

# 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](http://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

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# 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](http://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"> <li>• 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.</li> <li>• Handwritten statements are acceptable if they bear an SSA stamp and contain the specific date criteria mentioned above.</li> </ul>
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?\_\_\_\_\_.

Answer Key: F

### **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**

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# 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"> <li>Blood Deductible: Enter code 06 and the Medicare blood deductible amount. Leave blank if not applicable.</li> <li>Patient's SOC: Enter code 23 and the patients' SOC for the claim. Leave blank if not applicable.</li> <li>Pints of Blood: Enter code 38 and the number of pints of blood billed. Leave blank if not applicable.</li> <li>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</li> <li>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.</li> </ul>
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	Payers must be listed in the following order of payment: <ul style="list-style-type: none"> <li>OHC, if applicable, except Medicare supplemental insurance</li> <li>Medicare</li> <li>Medicare supplemental insurance (if applicable)</li> <li>Medi-Cal Inpatient Services (IP)</li> </ul>
51	HEALTH PLAN ID	Enter the Medicare contractor ID.
54 A – C	PRIOR PAYMENTS	Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50.  <b>NOTE</b> The Medicare payment amount must match the MNSIRA ALLOW/REIM amount <u>not</u> the NET REIMB AMT.
55	EST. AMOUNT DUE	On the corresponding Medicare line, enter the same total charges amount as in Box 47, line 23.
56	NPI	Submit an original <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 SPAN FROM	36 OCCURRENCE SPAN THROUGH	37 OCCURRENCE SPAN FROM	38 OCCURRENCE SPAN THROUGH
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 123456789	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	75 OTHER PROCEDURE DATE	76 ATTENDING NPI 1234567890	77 OPERATING NPI
78 OTHER NPI 2345678901	79 OTHER NPI	80 REMARKS	81 CC

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			<b>MEDICARE REMITTANCE ADVICE</b>							
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"> <li>• Enter code 06 and the blood deductible amount.</li> <li>• Enter code 38 and the number of pints of blood.</li> <li>• 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.</li> <li>• 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.</li> </ul>
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"> <li>• The Revenue Code must display "001" in column 42, line 23.</li> </ul>
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"> <li>• OHC, if applicable, except Medicare supplemental insurance</li> <li>• Medicare</li> <li>• Medicare supplemental insurance (if applicable)</li> <li>• Medi-Cal Outpatient Services</li> </ul>
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><b>NOTE</b> 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"> <li>• On the corresponding Medicare line, enter the total charges from Box 47, line 23.</li> <li>• 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.</li> </ul>
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 # 123456789	4 TYPE OF BILL 131
8 PATIENT NAME a DOE, JANE	9 PATIENT ADDRESS a	5 FED. TAX NO. 100116	6 STATEMENT COVERS PERIOD FROM 100116
10 BIRTHDATE 08241980	11 SEX F	12 DATE 100116	13
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862	863	864	865
866	867	868	869
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878	879	880	881
882	883	884	885
886	887	888	889
890	891	892	893
894	895		

20 Crossover Claims

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

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                          Medicare National Standard Intermediary Remittance Advice
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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

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**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.

<b>HEALTH INSURANCE CLAIM FORM</b> <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12</small>																																																																																																																											
1. MEDICARE <input checked="" type="checkbox"/> (Medicare#)                        MEDICAID <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) <b>123456789X</b>																																																																																																																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE, JOHN</b>				3. PATIENT'S BIRTH DATE    SEX MM DD YY    M <input checked="" type="checkbox"/> F <input type="checkbox"/> <b>06 21 62 M</b>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																			
5. PATIENT'S ADDRESS (No., Street) <b>1234 MAIN STREET</b>				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 <b>ANYTOWN</b>			STATE <b>CA</b>			CITY			STATE																																																																																																																		
ZIP CODE <b>958235555</b>			TELEPHONE (Include Area Code) <b>( 916 ) 555-5555</b>			ZIP CODE			TELEPHONE (Include Area Code)																																																																																																																		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>9000000A95001</b>				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH    SEX MM DD YY    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?    PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME <b>01002</b>																																																																																																																			
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>																																																																																																																			
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>																																																																																																																											
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 <b>DR. BOB SMITH</b>				17a. _____ 17b. NPI <b>0123456789</b>				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. <b>0</b>																																																																																																																											
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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; font-size: small;"> <thead> <tr> <th style="width: 5%;">1</th> <th style="width: 5%;">2</th> <th style="width: 5%;">3</th> <th style="width: 5%;">4</th> <th style="width: 5%;">5</th> <th style="width: 5%;">6</th> <th style="width: 10%;">DATE(S) OF SERVICE From MM DD YY To MM DD YY</th> <th style="width: 5%;">B. PLACE OF SERVICE</th> <th style="width: 5%;">C. EMG</th> <th style="width: 15%;">D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    MODIFIER</th> <th style="width: 5%;">E. DIAGNOSIS POINTER</th> <th style="width: 10%;">F. \$ CHARGES</th> <th style="width: 5%;">G. DAYS OR UNITS</th> <th style="width: 5%;">H. EPOSDT Family Plan</th> <th style="width: 5%;">I. ID. QUAL.</th> <th style="width: 10%;">J. RENDERING PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td>1</td><td></td><td></td><td></td><td></td><td></td><td>10 01 16 10 01 16 11</td><td></td><td></td><td>99214</td><td>1</td><td>55 00</td><td>1</td><td></td><td></td><td>NPI</td> </tr> <tr> <td>2</td><td></td><td></td><td></td><td></td><td></td><td>10 01 16 10 01 16 11</td><td></td><td></td><td>71020</td><td>2</td><td>60 00</td><td>1</td><td></td><td></td><td>NPI</td> </tr> <tr> <td>3</td><td></td><td></td><td></td><td></td><td></td><td>10 01 16 10 01 16 11</td><td></td><td></td><td>93000</td><td>3</td><td>50 00</td><td>1</td><td></td><td></td><td>NPI</td> </tr> <tr> <td>4</td><td></td><td></td><td></td><td></td><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>5</td><td></td><td></td><td></td><td></td><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>6</td><td></td><td></td><td></td><td></td><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	DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPOSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	1						10 01 16 10 01 16 11			99214	1	55 00	1			NPI	2						10 01 16 10 01 16 11			71020	2	60 00	1			NPI	3						10 01 16 10 01 16 11			93000	3	50 00	1			NPI	4															NPI	5															NPI	6															NPI
1	2	3	4	5	6	DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPOSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #																																																																																																												
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24. FEDERAL TAX I.D. NUMBER    SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>165 00</b>		29. AMOUNT PAID \$ <b>165 00</b>		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 <b>JOHN BROWN 651 FIRST STREET ANYTOWN, CA 958235555</b>				33. BILLING PROVIDER INFO & PH # <b>( 916 ) 555-5555</b> <b>JANE SMITH 1027 MAIN STREET ANYTOWN, CA 958235555</b>																																																																																																																			
a. <b>1234567890</b>				b. _____				a. <b>1234567890</b>		b. _____		c. _____		d. _____																																																																																																													

**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.

**Billing Tips**

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

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

**NOTES**

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# 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.

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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
			FROM	TO								
			MM DD YY	MM DD YY								
APPROVES (RECONCILE TO FINANCIAL SUMMARY)												
DOE	90000000A90015	4069852123000	073107	073107	92214		0001	45.20	45.20			0395
			073107	073107	93000		0001					
BLOOD DEDUCT	TOTAL	4069852123000	073107	073107	CUTBACK		SOC	45.20	45.20	36.16	9.04	
	0.00	0.00	COINS	9.04				0.00				
EXPLANATION OF DENIAL/ADJUSTMENT CODES												
0395	THIS IS A MEDICARE NON-COVERED BENEFIT. REBILL MEDI-CAL ON AN ORIGINAL CLAIM FORM, EXCEPT AID CODE 80 - QMB RECIPIENTS.											

Example: RAD code 0395

### 0442 Cutback (Zero Pay)

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

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT	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	300.00	280.44	0.00	224.35	56.09	56.09	117.60				
71020	15.00	14.57	0.00	11.66	2.91	2.91	11.88				
93000	75.00	72.04	0.00	57.63	14.41	14.41	47.16				
Claim Totals	390.00	367.05	0.00	293.64	73.41	73.41	176.64	-117.00	73.41	0.00	442

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

CA MEDI-CAL Remittance Advice Details												TO: ST. JOE'S HOSPITAL 1000 OAK STREET ANYTOWN, CA 93332-6720	
REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES												PAGE: 1 OF 1 PAGES	
PROVIDER NUMBER	CLAIM TYPE		WARRANT NO	ACS SEQ. NO		DATE							
1234567890	MCARE CROSSOVER		39248026	20000617		08/29/07							
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)

<b>CA MEDI-CAL</b> Remittance Advice Details										TO: VALLEY HOSPITAL 1000 SMITH STREET ANYTOWN, CA 98888-4444									
PROVIDER NUMBER 0123456789										CLAIM TYPE MCARE CROSSOVER		WARRANT NO 39248026		ACS SEQ. NO 20000617		DATE 09/29/07		PAGE: 1 OF 1 PAGES	
RECIPIENT NAME	RECIPIENT MEDICAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM TO MM/YY MM/YY		ACCOM/ PROC. CODE	MEDICAL REC NUM/ PATIENT ACCT#	DAY	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE						
APPROVES DOE	(RECONCILE TO FINANCIAL SUMMARY) 90000000A90071	0123825312500	082707	082707	<u>77057</u>	M847585914	0001	108.01	70.87	6.41-		<u>64.46</u>	0443						
BLOOD DEDUCT	0.00	DEDUCT	100.00	COINS	3.60	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**

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# 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