

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

Medicare/Medi-Cal Crossover Claims: Vision Care Billing Examples

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This section illustrates billing examples of Medicare/Medi-Cal crossover claims for Medicare approved vision care services on the *CMS-1500* and correlating *Medicare Remittance Notice (MRN)*. Refer to the *Medicare/Medi-Cal Crossover Claims: Vision Care* section in this manual for detailed policy information. Refer to the *CMS-1500 Completion for Vision Care* section in this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Note: A crossover claim reflects what was billed to Medicare, but only Medi-Cal-required fields are used for claims processing.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts, or dollar signs with the charges. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Hard Copy Billing Examples

Figures 1a and 1b show how to bill a hard copy Medicare/Medi-Cal crossover claim to Medi-Cal for Part B services billed to a Part B contractor.

CPT-4 code 92004 will be processed as a Medicare/Medi-Cal crossover claim in the following example.

Note: CPT-4 code 92015 (determination of refractive state) is not a Medicare benefit and may be billed to Medi-Cal directly without billing Medicare first.

1500 HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05											
PICA <input type="checkbox"/>											
1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					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 06 21 62 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) DOE JOHN						
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. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>		CITY		STATE				
ZIP CODE 95823		TELEPHONE (Include Area Code) (916) 555-5555			ZIP CODE		TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER 90000000A95001			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		SEX				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME 01002						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</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.					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 _____ DATE _____					SIGNED _____						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		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			17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. FROM MM DD YY TO MM DD YY						
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 36612			3. _____		23. PRIOR AUTHORIZATION NUMBER						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 01 07 07 01 07 11 1		92004	1	1		9130	1		NPI	-----	
2									NPI	-----	
3									NPI	-----	
4									NPI	-----	
5									NPI	-----	
6									NPI	-----	
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO. 12345678		27. ACCEPT ASSIGNMENT? (For gmt claims, see b3300) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 9130	29. AMOUNT PAID \$	30. BALANCE DUE \$ 9130			
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.) <i>Jane Smith</i> SIGNED Jane Smith DATE 07/30/07			32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 0123456789 b.						

Figure 1a. Billing Medi-Cal for Part B Services Billed to a Part B Contractor.

Jane Smith, O.D.
 1027 Main Street
 Anytown, CA 95823-5555

6/01/07

MEDICARE REMITTANCE NOTICE Medicare Contractor (12345)											
BENEFICIARY NAME H.I.C. NO./EX NO. CONTROL NUMBER	SERVICE		PLACE TYPE	PROCEDURE CODE-MODIFIER	AMOUNT BILLED	AMOUNT ALLOWED	SEE NOTE	DEDUCTIBLE	COINSURANCE	PAYMENT	INTEREST
	FROM MO-DAY	TO DAY-YR									
JOHN DOE 12345678	070107	070107	11	92004	52.20	52.20		30.00	12.20	10.00	
CLAIM TOTALS					52.20	52.20		30.00	12.20	10.00	0.00

Figure 1b. Simplified Medicare Remittance Notice (MRN) Example.

Medicare contractor name and contractor code included at top for illustration purposes only. Providers should refer to an actual MRN for the accurate contractor name and MRN to submit on claims.