

Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999 (remit cd9000)

Part 2

Appeal Form Completion (appeal form)

CIF Completion (cif co)

CMS-1500: Completion (cms comp)

CMS-1500: Tips for Billing (cms tips)

Acronyms

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

NOTES

Claim Denial Description

Denied claims represent claims that are incomplete, services billed that are not payable or information given by the provider that is inappropriate. Many RAD codes and messages include billing advice to help providers correct denied claims. It is important to verify information on the original claim against the RAD.

Free-Form Denial Codes

Free-form denial codes indicate free-form denial messages that allow Medi-Cal claims examiners to return unique messages that more accurately describe claim submittal errors and denial reasons. Free-form denial codes contain four-digits beginning with the prefix 9. Refer to the *Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999* section of the Part 1 provider manual for the complete list.

10 Most Common Denial Messages

Denial #	RAD Code	Message
1	0010	This service is a duplicate of a previously paid claim.
2	0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
3	0314	Recipient is not eligible for the month of service billed.
4	0369	Medical transportation requires Emergency Statement or TAR (<i>Treatment Authorization Request</i>).
5	0031	The provider was not eligible for the services billed on the date of service.
6	0376	Billed procedure code does not match TAR procedure code. New claim and/or TAR is required.
7	9984	Emergency service indicator on claim is not valid for non-emergency services.
8	0036	RTD (<i>Resubmission Turnaround Document</i>) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
9	0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
10	0006	The date(s) of service reported on the claim is not within the TAR (<i>Treatment Authorization Request</i>) authorized period.

Denied Claim Follow-Up Options

When providers receive confirmation that a claim has been denied, they can pursue follow-up options to get the claim paid, depending on the reason for the denial. There are four main follow-up procedures available to providers:

- Rebill the claim
- Submit a *Claims Inquiry Form* (CIF)
- Submit an appeal
- Correspondence Specialist Unit (CSU)

Timeliness Policy

Timeliness must be adhered to for proper submission of follow-up claim forms.

Follow-Up Action	Submission Deadline
Rebill a Claim	<u>Six months</u> from the month of service
Submit a CIF	Within <u>six months</u> of the denial date (date on RAD)
Submit an Appeal	Within <u>90 days</u> of the denial date (date on RAD)

NOTES

CIF Submission Exceptions

Do not submit a CIF for the following Remittance Advice Details (RAD) code messages. Providers should submit an *Appeal Form* instead. A review by a person in the appeals unit is commonly used to resolve denials if the claim has a unique circumstance needing human intervention. Additional information is available in the *Appeal Process Overview* and *Appeal Form Completion* sections of the appropriate provider manual.

RAD Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.
0525	NCCI (National Correct Coding Initiative) void of a column 2 claim previously paid when a column 1 claim has been processed for the same provider and date of service.
9940	NCCI (National Correct Coding Initiative) claim line is billed with multiple NCCI modifiers.
9941	NCCI (National Correct Coding Initiative) column 2 procedure code is not allowed when column 1 procedure has been paid.
9942	NCCI (National Correct Coding Initiative) quantity billed is greater than the allowed MUE (Medically Unlikely Edit) quantity.

Denied Claim Follow-Up Procedures

Denial Code #1

Denied Claim Message

RAD CODE: 0010	This service is a duplicate of a previously paid claim.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0010 is to submit an appeal within 90 days.

Billing Tips

Verify the:

- Provider number
- Recipient number
- "From-Thru" date of service
- Procedure code
- Modifier
- Rendering provider number

NOTES

Denial Code #2

Denied Claim Message

RAD CODE: 0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0037 is to bill the Managed Care Plan (MCP).

Billing Tips

- Verify the recipient's eligibility.
- Verify the recipient's 14-character ID number on the RAD.
- Check the county code.
 - Verify county code in the *MCP: Code Directory* section of the Part 1 provider manual.

NOTES

Denial Code #3

Denied Claim Message

RAD CODE: 0314	Recipient is not eligible for the month of service billed.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0314 is to submit an appeal within 90 days or rebill the claim.

Billing tips

- Verify that the recipient has a SOC (Share of Cost) and is eligible for the month of service.
- Verify date of service on the claim is correct.

NOTES

Denial Code #4

Denied Claim Message

RAD CODE: 0369	Medical transportation requires Emergency Statement or TAR (<i>Treatment Authorization Request</i>).
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0369 is to submit an appeal within 90 days or rebill the claim.

Billing Tips

- Verify TAR number is present on the claim.
- Check that the TAR number is correct.
- Include an emergency statement in the *Additional Claim Information* field (Box 19) or an attachment for all emergency transportation.
- Verify that emergency indicator “X” is in the *EMG* field (Box 24C).
- Ensure that emergency statements are signed and dated by the provider. Emergency statements must support that an emergency existed. The statement may be made by the provider of the emergency transportation. The emergency statement must include:
 - The name of the person or agency that requested the service
 - The nature of the emergency
 - The name of the hospital to which a recipient was transported
 - Clinical information on a recipient’s condition
 - The reason the services were considered to be immediately necessary (medical necessity)
 - The name of the physician accepting responsibility for the recipient

NOTES

Denial Code #5

Denied Claim Message

RAD CODE: 0031	The provider was not eligible for the services billed on the date of service.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0031 is to rebill the claim.

Billing Tips

- Verify date of service on the claim is correct.
- Verify billing provider number on the claim is correct.
- Verify rendering provider number on the claim is correct.

NOTES

Denial Code #6

Denied Claim Message

RAD CODE: 0376	Billed procedure code does not match TAR procedure code. New claim and/or TAR is required.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0376 is to submit an appeal within 90 days or rebill the claim.

Billing Tips

- Verify the procedure/modifier combination is appropriate for the services being billed.
- Verify the procedure/modifier on the claim matches the procedure/modifier on the TAR.
- When billing for supply code 9999A, determine whether the TAR is a drug TAR or an other TAR. For drug TARs, use the *Pharmacy Claim Form (30-1)*. For other TARs, use the *CMS-1500* claim form.

NOTE

Refer to the *Pharmacy Claim Form (30-1) Completion* and *CMS-1500 Completion* sections in the appropriate Part 2 provider manual for additional information.

NOTES

Denial Code #7

Denied Claim Message

RAD CODE: 9984	Emergency service indicator on claim is not valid for non-emergency services.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 9984 is to make corrections and rebill the claim.

Billing Tips

- When billing for emergency services, providers must place an "X" in the *EMG* field (Box 24C).
- When billing for non-emergency services, providers must leave the *EMG* field (Box 24C) blank.

NOTES

Denial Code #8

Denied Claim Message

RAD CODE: 0036	RTD (<i>Resubmission Turnaround Document</i>) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0036 is to rebill the claim or submit a *Claims Inquiry Form* (CIF) within six months.

Billing Tips

- RTDs automatically deny when 45 days old.

NOTES

Denial Code #9

Denied Claim Message

RAD CODE: 0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0002 is to submit an appeal within 90 days.

Billing Tips

- Verify recipient's eligibility with a valid Medi-Cal BIC prior to rendering service, except in an emergency.
- Verify eligibility on the Point of Service (POS) network.
- Check recipient's date of birth and the issue date of the BIC.
- Keep the record of the Eligibility Verification Confirmation (EVC) number.

NOTE

Refer to the *Eligibility: Recipient Identification Cards* section of the appropriate Part 1 provider manual.

NOTES

Denial Code #10

Denied Claim Message

RAD CODE: 0006	The date(s) of service reported on the claim is not within the TAR (<i>Treatment Authorization Request</i>) authorized period.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0006 is to rebill the claim or submit an appeal within 90 days of the denial date.

Billing Tips

- Verify date(s) of service on the claim. If incorrect, resubmit the claim with the correct date of service.
- Verify the approved date(s) of service on the TAR. If incorrect, request in writing a correction of the TAR from your local Medi-Cal field office.
- Refer to the *TAR Field Office Addresses* (tar field) section of the appropriate Part 2 provider manual for field office addresses.

NOTES

Common Billing Errors

The following fields must be completed accurately and completely on the *CMS-1500* claim form to avoid claim suspense or denial. The following table can be found in the *CMS-1500 Tips for Billing* section (cms tips) in the appropriate Part 2 provider manual.

Box #	Field Name	Error
1	MEDICARE/ MEDICAID	Not checking appropriate box Billing Tip: Check both the Medicaid and Medicare boxes when billing Medicare crossover claims.
1A	INSURED'S ID NUMBER	Entering the recipient Medi-Cal ID number incorrectly Billing Tip: Verify that the recipient is eligible for the services rendered by using the POS network or telephone Automated Eligibility Verification System (AEVS). Do not enter the Medicare ID number on a Medi-Cal claim.
2	PATIENT'S NAME	Not using commas between each segment of the patients name Billing Tip: <i>Patient's Name</i> field (Box 2) requires commas between each segment of the patient's name: last, first, middle initial (without a period). For example, for a patient named James T. Smith Jr., enter: SMITH, JAMES, T, JR
19	ADDITIONAL CLAIM INFORMATION	Reducing font size or abbreviating terminology to fit in the field Billing Tip: If additional information cannot be entered completely, attach additional information to the claim. Reducing font size and abbreviating terminology may result in scanning difficulties and/or medical review denials.
21.1 21.2	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Entering more than two diagnosis codes Billing Tip: No description is required. Enter additional diagnosis codes in the <i>Additional Claim Information</i> field (Box 19). Claims submitted to Medi-Cal require an ICD indicator in the <i>ICD-Ind.</i> field (Box 21). Enter the ICD indicator "0" for claims that will be received by the Fiscal Intermediary on or after October 1, 2015. Claims submitted without a diagnosis code do not require an ICD indicator.
23	PRIOR AUTHORIZATION NUMBER	Physician and podiatry services requiring a TAR or SAR must enter the 11-digit TAR Control Number (TCN). It is not necessary to attach a copy of the <i>Adjudication Response</i> to the claim. Billing Tip: Recipient information on the claim must match the _____. Only one TCN can cover the services billed on any one claim.

Answer Key: TAR

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Box #	Field Name	Error
24B	PLACE OF SERVICE	<p>Entering the wrong Place of Service two-digit code</p> <p>Billing Tip 1: Check instructions in the <i>CMS-1500 Completion</i> (cms comp) section of the appropriate Part 2 provider manual for the correct two-digit code. Enter a Medi-Cal local Place of Service code instead of a national Place of Service code.</p>
24C	EMG (OR DELAY REASON)	<p>Delay Reason Code: If there is no emergency indicator in the <i>EMG</i> field (Box 24C), and only a delay reason code is placed in this box. Enter the code in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the shaded, top portion of this box.</p> <p>Include the required documentation. Only one delay reason code is allowed per claim. If more than one code is present, the first occurrence is applied to the entire claim. Refer to the <i>CMS-1500: Submission and Timeliness Instructions</i> section (cms sub) in the appropriate Part 2 provider manual.</p> <p>Emergency Code: Enter an "X" when billing for emergency services. Claims without an "X" in this field may be reduced or denied. Only one emergency indicator is allowed per claim. The emergency indicator must be placed in the unshaded, bottom portion of the <i>EMG</i> field (Box 24C).</p> <p>An Emergency Certification Statement is required for all OBRA/IRCA recipients and for any service rendered under emergency conditions that would otherwise have required authorization, including: emergency services by allergists, podiatrists, medical transportation providers, portable imaging providers, psychiatrists and out-of-state providers.</p> <p>For emergencies in which emergency medical transportation was provided, providers must include an emergency statement. The statement must include:</p> <ul style="list-style-type: none"> • The name of the person or agency that requested the service • The nature of the emergency • The name of the hospital to which a recipient was transported • Clinical information on a recipient's condition • The reason the services were considered to be immediately necessary (medical necessity) • The name of the physician accepting responsibility for the recipient <p>A mere statement that an emergency existed is not sufficient.</p>

Box #	Field Name	Error
24D	PROCEDURES, SERVICES OR SUPPLIES	Omitting modifiers or entering incorrect information when required Billing Tip: Do not use Medicare modifiers. Enter procedure description, if necessary, in the <i>Additional Claim Information</i> field (Box 19).
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	Submitting unsigned claims or claims with illegible signatures. Using initials or stamped signatures or signature extending outside the box. Billing Tip: Signatures must be written, not printed, in blue or black ink. Do not allow signature to extend outside the box. Stamps, initials or facsimiles are not acceptable.
32	SERVICE FACILITY LOCATION INFORMATION	Entering the wrong facility ID number for the POS entered in field 24B. Omitting the facility ID number when a facility-related Place of Service code is entered in field 24B. Billing Tip: Enter the facility ID number/NPI in field A or B.
33	PHYSICIAN, SUPPLIER INFO & PH #	Entering the wrong nine-digit ZIP code according to the 10-digit NPI on file Billing Tip: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.

NOTES

Learning Activities

Learning Activity 1: Matching Terms Puzzle

Medi-Cal Knowledge: Match the terms in the second column to the best available answer in the second column.

- | | | |
|-----------|-----------------------|---------------------------------------|
| 1. _____ | BIC | A) Client Index Number |
| 2. _____ | CIN | B) Resubmission Turnaround Document |
| 3. _____ | EOB | C) Health Care Plan |
| 4. _____ | HCP | D) Share of Cost |
| 5. _____ | NPI | E) ID card |
| 6. _____ | POE | F) Provider Number |
| 7. _____ | RAD | G) Proof of Eligibility |
| 8. _____ | RTD | H) TAR Control Number |
| 9. _____ | Spend Down | I) Remittance Advice Details |
| 10. _____ | Authorization Request | J) Explanation of Benefits |
| 11. _____ | TCN | K) TAR or SAR |
| 12. _____ | DHCS | L) Department of Health Care Services |

Answer Key: 1) E; 2) A; 3) J; 4) C; 5) F; 6) G; 7) I; 8) B; 9) D; 10) K; 11) H; 12) L

Learning Activity 2: Word Scramble

Unscramble the following words:

1. ematceRitn _____
2. OCS _____
3. alenDsi _____
4. wol-uplFo _____
5. msleTinise _____
6. CCNI _____
7. cRiiptene _____
8. ribesbrcSu _____
9. Mngaaed eraC alnP _____
10. CDI iidncrato _____

Answer Key: 1) Remittance; 2) SOC; 3) Denials; 4) Follow-up; 5) Timeliness;
6) NCCI (National Correct Coding Initiative); 7) Recipient; 8) Subscriber;
9) Managed Care Plan; 10) ICD indicator

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

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

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

Provider Manual References

Part 1

Medicare/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)*

Acronyms

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

NOTES

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.)
- **Health Insurance Claim (HIC) number:** The Medicare recipient's identification number.

Brainteaser

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

Answer Key: coinsurance, deductible

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. PCPrint 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.

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

Category	Description
Coughs and colds	Symptomatic relief
Non-prescription drugs	Part D, not Medi-Cal; covers insulin, syringes and smoking cessation products
Prescription vitamins and minerals	Select single vitamins and minerals pursuant to <i>Treatment Authorization Request</i> (TAR) or utilization restrictions. Combination vitamin and mineral products are not a benefit. Vitamins or minerals used for dietary supplementation are not a benefit.
Weight control	Anorexia, weight loss or weight gain

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.

Brainteaser

1. What types of services does Medicare Part A cover? _____
2. What types of services does Medicare Part B cover? _____ and _____

Answer Key: 1) Inpatient; 2) Outpatient, professional

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 Health Insurance Claim number (HIC) _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Part B	Subscriber has Part B Medicare coverage with HIC 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 HIC 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 HIC 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 HIC 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 HIC number _____. Medicare Part A and Part B-covered services must be billed to Medicare before billing Medi-Cal.
Part D	Subscriber has Part D Medicare coverage with HIC 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 HIC # _____.
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 does will not appear on RAs 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 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.

Brainteaser

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

Answer Key: restricted, Medicare services only

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) to automatically cross over Medi-Cal claims 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.

Brainteaser

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

1. _____
2. _____

Answer Key: 1) Claim is unassigned; 2) Medicare denied 100% of the claim

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 DHCS 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.**

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 <u>signed, dated and stamped</u> by Social Security Administration (SSA) or any documentation on SSA or Department of Health and Human Services (HHS) letterhead	<ul style="list-style-type: none"> • 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.

Brainteaser

Which OHC code is used to identify a Medicare HMO?_____.

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

The following billing tips will help prevent Medi-Cal rejections, delays, mispayments 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
Xerox State Healthcare, LLC
P.O. Box 15500
Sacramento, CA 95852-1500

All Other Provider Types
Xerox State Healthcare, LLC
P.O. Box 15700
Sacramento, CA 95852-1700

Hard Copy Submission Requirements

Inpatient Services

Part A Services Billed to Part A Contractor

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

Follow these instructions to bill for services rendered:

Box #	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.

14 Crossover Claims

Box #	Form Fields	Instructions
39 – 41 A – D	VALUE CODES AND AMOUNTS	<ul style="list-style-type: none"> 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.
47	TOTAL CHARGES AMOUNT	The Total Charges and amount must match the Medicare RA in column 42, line 23.
50	PAYER NAME	<p>Payers must be listed in the following order of payment:</p> <ul style="list-style-type: none"> 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 – C	PRIOR PAYMENTS	<p>Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50.</p> <p>NOTE The Medicare payment amount must match the MNSIRA ALLOW/REIM amount <u>not</u> the NET REIMB AMT.</p>
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 <i>UB-04</i> claim form using the provider NPI in effect appropriate for the date of service on the claim
57 A – 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 – C	INSURED'S UNIQUE ID	Enter the beneficiaries HIC 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

$$\begin{aligned}
 & \text{SUM (Blood deductible + Medicare deductible + Medicare coinsurance)} \\
 & - \text{SUM (SOC, OHC, Medicare supplemental insurance payments)} \\
 & = \text{Amount Due}
 \end{aligned}$$

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2	3 PAT CNTL # 12345	4 TYPE OF BILL 111
9 PATIENT NAME a DOE, JANE	9 PATIENT ADDRESS b	5 FED. TAX NO. 100116	6 STATEMENT COVERS PERIOD FROM 100716
10 BIRTHDATE 08241980	11 SEX F	12 DATE 100116	13 HR 05
14 TYPE 1	15 SFC 11	16 DHR 01	17 STAT 01
31 OCCURRENCE CODE 50	32 OCCURRENCE DATE 120816	33 OCCURRENCE CODE	34 OCCURRENCE DATE
35 OCCURRENCE CODE	36 OCCURRENCE DATE	37 OCCURRENCE CODE	38 OCCURRENCE DATE
39 VALUE CODES AMOUNT A1 99200	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT	42 VALUE CODES AMOUNT
43 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE
46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
001	PAGE OF	CREATION DATE	TOTALS TOTAL CHARGE 967250
50 PAYER NAME A MEDICARE B I/P MEDI-CAL	51 HEALTH PLAN ID 54321	52 REL INFO	53 ASG BEN
54 PRIOR PAYMENTS 304952	55 EST. AMOUNT DUE 967250	56 NPI 12456789	57 OTHER PRV ID
58 INSURED'S NAME A JANE DOE	59 P.REL.	60 INSURED'S UNIQUE ID 123456789X 90000000A95001	61 GROUP NAME
62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
88 DX D1D1D1D	A	B	C
89 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI
74 PRINCIPAL PROCEDURE DATE	a OTHER PROCEDURE DATE	b OTHER PROCEDURE DATE	75 OTHER PROCEDURE DATE
c OTHER PROCEDURE DATE	d OTHER PROCEDURE DATE	e OTHER PROCEDURE DATE	76 ATTENDING NPI 1234567890
77 OPERATING NPI	78 OTHER NPI 2345678901	79 OTHER NPI	QUAL
80 REMARKS	81 CC a	b	c
d	e	f	g

Example: Inpatient UB-04 Crossover Claim Form

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

UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN, CA 95823-5555			MEDICARE REMITTANCE ADVICE							
NPI: 0123456789 Reimbursement Rate: 032 Claim Type: Inpatient Date: 12/08/16 Remittance Number: 032 Page 1										
PATIENT NAME	HIC NUMBER	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	123456789X 12345	100116	100716	7	0	9672.50	992.00	0.00	0.00	0.00
			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 #	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 <i>Medicare National Standard Intermediary Remittance Advice</i> (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 – 41 A – D	VALUE CODES AND AMOUNTS	Enter code 23 and the patient's SOC for the claim. Leave blank, if not applicable. <ul style="list-style-type: none"> • 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.
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. <ul style="list-style-type: none"> • The Revenue Code must display "001" in column 42, line 23.
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.

18 Crossover Claims

Box #	Field Name	Instructions
50	PAYER NAME	<p>Payers must be listed in the following order of payment:</p> <ul style="list-style-type: none"> • 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 – C	PRIOR PAYMENTS	<p>Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50.</p> <p>NOTE The Medicare payment amount must match the MNSIRA ALLOW/REIM amount <u>not</u> the NET REIMB AMT.</p>
55	ESTIMATED AMOUNT DUE	<ul style="list-style-type: none"> • 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 <i>UB-04</i> claim form using the provider NPI in effect appropriate for the date of service on the claim
76, 77, 78, 79	ATTENDING, OPERATING, & OTHER	Enter appropriate provider NPI.

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3 PAT. CNTL # D. MED. REC. # 123456789		4 TYPE OF BILL 131	
8 PATIENT NAME a DOE, JANE				9 PATIENT ADDRESS a			
10 BIRTHDATE 08241980		11 SEX F		12 DATE 100116		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
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618		619		620		621	
622		623		624		625	
626		627		628		629	
630		631		632		633	
634		635		636		637	
638		639		640		641	
642		643		644		645	
646		647		648		649	
650		651		652		653	
654		655		656		657	
658		659		660		661	
662		663		664		665	
666		667		668		669	
670		671		672		673	
674		675		676		677	
678		679		680		681	
682		683		684		685	
686		687		688		689	
690		691		692		693	
694		695		696		697	
698		699		700		701	
702		703		704		705	
706		707		708		709	
710		711		712		713	
714		715		716		717	
718		719		720		721	
722		723		724		725	
726		727		728		729	
730		731		732		733	
734		735		736		737	
738		739		740		741	
742		743		744		745	
746		747		748		749	
750		751		752		753	
754		755		756		757	
758		759		760		761	
762		763		764		765	
766		767		768		769	
770		771		772		773	
774		775		776		777	
778		779		780		781	
782		783		784		785	
786		787		788		789	
790		791		792		793	
794		795		796		797	
798		799		800		801	
802		803		804		805	
806		807		808		809	
810		811		812		813	
814		815		816		817	
818		819		820		821	
822		823		824		825	
826		827		828		829	
830		831		832		833	
834		835		836		837	
838		839		840		841	
842		843		844		845	
846		847		848		849	
850		851		852		853	
854		855		856		857	
858		859		860		861	
862		863		864		865	
866		867		868		869	
870		871		872		873	
874		875		876		877	
878		879		880		881	
882		883		884		885	
886		887		888		889	
890		891		892		893	
894		895		896		897	

20 Crossover Claims

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

```

=====
                          Medicare National Standard Intermediary Remittance Advice
=====
Uptown Medical Center          FPE:      02/01/17      Medicare Contractor
140 Second Street             PAID:     11/15/16      1234 B Street
Anytown, CA 95823-5555       CLM#:     166           Anytown, CA 98765-5555
0123456789                   TOB:      131           555-555-5555
=====
PATIENT: DOE, JANE          PCN: 123456789
HIC: 123456789X            MRN: 000193638
PAT STAT: CLAIM STAT: 19   SVC FROM: 10/01/2016  THRU: 10/01/2016  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 PCPrint 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 #	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 <i>Medicare</i> and <i>Medicaid</i> boxes.
1A	INSURED'S ID NUMBER	Enter the recipient's HIC number.
9A	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the 14-character Medi-Cal recipient identification number from the Beneficiary Identification Card.
10D	CLAIM CODES (DESIGNATED BY NUCC)	Enter the patient's SOC for the service (leave blank if not applicable).
11C	INSURANCE PLAN NAME OR PROGRAM NAME	Enter the Medicare Contractor ID.
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only. An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. (The legacy Medi-Cal ID was previously required in this field for crossovers.)
32	SERVICE FACILITY LOCATION INFO.	Enter the full address where services were provided, including the nine-digit ZIP code.
32A	SERVICE FACILITY NPI	Enter the NPI of the Service Facility.
33	BILLING PROVIDER INFORMATION	Enter the full billing address, including the nine-digit ZIP code.
33A	BILLING PROVIDER NPI	Enter the NPI of the Billing Provider.

HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12</small>																																																																																								
1. MEDICARE <input type="checkbox"/> PICA <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicare#) <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789X																																																																														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN				3. PATIENT'S BIRTH DATE MM DD YY SEX 06 21 62 M <input checked="" type="checkbox"/> <input type="checkbox"/>				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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				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		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:																																																																																
a. OTHER INSURED'S POLICY OR GROUP NUMBER 9000000A95001				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)																																																																																
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																																																																																
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE MM DD YY QUAL				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY 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 FROM MM DD YY TO MM DD YY																																																																																
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0																																																																																								
A. D1D1D1D1			B. D2D2D2D2			C. D3D3D3D3			D. _____																																																																															
E. _____			F. _____			G. _____			H. _____																																																																															
I. _____			J. _____			K. _____			L. _____																																																																															
22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																																								
23. PRIOR AUTHORIZATION NUMBER																																																																																								
<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>1</th> <th>2</th> <th>3</th> <th>4</th> <th>5</th> <th>6</th> <th>F. \$ CHARGES</th> <th>G. DAYS OR UNITS</th> <th>H. EPOSDT Family Plan</th> <th>I. ID. QUAL.</th> <th>J. RENDERING PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td>10</td><td>01</td><td>16</td><td>10</td><td>01</td><td>16</td><td>11</td><td>99214</td><td>1</td><td>55 00</td><td>NPI</td> </tr> <tr> <td>10</td><td>01</td><td>16</td><td>10</td><td>01</td><td>16</td><td>11</td><td>71020</td><td>2</td><td>60 00</td><td>NPI</td> </tr> <tr> <td>10</td><td>01</td><td>16</td><td>10</td><td>01</td><td>16</td><td>11</td><td>93000</td><td>3</td><td>50 00</td><td>NPI</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td>NPI</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td>NPI</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td>NPI</td> </tr> </tbody> </table>												1	2	3	4	5	6	F. \$ CHARGES	G. DAYS OR UNITS	H. EPOSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	10	01	16	10	01	16	11	99214	1	55 00	NPI	10	01	16	10	01	16	11	71020	2	60 00	NPI	10	01	16	10	01	16	11	93000	3	50 00	NPI											NPI											NPI											NPI
1	2	3	4	5	6	F. \$ CHARGES	G. DAYS OR UNITS	H. EPOSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #																																																																														
10	01	16	10	01	16	11	99214	1	55 00	NPI																																																																														
10	01	16	10	01	16	11	71020	2	60 00	NPI																																																																														
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										NPI																																																																														
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										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																																																																													
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 165 00		29. AMOUNT PAID \$ 165 00																																																																												
30. Rsvd for NUCC Use				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 <i>Jane Smith</i> DATE 10/21/16				32. SERVICE FACILITY LOCATION INFORMATION JOHN BROWN 651 FIRST STREET ANYTOWN, CA 958235555				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN, CA 958235555																																																																												
a. 1234567890				b. _____				a. 1234567890		b. _____																																																																														

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

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

10/01/16

Medicare Remittance Notice											
Medicare Contractor (12345)											
BENEFICIARY NAME H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE		PLACE TYPE	PROCEDURE	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
	FROM MO-DAY	TO DAY-YR		CODE-MODIFIER							
JOHN DOE 570570A	10-01-16	10-01-16	11 11	99214	55.00	40.00		0.00	08.00	32.00	
	10-01-16	10-01-16		71020	60.00	50.00		0.00	10.00	40.00	
	10-01-16	10-01-16		93000	50.00	45.00		0.00	09.00	36.00	
CLAIM TOTALS					165.00	133.00		0.00	27.00	108.00	0.00

Example: Simplified Medicare Remittance Notice

Inpatient Part B-Only Services

Part B-Only Services Billed to a Part A Contractor

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

Reminders:

- Submit the *UB-04* claim form, including each of the appropriate accommodation and ancillary services.
- Enter the payment amount in the appropriate *Prior Payment* field (Box 54) when Part B payment appears on a MNSIRA.
- Attach the MNSIRA labeled “ancillary” or “Part B” to the straight Medi-Cal claim. For providers who receive an ERA, the single claim detail level MNSIRA printed with Medicare’s free PCPrint 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.

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, mispayments 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 as well as corresponding Remittance Advice Details (RAD) code examples.

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.

NOTES

The most common RAD codes and messages related to crossover claims are listed in the following table.

RAD Code	Description
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0371	Line detail crossover submitted incorrectly on Medi-Cal claim; submit only copy of Medicare claim and EOMB (<i>Explanation of Medicare Benefits</i>) to Crossover Unit, P.O. Box 15700, Sacramento, CA 95852-1700.
0372	This crossover must be billed with line-specific information. Please resubmit with line item information.
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.
0442	Medicare payment meets or exceeds Medi-Cal maximum reimbursement.
0443	Medi-Cal payment may not exceed the maximum amount allowed by Medi-Cal.
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.
9091	The date of service does not match the submitted date of report.

Refer to the *Remittance Advice Details (RAD) Codes and Messages* sections of the Part 1 provider manual for a complete list of RAD codes and billing tips.

Brainteaser

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

Answer Key: amount allowed

Payment Examples

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

0395 Medicare Non-Covered Benefit

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

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT	COINSUR	BILLED TO MEDI-CAL	MEDI-CAL ALLOWED	COMPUTED MEDI-CAL AMOUNT	DEDUCT PLUS COINSUR	PAID AMOUNT	RAD CODE
				"Medicare Allowed" minus "Deduct" X 80%	"Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	"Deduct" plus "Coinsur"	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.)	"Medi-Cal Allowed" minus "Computed Medicare Amount"	"Deduct" plus "Coinsur"	The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	
99214	50.00	45.20	0.00	36.16	9.04	9.04	45.20				
93000	50.00	0.00	0.00	0.00	0.00	0.00	0.00		-		0395
Claim Totals	100.00	45.20	0.00	36.16	9.04	9.04	45.20	9.04	9.04	9.04	

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

CA MEDI-CAL Remittance Advice Details										TO: JOHN DOE, M.D. 400 CALIFORNIA STREET ANYTOWN, CA 95344	
REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES										PAGE: 1 OF 1 PAGES	
PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE							
0123456789	MCARE CROSSOVER	39248026	20000617	12/03/07							
RECIPIENT NAME	RECIPIENT MEDICAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES	ACCOM/PROC. CODE	PATENT ACCOUNT NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT	PAID AMOUNT	RAD CODE
DOE	90000000A90015	4069852123000	073107 073107	92214 93000		0001 0001	45.20	45.20			0395
BLOOD DEDUCT	TOTAL 0.00	4069852123000 0.00	073107 COINS	9.04	CUTBACK	0.00	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.										

Example: RAD code 0395

0442 Cutback (Zero Pay)

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

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT	COINSUR	BILLED TO MEDI-CAL	MEDI-CAL ALLOWED	COMPUTED MEDI-CAL AMOUNT	DEDUCT PLUS COINSUR	PAID AMOUNT	RAD CODE
				"Medicare Allowed" minus "Deduct" X 80%	"Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	"Deduct" plus "Coinsur"	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.)	"Medi-Cal Allowed" minus "Computed Medicare Amount"	"Deduct" plus "Coinsur"	The lesser of "Computed Medicare Amount" or "Deduct plus Coinsur" (negative = 0)	
99214	300.00	280.44	0.00	224.35	56.09	56.09	117.60				
71020	15.00	14.57	0.00	11.66	2.91	2.91	11.88				
93000	75.00	72.04	0.00	57.63	14.41	14.41	47.16				
Claim Totals	390.00	367.05	0.00	293.64	73.41	73.41	176.64	-117.00	73.41	0.00	442

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

CA MEDI-CAL Remittance Advice Details												TO: ST. JOE'S HOSPITAL 1000 OAK STREET ANYTOWN, CA 93332-6720	
PROVIDER NUMBER: 1234567890												DATE: 08/29/07	
CLAIM TYPE: MCARE CROSSOVER												PAGE: 1 OF 1 PAGES	
WARRANT NO: 39248026												REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES	
ACS SEQ. NO: 20000617													
RECIPIENT NAME	RECIPIENT MEDICAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES		ACCOM. PROC. CODE	PATIENT CONTROL NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT	PAID AMOUNT	RAD CODE	
DOE	90000000A90715	0213820410700	FROM	TO									
			MMDYY	MMDYY									
APPROVES (RECONCILE TO FINANCIAL SUMMARY)													
			071907	071907	73030TC	4006300	0001	130.10	22.92				
			071907	071907	73060TC		0001	115.30	18.34				
BLOOD DEDUCT	TOTAL	0213820410700	071907	071907	CUTBACK	49 08	SOC	245.40	41.26	196.32		0442	
	0.00 DEDUCT		0 00	COINS				0 00					
EXPLANATION OF DENIAL/ADJUSTMENT CODES													
442 MEDICARE PAYMENT MEETS OR EXCEEDS MEDI-CAL MAXIMUM REIMBURSEMENT.													

Example: RAD code 0442

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

0443 Cutback with Deductible

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

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	MEDICARE PAYMENT	COINSUR	BILLED TO MEDI-CAL	MEDI-CAL ALLOWED	COMPUTED MEDI-CAL AMOUNT	DEDUCT PLUS COINSUR	PAID AMOUNT	RAD CODE
			From RA	From RA	From RA	"Deduct" plus "Coinsur"	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.)	"Medi-Cal Allowed" minus "Medicare Payment"	"Deduct" plus "Coinsur"	The lesser of "Computed Medi-Cal Amount" or "Deduct plus "Coinsur" (negative = 0)	
<u>77057</u>	108.01	108.01					70.87				
Claim Totals	108.01	108.01	100.00	6.41	1.60	101.60	70.87	64.46	101.60	64.46	443

Example: Pricing for 0443 Cutback (with deductible)

CA MEDI-CAL Remittance Advice Details										TO: VALLEY HOSPITAL 1000 SMITH STREET ANYTOWN, CA 95888-4444		
PROVIDER NUMBER		CLAIM TYPE		WARRANT NO		ACS SEQ. NO		DATE		PAGE: 1 OF 1 PAGES		
0123456789		MCARE CROSSOVER		39248026		20000617		09/29/07				
RECIPIENT NAME	RECIPIENT MEDICAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES		ACCOM/ PROC. CODE	MEDICAL REC NUM/ PATIENT ACCT#	DAY	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT	PAID AMOUNT	RAD CODE
			FROM	TO								
			MM/YY	MM/YY								
APPROVES DOE	(RECONCILE TO FINANCIAL SUMMARY) 90000000A90071	0123825312500	082707	082707	<u>77057</u>	M847585914	0001	108.01	<u>70.87</u>	6.41-	<u>64.46</u>	0443
BLOOD DEDUCT	0.00	DEDUCT	100.00	COINS	<u>3.60</u>	CUTBACK	37.14	SOC	0.00			
EXPLANATION OF DENIAL/ADJUSTMENT CODES												
443 MEDICAL PAYMENT MAY NOT EXCEED THE MAXIMUM AMOUNT ALLOWED BY MEDI-CAL.												

Example: RAD code 0443

NOTES

Charpentier Claims

A permanent injunction (Charpentier v. Belshé [Coye/Kizer]) filed December 29, 1994, allows providers to rebill Medi-Cal for supplemental payment for Medicare/Medi-Cal Part B services, excluding physician and laboratory services. This supplemental payment applies to crossover claims when Medi-Cal's allowed rates or quantity limitations exceed the Medicare-allowed amount.

NOTE

Part A intermediaries do not use a fee schedule to determine allowed amounts for each service; therefore, this only applies to Part B services billed to Part B contractors. All Charpentier rebilled claims must have been first processed as Medicare/Medi-Cal crossover claims.

The following definitions apply to Charpentier rebills:

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

Pricing Information

Cutback

If there is a price on file, crossover claims will be cut back with RAD code **0444: For non-physician claims, see Charpentier billing instructions in the provider manual. Medi-Cal automated system payment does not exceed the Medicare allowed amount.**

Medicare-Allowed Amount

If there is no price on file, Medi-Cal adopts the Medicare-allowed amount and a 0444 cutback is not reflected on the RAD.

Exceeds Medicare Rate

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

NOTE

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

Brainteaser

A Charpentier claim may be billed for?

1. _____ 2. _____ 3. _____

Answer Key: 1) rates; 2) limitations; 3) rates and limitations

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
- Identify modifiers used by a surgical team member
- Review pre-operative and post-operative services policy
- Identify modifiers for Non-Physician Medical Practitioners (NMPs)
- Discuss the discontinuation of local modifier ZS
- Provide general information regarding anesthesia-related drug and supply modifiers
- Explain “By Report” documentation

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

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)

Modifiers: Approved List (modif app)

Modifiers Used With Procedure Codes (modif used)

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

Radiology (radi)

Radiology: Diagnostic (radi dia)

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)

Acronyms

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

NOTES

Description

The use of modifiers is an important 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:

Anesthesia Drugs & Supplies: UA, UB

Evaluation and Management: 24, 25

General Use: 22, 26, 52, 54, 55, 62, 66, 78, 79, 99

Non-physician Medical Practitioner: U7, SA, SB

Radiology: 26, TC

Use of a modifier with a CPT-4 or HCPCS code does not ensure reimbursement. Documentation of medical necessity may also be required for certain procedure codes.

Surgical Modifier Policies

Refer to the *Modifiers: Approved List* section (modif app) in the Part 2 provider manual for a complete list of approved modifier codes for billing Medi-Cal. Modifiers not listed in the *Modifiers: Approved List* section are unacceptable for billing Medi-Cal.

Surgical Procedures Codes and Modifiers

Inappropriate Modifier Use

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.

4 Surgical Modifiers

Claim Form Placement

Modifier form locations appear as “XX.” See claim form examples below:

24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTNER	F. \$ CHARGES	G. DAYS OR UNITS	H. FROD/ Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY										
10	11	16				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	101116		

Sample: Partial UB-04 Claim Form

Billing Modifiers for Surgical Procedures

Primary Surgeon Modifiers

Codes

Modifier	Description
AG	Primary Surgeon
	Multiple Primary Surgeons
50	Bilateral Procedure
51	Multiple Procedures
99	Multiple Modifiers

Modifier Description

Primary Surgeon (Modifier AG)

The primary surgeon or podiatrist is required to use modifier AG on the only, or the highest valued, procedure code being billed for the date of service.

NOTE

Modifier AG exception: CPT-4 code 58565 (hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) must not be billed with modifier AG. Claims submitted with code 58565 and modifier AG will be returned to the provider. See the *Sterilization (ster)* section in the appropriate Part 2 provider manual for details.

Multiple Primary Surgeons (Modifier AG)

Two or more surgeons may use modifier AG for the same patient on the same date of service, 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 Exceptions

The following medical policies have been established for specific, multiple surgeries and are not reimbursable 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-4 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-4 codes 58700, 58720, 58900 – 58943) billed on the same date of service as a hysterectomy (CPT-4 codes 58150 – 58285) is not separately reimbursable.
- A vaginal delivery (CPT-4 codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT-4 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 bladder catheter (CPT-4 codes 51701 and 51702) is not separately reimbursable when billed with CPT-4 codes 10021 – 69979.
- CPT-4 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-4 code within the ranges of 0100 – 69999 and 96360 – 96549.

National Correct Coding Initiative (NCCI)

A number of surgical procedures are subject to NCCI edits. To process correctly, claims submitted for multiple surgical procedures on the same day may require the addition of an NCCI-associated modifier. Information about NCCI-associated modifiers is included in the *Surgery: Billing with Modifiers* section of the Part 2 provider manual (surg bill mod, page 5).

Bilateral Procedures (Modifier 50)

Modifier 50 is used when bilateral procedures performed add significant time or complexity to patient care at a single operative session.

NOTE

Check CPT-4 code for procedure descriptor.

6 Surgical Modifiers

Claim Form Examples Using Modifier 50

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) LINE 1: BUNIONECTOMY, RT FOOT. LINE 2: BUNIONECTOMY, LT FOOT.										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. D1D1D1D B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE From To			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. SPOBT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	10	11	16	21	28290	AG			16171	1		NPI	
2	10	11	16	21	28290	50			16171	1		NPI	
3												NPI	
4												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
1	BUNIONECTOMY, RT FOOT	28290AG	101116	1	16171		1
2	BUNIONECTOMY, LF FOOT	2829050	101116	1	16171		2
3							3
4							4
5							5
6							6
7							7

Sample: Partial UB-04 Claim Form

69 YR 01	D1D1D1D	A	B	C	D	E	F	G	H	68
0										
69 ADMIT DX.		70 PATIENT REASON DX.	a	b	71 IIPS CODE	72 ECI	a	b	c	73
74	PRINCIPAL PROCEDURE CODE	DATE	9	OTHER PROCEDURE CODE	DATE	10	OTHER PROCEDURE CODE	DATE	11	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	b1	c	d	e	f	g	h	i	j
	LINE 1: BUNIONECTOMY, RT FOOT									
	LINE 2: BUNIONECTOMY, LT FOOT									

Sample: Partial UB-04 Claim Form: Remarks field (Box 80)

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.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) LINES 4 AND 6: MODIFIERS 50 + 51. SEE ATTACHMENT.										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. D1D1D1D B. D2D2D2D C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER						
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										F. \$ CHARGES		G. DAYS OR UNITS	H. EPSON Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #	
1	10	11	16		21		68720	AG			16171	1		NPI		
2	10	11	16		21		68720	50			16171	1		NPI		
3	10	11	16		21		31200	51			12128	1		NPI		
4	10	11	16		21		31200	99			12128	1		NPI		
5	10	11	16		21		30130	51			10000	1		NPI		
6	10	11	16		21		30130	99			10000	1		NPI		

Sample: Partial CMS-1500 Claim Form

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	DACRYOCYSTORHINOSTOMY	68720AG	101116	1	16171		1
2	DACRYOCYSTORHINOSTOMY	6872050	101116	1	16171		2
3	ETHMOIDECTOMY	3120051	101116	1	12128		3
4	ETHMOIDECTOMY	3120099	101116	1	12128		4
5	EXCISION TURBUNATE	3012051	101116	1	10000		5
6	EXCISION TURBUNATE	3013099	101116	1	10000		6

Sample: Partial UB-04 Claim Form

06	D1D1D1D	D2D2D2D	B	C	D	E	F	G	H	Q	88	
07	0											
69	ADMIT DX	70	PATIENT REASON DX	71	ICD CODE	72	EQ	a	b	c	73	
74	PRINCIPAL PROCEDURE CODE	75	OTHER PROCEDURE CODE	76	OTHER PROCEDURE CODE	77	OTHER PROCEDURE CODE	78	ATTENDING NPI	1234567890	QUAL	
79	OPERATING NPI	2345678901	QUAL	79	OTHER NPI	79	OTHER NPI	79	OTHER NPI	79	OTHER NPI	
80	REMARKS										81	CC
LINES 4 AND 6: MODIFIER 99=50+51. SEE ATTACHMENT.											a	
LINES 4 AND 6: MODIFIER 99=50+51. SEE ATTACHMENT.											b	
LINES 4 AND 6: MODIFIER 99=50+51. SEE ATTACHMENT.											c	
LINES 4 AND 6: MODIFIER 99=50+51. SEE ATTACHMENT.											d	

Sample: Partial UB-04 Claim Form: Remarks field (Box 80)

Multiple Procedures (Modifier 51)

The multiple procedures modifier identifies the secondary, additional or lesser procedures for multiple procedures that are performed on the same day or at the same operative session.

Reimbursement Rule:

CPT-4 Code/Modifier	Reimbursement Formula
41150 AG	100% of full-fee rate
38720 51	50% of full-fee rate
15120 51	50% of full-fee rate
31600 51	50% of full-fee rate

Billing Tip: 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.

Modifier 51 Versus Modifier 99

- Modifier 51 describes second, third or subsequent differing procedures.
- Modifier 99 describes third and subsequent identical procedures.

Assistant Surgeon Modifiers**Codes**

Modifier	Description
80	Assistant Surgeon
99	Multiple Modifiers

Modifier Descriptions**Assistant Surgeon (Modifier 80)**

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 any multiple surgical procedures must be identified by the use of modifier 99 (multiple modifiers).

NOTE

Not all surgical procedures reimburse for an assistant surgeon. To determine if there are any restrictions refer to the *TAR and Non-Benefit: Introduction to List* section (tar and non) in the appropriate Part 2 provider manual to verify.

Multiple Modifiers (Modifier 99)

Under certain circumstances two or more modifiers may be necessary to completely define a service.

- Use modifier 99 with the appropriate procedure code.
- Explain modifier 99 in the *Remarks* field (Box 80) for *UB-04* claims and *Additional Claim Information* field (Box 19) for *CMS-1500* claims.

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. If billing multiple codes that have “each additional” in the descriptor use 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.

CMS-1500 Form

Current Billing Method

	24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY	CPT/HCPCS			MODIFIER								
1	02	11	16	21		15002	AG		42500	1		NPI		
2	02	11	16	21		15003	51		20000	1		NPI		
3	02	11	16	21		15003	51		20000	1		NPI		
4	02	11	16	21		15003	51		20000	1		NPI		
5												NPI		
6												NPI		

Preferred Billing Method

	24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY	CPT/HCPCS			MODIFIER								
1	02	11	16	21		15002	AG		42500	1		NPI		
2	02	11	16	21		15003	51		60000	3		NPI		
3												NPI		
4												NPI		
5												NPI		
6												NPI		

UB-04 Form

Current Billing Method

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1		15002AG	021116	1	42500
2		1500351	021116	1	20000
3		1500351	021116	1	20000
4		1500351	021116	1	20000

Preferred Billing Method

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1		15002AG	021116	1	42500
2		1500351	021116	3	60000
3					
4					

Other Surgical Modifiers

If modifiers U7, 22, 62, 66, 78, 79 or 80 are used for multiple surgical procedures billed by someone other than the primary surgeon (AG), then use modifier 99 with the appropriate procedure code. Explain modifier 99 in the *Remarks* field (Box 80) on *UB-04* claims and *Additional Claim Information* field (Box 19) on *CMS-1500* claims.

NOTE

When billing for a primary surgeon with modifier AG, use modifier 51 for second, third or subsequent differing procedures. Use modifier 99 for third or subsequent identical procedures.

Complex Operative Procedure Modifiers

Codes

Modifier	Description
22	Increased Procedural Services

Modifier Descriptions

Increased Procedural Services (Modifier 22)

Describes procedures involving significantly increased operative complexity and/or time in a significantly altered surgical field resulting from the effects of:

- 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.

NOTES

Additional Surgeon(s) Modifiers

Codes

Modifier	Description
62	Two Surgeons
66	Surgical Team

Modifier Descriptions

Two Surgeons (Modifier 62)

Identifies a surgical procedure that requires two surgeons who are performing distinct parts of a procedure.

NOTE

Each surgeon would bill with modifier 62.

Surgical Team (Modifier 66)

Indicates the services of all physician members of a surgical team. Anesthesiologists must submit a separate claim for services.

NOTE

CPT-4 guidelines for modifier 66 allow each member of a surgical team to bill separately for their services; however, Medi-Cal requires that all team members bill on the same claim form.

Operative/Postoperative Modifiers

Codes

Modifier	Description
52	Reduced services
54	Surgical care only
55	Postoperative Management only
58 NCCI-associated	Staged or related procedure by the same physician during the postoperative period

Modifier Descriptions

Reduced Services (Modifier 52)

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

Operative Postoperative Management (Modifier 54)

Surgical care only

Operative Postoperative Management (Modifier 55)

Post-operative management only

Staged or Related Procedure Postoperative Period (Modifier 58)

May be used with CPT-4 codes 15002 – 15429 and 52601 to address subsequent part(s) of a staged procedure.

Additional Operative Procedure Modifiers

Codes

Modifier	Description
78 NCCI-associated	Unplanned return to operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period
79 NCCI-associated	Unrelated procedure or service by the same physician during the postoperative period

Modifier Descriptions

Return to Operating Room (Modifier 78)

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

Return to Operating Room (Modifier 79)

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

Use of Discontinued Procedure Modifiers

Codes

Modifier	Description
53	Discontinued procedure; requires "By Report" documentation
73	Discontinued procedure in an outpatient hospital/ambulatory surgery center prior to the administration of anesthesia
74	Discontinued procedure in an outpatient hospital/ambulatory surgery center after administration of anesthesia

NOTE

A number of surgical procedures are subject to NCCI edits. To process correctly, claims submitted for multiple surgical procedures on the same day may require the addition of an NCCI-associated modifier. Information about NCCI-associated modifiers is included in the *Correct Coding Initiative: National (correct)* section in the appropriate Part 2 provider manual.

Brainteasers:

1. A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 10, 2016. The cone biopsy was performed on January 17, 2016. What modifier should be used for the cone biopsy? _____
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 Key: 1) 79; 2) 78

Evaluation and Management (E&M) Modifiers

E&M Examinations

Policy for Pre-Operative Visits Before or on the Day of Surgery

When performing a pre-operative visit on the day of or the day before a surgical procedure, the same primary or assistant surgeon must document medical justification in the *Remarks* field (Box 80) of the *UB-04* claims form or the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form. Exceptions to this policy may be made when the pre-operative visit is an initial emergency visit requiring extended evaluation or detention.

Postoperative

Office visits, hospital visits and consultations 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.

Code Exceptions

Modifier	Description
24 NCCI-associated	Unrelated E&M service by the same physician during a postoperative period
25 NCCI-associated	Significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service

NOTE

Modifiers 24 and 25 require documentation.

NOTES

Non-Physician Medical Practitioner (NMP)

Non-Physician Medical Practitioners (NMPs) include:

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

Codes

Modifier	Description
U7	Physician assistant service
SA	Nurse practitioner rendering service in collaboration with a physician
SB	Nurse midwife

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.

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 modifiers 80 and 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. Separate reimbursement is not made for physician supervision of an NMP.

NMP Services Claim Examples

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) CNM, JANE SMITH, NPI 1234567890										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE		ORIGINAL REF. NO.		
A. D1D1D1D B. _____ C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER				
E. _____ F. _____ G. _____ H. _____														
I. _____ J. _____ K. _____ L. _____														
24. A. DATE(S) OF SERVICE		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. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From MM DD YY To MM DD YY		SERVICE												
1 02 11 16		11		57452		SB				27500	1		NPI	1098765432
2													NPI	
3													NPI	
4													NPI	

Sample: Partial CMS-1500 Claim Form

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	COLPOSCOPY	57452SA	021116	1	27500		1
2							2
3							3
4							4
5							5
20	PAGE	OF	CREATION DATE	TOTALS			23
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASO BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	A
						57 OTHER PFM ID	B
							C
58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.			A
							B
							C
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME					A
							B
							C
66 DX	D1D1D1D A B C D E F G H I J K L M N O P Q R						68
0							
69 ADMIT. DX.	70 PATIENT REASON DX.	71 HPPS CODE	72 ECI	73			
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 OTHER PROCEDURE CODE	77 OPERATING	78 ATTENDING NPI	0123456789	QUAL	
				LAST		FIRST	
				77 OPERATING	NPI	QUAL	
				LAST		FIRST	
80 REMARKS	81 CC			78 OTHER	NPI	QUAL	
NP, JANE SMITH, NPI # 1234567890	a			LAST		FIRST	
	b			79 OTHER	NPI	QUAL	
	c			LAST		FIRST	
	d						

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC® NUBC SYSTEMS LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: Partial UB-04 Claim Form

Anesthesia Related Drugs and Supplies Modifiers

Codes

Modifier	Description
UA	Supplies and drugs used in surgical procedures with other than general anesthesia or no anesthesia
UB	Supplies and drugs used in surgical procedures with general anesthesia

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.

HIPAA Code Conversion for Local Modifier ZS

On August 1, 2015, DHCS discontinued local modifier ZS (professional and technical component). When billing for both the professional and technical components, a modifier is neither required nor allowed per HIPAA compliance and CMS guidelines.

The termination of local modifier ZS affects claims and TARs for all split-billable procedures except for MRI, MRA and PET procedures. See the relevant sections of the Part 2 Medi-Cal Billing and Policy manual for details pertaining to the use of modifiers for MRI, MRA and PET procedures.

Claim Completion

Physician Billing: The physician bills for both the professional (26) and technical (TC) components and then reimburses the facility for the technical component (TC), according to their mutual agreements.

A *CMS-1500* claim form is completed with the procedure code on one claim line and without a modifier in the *Procedures, Services or Supplies/Modifier* field (Box 24D).

Facility Billing: The facility bills for both the technical (TC) and professional components (26) and then reimburses the physician for the professional component, according to their mutual agreements.

A *UB-04* claim form is completed with the procedure code on one claim line and without a modifier in the *HCPCS/Rate/HIPPS Code* field (Box 44).

Attachments – By Report

Attachment Requirements

The following is a list of Medi-Cal services that require “By Report” attachments:

- Surgical procedures
- Complicated procedures
- Unlisted services
 - No specific CPT-4 description of service
 - Requires a TAR
 - Time involved
 - Nature and purpose of procedure
 - Relation to diagnosis
- Anesthesia time

Documentation Requirements

The following is a list of required “By Report” documentation:

- Patient’s name
- Date of service
- Procedure code
- Operative report
- Estimated follow-up days
- Size, number and location of lesions (if applicable)

Learning Activities

Modifier Review

1. An assistant surgeon was involved in performing the procedure. What modifier should be used to bill for the assistant's services?
 - a. 99
 - b. 80
 - c. 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.
 - a. True
 - b. False
3. Procedures billed with modifier 51 are reimbursed at what percentage of the Medi-Cal maximum allowable?
 - a. 50%
 - b. 100%
 - c. Both
4. Is it possible to bill with more than one primary surgical procedure with modifier AG on the same date of service?
 - a. Yes
 - b. No
5. What modifier do I use if both the professional and technical components were performed after August 1, 2015?
 - a. 26
 - b. ZS
 - c. TC
 - d. None
6. For dates of service on or after October 1, 2015, providers should use the letter "O" to document the ICD indicator?
 - a. True
 - b. False

Answer key: 1) b; 2) a; 3) c; 4) a; 5) d; 6) b

Acronyms

AEVS	Automated Eligibility Verification System
ALLOW	Allowed
AMT	Amount
A/R	Accounts Receivable
BIC	Benefits Identification Card
CCN	Claim Control Number
CIF	Claims Inquiry Form
CIN	Client Index Number
CMC	Computer Media Claims
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
COBC	Coordination of Benefits Contractor
CPT-4	Current Procedural Terminology 4th Edition
CWF	Common Working File
DHCS	Department of Health Care Services
DOB	Date of Birth
DOI	Date of Issue
DOS	Date of Service
E&M	Evaluation and Management
EMG	Emergency
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
ERA	Electronic Remittance Advice
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
GHI	Group Health Incorporated
HCP	Health Care Plan
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIC	Health Insurance Claim
HMO	Health Maintenance Organization
ID	Identification
IP	Inpatient Services

LTC	Long Term Care
MAC	Medicare Administrative Contractor
MCP	Managed Care Plan
MAPD	Medicare Advantage Prescription Drug
MNSIRA	Medicare National Standard Intermediary Remittance Advice
MREP	Medicare Remit Easy Print Software
MRN	Medicare Remittance Notice
MSA	Medi-Cal Savings Account
NCCI	National Correct Coding Initiative
NMP	Non-Physician Medical Practitioner
NF	Nursing Facility
NP	Nurse Practitioner
NPI	National Provider Identifier
OHC	Other Health Coverage
OP	Outpatient Services
PA	Physician Assistant
PC	Personal Computer
PDP	Prescription Drug Plan
PFFS	Private Fee-For-Service
POE	Proof of Eligibility
POS	Point of Service
PPO	Preferred Provider Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RAD	Remittance Advice Details
REIMB	Reimbursable
RTD	Resubmission Turnaround Document
SNP	Special Needs Plan
SOC	Share of Cost
SSA	Social Security Administration
SSN	Social Security Number
TAR	Treatment Authorization Request
TCN	TAR Control Number
TSC	Telephone Service Center