Medi-Cal Provider Training 2021

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

**Medi-Cal Learning Portal (MLP)**

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

**How can you get started using the MLP?**

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

**How can you benefit from using the MLP?**

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

**Free Services for Providers**

**Provider Seminars and Webinars**

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

**Regional Representatives**

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

**Small Provider Billing Assistance and Training Program**

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

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

Table of Contents ......................................................................................................................... v

## Inpatient Common Denials ........................................................................................................ 1
  - Introduction ........................................................................................................................... 1
  - Claim Denial Description ........................................................................................................ 2
  - Overview of Claims Follow-Up Options .................................................................................. 3
  - Inpatient Services RAD Code Chart ...................................................................................... 4
  - Denied Claim Root Causes ...................................................................................................... 5
  - Inpatient Common Billing Errors ........................................................................................... 16
  - Knowledge Review .................................................................................................................. 18
  - Resource Information .............................................................................................................. 19

## Outpatient Common Denials ....................................................................................................... 1
  - Introduction ........................................................................................................................... 1
  - Claim Denial Description ........................................................................................................ 2
  - Overview of Claims Follow-Up Options .................................................................................. 3
  - Outpatient Services RAD Code Chart .................................................................................... 4
  - Denied Claim Root Causes ...................................................................................................... 5
  - Outpatient Common Billing Errors ........................................................................................ 15
  - Resource Information .............................................................................................................. 21

## Crossover Claims ....................................................................................................................... 1
  - Introduction ........................................................................................................................... 1
  - Crossover Claim Description .................................................................................................. 2
  - Medicare Health Care Benefits .............................................................................................. 3
  - Medicare/Medi-Cal Crossover Claim Policies .......................................................................... 6
  - Medicare/Medi-Cal Crossover Claim Billing .......................................................................... 9
  - Crossover Claim Submission .................................................................................................. 15
  - Crossover Claim Follow-Up .................................................................................................... 30
  - Crossover Pricing Examples ................................................................................................... 32
  - Charpentier Claims ................................................................................................................. 36
  - Knowledge Review ................................................................................................................ 38
  - Resource Information .............................................................................................................. 39

## Surgical Modifiers ...................................................................................................................... 1
  - Introduction ........................................................................................................................... 1
  - Description ............................................................................................................................. 2
Surgical Procedures with Modifiers ................................................................. 3
Other Surgical Modifiers .............................................................................. 11
By Report Documentation ........................................................................... 19
Learning Activity .......................................................................................... 21
Resource Information .................................................................................... 22
Appendix ........................................................................................................ 1
Acronyms ....................................................................................................... 1
Module A Answer Key ................................................................................... 1
Module B Answer Key ................................................................................... 2
Module C Answer Key ................................................................................... 4
Module D Answer Key ................................................................................... 5
Inpatient Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages providers receive when billing for inpatient services on the UB-04 claim form.

Module Objectives

- Identify common claim denial messages for inpatient services
- Provide an overview of claims follow-up options
- Offer billing tips to prevent claim denials

Acronyms

A list of current acronyms is located in the Appendix section of each complete workbook.
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 Remittance Advice Details (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 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 through 9999 section (remit cd9000) of the Part 1 provider manual for the complete list.
Overview of Claims Follow-Up Options

When providers receive confirmation that a claim has been denied, they can pursue follow-up options to get the claim reimbursed, 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
- Contact the Correspondence Specialist Unit (CSU)

Timeliness Policy

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

<table>
<thead>
<tr>
<th>Follow-Up Action</th>
<th>Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebill a Claim</td>
<td>Six months from the month of service</td>
</tr>
<tr>
<td>Submit a CIF</td>
<td>Within six months of the denial date on the RAD</td>
</tr>
<tr>
<td>Submit an Appeal</td>
<td>Within 90 days of the denial date on the RAD</td>
</tr>
</tbody>
</table>
Inpatient Services RAD Code Chart

Top Common RAD Code Denials
Denied Claim Root Causes

RAD Code 0005

Denied Claim Message

| RAD Code: 0005 | The service billed requires an approved TAR (Treatment Authorization Request). |

Root Cause of Denial

TAR field number on the claim was blank or the TAR listed on the claim was not approved.

Billing Tips

- Verify the TAR number on the claim.
- Verify the date(s) of service on the claim matches the date(s) on the TAR.
- Verify the TAR was approved.
- Rebill claim and enter approved 11-digit TAR number in field 63 of your claim form.

Notes:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

5
RAD Code 0010

Denied Claim Message

| RAD Code: 0010 | This service is a duplicate of a previously paid claim. |

Root Cause of Denial

Claim history identifies a payment for a National Provider Identifier (NPI) with the same recipient ID, date of service and procedure code.

Billing Tips

- Ensure you have reconciled all payments with the RAD.
- Verify the following on the RAD:
  - Provider number
  - Recipient number
  - “From-Thru” date of service
  - Procedure code
  - Modifier (if appropriate)
- If unable to locate claim payment on the RAD and are within six months from the month of service, you can submit a CIF tracer to assist in locating your Warrant Number and payment date.
  - CIF tracer does not keep your claim timely.
- Submit an appeal within 90 days from the date on the RAD.
- Should the denied provider choose to dispute the claim and there is no resolution between the two providers regarding the dates in question, Medi-Cal could recoup the full reimbursement of the original erroneously paid claim, and will not make an adjustment without a correction request from that provider.
- Incorrectly paid and denied claims can also create incorrect provider reimbursement data and inaccuracies in the health service records that may impact beneficiary share of cost (SOC), access to services and estate recovery.
- For assistance in resolving these issues, providers are advised to write to the Correspondence Specialist Unit (CSU) at:
  
  Correspondence Specialist Unit  
P.O. Box 13029  
Sacramento, CA 95813-4029
RAD Code 0314

Denied Claim Message

| RAD Code: 0314 | Recipient is not eligible for the month of service billed |

Root Cause of Denial

Recipient has an unmet share of cost (SOC) on the date of service.

Billing Tips

- Verify if the recipient’s share of cost has been met and spent down in the Point of Service (POS) Network, ensuring the recipient is eligible for the month of service.
- Verify date of service on the claim is correct.
- Submit an appeal within 90 days from the date of service on the RAD.

Attach a copy of the eligibility printout as proof the share of cost (SOC) has been met.

Notes:

________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
RAD Code 9286

Denied Claim Message

| RAD Code: 9286 | Cost center code missing/invalid |

Root Cause of Denial

The cost center code is either missing or invalid.

Billing Tips

- Refer to the Ancillary Codes section (ancil cod) of the Part 2 provider manual for ancillary codes in Medi-Cal.
- Review your UB-04 claim form and make sure you have only billed with the appropriate ancillary codes shown in the provider manual.
- Rebill the claim with the correct information if within six months from the month of service.
- If outside the six-month billing limit, submit a CIF within six months from the date of the RAD.
- Submit an appeal within 90 days from the date of the RAD.

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
RAD Code 0021

Denied Claim Message

| RAD Code: 0021 | The claim was received after the one-year maximum billing limitation. |

Root Cause of Denial

Claims submitted more than 12 months from the month of service must always use delay reason code “10” and must be billed hard copy with the appropriate attachments.

Billing Tips

- Refer to Part 2- UB 04 Submission and Timeliness Instructions – ub sub 2-6 for a list of documentation requirements
- Claims must be submitted to the Over-One Year Claims Unit and must include a copy of the recipient’s proof of eligibility with appropriate documentation attached.
- Claims must be submitted to the following special address:
  
  California MMIS Fiscal Intermediary  
  Over-One-Year Attention: Claims Preparation Unit  
  P.O. Box 13029  
  Sacramento, CA 95813-4029

Notes:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
RAD Code 0076

Denied Claim Message

| RAD Code: 0076 | The submitted documentation was not adequate. |

Root Cause of Denial

The submitted documentation was not adequate.

Billing Tips

Inpatient providers should verify:

- Date of birth
- Admit
  - Date
  - Hour
  - Date is chronological sequence with discharge date
- Discharge
  - Date
  - Hour
  - Date is prior to “thru” date
- “From” date of service is in chronological sequence with “thru” date
- Surgery/delivery date is:
  - Missing or invalid
  - Before admission on or after discharge date
A  Inpatient Common Details
Page updated: March 2021

- Primary diagnosis procedure code is on file or not missing, invalid or unclear
- Secondary diagnosis procedure code is on file
- Primary surgical procedure code is on file or not missing, invalid or unclear
- Secondary surgical procedure code is on file
- Attending physician provider number
- Family Planning EPSDT indicator
- Cost Center
  - Charge number
  - Code
  - Accommodation
  - Units of Service
- Blood deductible amount
- Medicare
  - Date of RA (Remittance Advice)/EOMB (Explanation of Medicare Benefits)
  - Deductible amount
  - Coinsurance amount
- Total charges billed is entered and valid
- Recipient Share of Cost amount
- Net amount is entered and valid

Notes:

_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
RAD Code 9952

Denied Claim Message

| RAD Code: 9952 | Type of Bill Code for APR-DRG Claim Invalid or Missing |

Root Cause of Denial

The Type of Bill Code entered on the claim was not correct or Type of Bill Code was missing and was required for the type of services being billed.

Billing Tips

- Verify the appropriate three-character Type of Bill Code entered on the claim is correct.
- Refer to the *UB-04 Completion: Inpatient Services* section (ub comp ip) of the Part 2 provider manual for a complete list of Type of Bill code
RAD Code 0037

Denied Claim Message

| RAD Code: 0037 | Health Care Plan enrollee, capitated service not billable to Medi-Cal. |

Root Cause of Denial

Providers did not verify recipient eligibility prior to rendering services for each recipient who presents a plastic Benefits Identification Card (BIC), Managed Care Plan (MCP) card, Paper Immediate Need or Minor Consent card.

Billing Tips

- Verify the recipient's eligibility.
- Verify the recipient’s 14-character ID number on the RAD is the same as what was reported on the eligibility response and claim.
- Check the county code.
  - Contact the managed care plan for any specific billing instructions.
  - Bill the Managed Care Plan (MCP).

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
RAD Code 9128

Denied Claim Message

| RAD Code: 9128 | Type of Admit missing/invalid. |

Root Cause of Denial

The type of Admit was missing or invalid in Field 14.

Billing Tips

- Verify the type of Admit was entered on the claim
- Refer to the *UB-04 Completion: Inpatient Services* section (ub comp ip) of the Part 2 provider manual for list of Admission types.
- Rebill the claim with corrections if six months from the month of service or submit a CIF
RAD Code 9291

Denied Claim Message

| RAD Code: 9291 | Total charges billed invalid |

Root Cause of Denial

The Total charges billed are invalid.

Billing Tips

- Enter full dollar amount and cents. Do not enter a decimal point (.) or dollar sign ($)
- Enter the usual and customary charges in the Total Charges field (Box 47). Ensure that you enter code “001” in the Revenue Code column (Box 42) to designate the total charge line.
- Refer to the UB-04 Completion: Inpatient Services section (ub comp ip) of the Part 2 provider manual.
Inpatient Common Billing Errors

The following fields must be completed accurately and completely on the UB-04 claim form to avoid claims suspense or denial.

**Note:** The following table can be found in *UB-04 Tips for Billing: Inpatient Services* section (ub tips ip) in the Part 2 Inpatient Services manual.

<table>
<thead>
<tr>
<th>Box #</th>
<th>Field Name</th>
<th>Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 thru 24</td>
<td>Condition Codes</td>
<td>Omitting codes or entering a Medi-Cal local billing limit exception code (X0, X1 thru X9)</td>
</tr>
<tr>
<td></td>
<td><strong>Billing Tip:</strong> The delay reason code is entered (Box 37A) of the claim. Enter codes in numeric-alpha order. For example, 80, 82, A1</td>
<td></td>
</tr>
<tr>
<td>39 thru 41</td>
<td>Value Codes and Amount (Patient’s SOC)</td>
<td>Missing value code information. Entering only the value code and not the amount. Entering only the amount and not the value code</td>
</tr>
<tr>
<td>(A thru D)</td>
<td><strong>Billing Tip:</strong> Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest level. Value code information is required for Medicare/Medi-Cal crossovers</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Payer Name</td>
<td>Missing all payer information</td>
</tr>
<tr>
<td>(A thru C)</td>
<td><strong>Billing Tip:</strong> Enter the “I/P” indicator.  Example: I/P MEDI-CAL</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Prior Payments (Other Coverage)</td>
<td>Missing prior payment or Other Health Coverage not indicated</td>
</tr>
<tr>
<td>(A thru B)</td>
<td><strong>Billing Tip:</strong> Enter the patient’s other health insurance payment. Do not enter a decimal, dollar ($), plus (+) or minus (-) sign. Do not enter Medicare payments in this box.</td>
<td></td>
</tr>
<tr>
<td>Box #</td>
<td>Field Name</td>
<td>Error</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Missing or incorrect NPI number</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Billing Tip:</strong> Enter the NPI</td>
</tr>
<tr>
<td>60</td>
<td>Insured’s Unique ID</td>
<td>Entering the recipient’s Medi-Cal ID number incorrectly</td>
</tr>
<tr>
<td>(A thru C)</td>
<td></td>
<td><strong>Billing Tip:</strong> Verify the recipient is eligible for the services rendered by using the POS network. Do not enter the Medicare ID number</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Codes</td>
<td>Entering EVC number instead of the TAR number</td>
</tr>
<tr>
<td>(A thru C)</td>
<td></td>
<td><strong>Billing Tip:</strong> The EVC number is only for verifying eligibility and should not be entered on the claim.</td>
</tr>
<tr>
<td>66</td>
<td>DX</td>
<td>Missing ICD indicator</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Billing Tip:</strong> An ICD Indicator of “0” is required for dates of service/discharge on or after October 1, 2015</td>
</tr>
<tr>
<td>74</td>
<td>Principal Procedure Code and Date</td>
<td>Missing or incorrect ICD-10-PCS code or a CPT/HCPCS procedure code entered</td>
</tr>
<tr>
<td>(A thru B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>Attending Physician ID</td>
<td>Missing or incorrect attending physician’s NPI</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Billing Tip:</strong> Do not enter the operating or admitting NPI in this field. Enter attending physician’s NPI</td>
</tr>
<tr>
<td>77</td>
<td>Operating Physician ID</td>
<td>Missing or incorrect operating physician’s Medi-Cal provider number/ID Qualifier/NPI. Enter operating physician’s NPI number here</td>
</tr>
<tr>
<td>78 and 79</td>
<td>Other (Admitting Physician Provider Number) NPI</td>
<td>Enter the admitting physician’s NPI here</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>Reducing font size or abbreviating terminology to fit in the field</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Billing Tip:</strong> If additional information cannot be completely entered in this field, attach the additional information to the claim. Reducing font size and abbreviating terminology may result in scanning difficulties and/or medical review denials</td>
</tr>
</tbody>
</table>
Knowledge Review

Match the RAD Denial Codes in the second column to the most appropriate definition in the third column. Enter the letter that precedes the definition in the blank area of the first column.

<table>
<thead>
<tr>
<th>Enter Letter</th>
<th>RAD Code</th>
<th>RAD Code Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RAD 0005</td>
<td>A) Cost Center missing/invalid.</td>
</tr>
<tr>
<td></td>
<td>RAD 0010</td>
<td>B) The service billed requires an approved TAR (Treatment Authorization Request).</td>
</tr>
<tr>
<td></td>
<td>RAD 0314</td>
<td>C) Total Charges billed invalid.</td>
</tr>
<tr>
<td></td>
<td>RAD 9286</td>
<td>D) The claim was received after the one year maximum billing limitation.</td>
</tr>
<tr>
<td></td>
<td>RAD 0021</td>
<td>E) Type of Bill Code for APR-DRG claim invalid or missing.</td>
</tr>
<tr>
<td></td>
<td>RAD 0076</td>
<td>F) The submitted documentation was not adequate.</td>
</tr>
<tr>
<td></td>
<td>RAD 9952</td>
<td>G) This service is a duplicate of a previously paid claim.</td>
</tr>
<tr>
<td></td>
<td>RAD 0037</td>
<td>H) Cost center code missing/invalid</td>
</tr>
<tr>
<td></td>
<td>RAD 9128</td>
<td>I) Health Care Plan enrollee, capitated service not billable to Medi-Cal.</td>
</tr>
<tr>
<td></td>
<td>RAD 9291</td>
<td>J) Recipient is not eligible for the month of service billed.</td>
</tr>
</tbody>
</table>

See the Appendix for the Answer Key
Resource Information

References

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

Provider Manual References

Part 1

Appeal Process Overview (Appeal)
CIF Overview (cif)
Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit) "Click" on Link: Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations.

Part 2

Ancillary Codes (ancil cod)
Appeal Form Completion (appeal form)
CIF Special Billing Instructions for Inpatient Services (cif sp ip)
Diagnosis-Related Groups (DRG): Inpatient Services (diagnosis ip)
Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals (ob rev drg)
UB-04 Completion: Inpatient Services (ub comp ip)
UB-04 Tips for Billing: Inpatient Services (ub tips ip)

Notes:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

19
Outpatient Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages providers receive when billing for outpatient services on the UB-04 claim form.

Module Objectives

- Identify common claim denial messages for outpatient services
- Provide the root causes for denied claims
- Offer billing tips to prevent claim denials

Acronyms

A list of current acronyms is located in the Appendix section of each complete workbook.
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 Remittance Advice Details (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 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 through 9999 section (remit cd9000) of the Part 1 provider manual for the complete list.
Overview of Claims 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
- Contact the Correspondence Specialist Unit (CSU)

**Timeliness Policy**

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

<table>
<thead>
<tr>
<th>Follow-up Action</th>
<th>Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebill a Claim</td>
<td>Six months from the month of service.</td>
</tr>
<tr>
<td>Submit a CIF</td>
<td>Within six months of the denial date (on RAD)</td>
</tr>
<tr>
<td>Submit an Appeal</td>
<td>Within 90 days of the denial date on the RAD</td>
</tr>
</tbody>
</table>

**Notes:**

_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
Outpatient Services RAD Code Chart

Top Common RAD Code Denials

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Denied Claim Root Causes

RAD Code 0010

| RAD Code: 0010 | This service is a duplicate of a previously paid claim. |

**Root Cause of Denial**

Claim history identifies a payment for a National Provider Identifier (NPI) with the same recipient ID, date of service and procedure code.

**Billing Tips**

- Ensure that you have reconciled all payments with the RAD.
- Verify the following on the RAD:
  - Provider number
  - Recipient number
  - “From-Thru” date of service
  - Procedure code
  - Modifier
- If unable to locate claim payment on the RAD and are within six months from the month of service, you can submit a CIF tracer to assist in locating your Warrant Number and payment date.
  - CIF tracer does not keep your claim timely.
- Submit an appeal within 90 days from the date on the RAD.
- Should the denied provider choose to dispute the claim and there is no resolution between the two providers regarding the dates in question, Medi-Cal could recoup the full reimbursement of the original erroneously paid claim, and will not make an adjustment without a correction request from that provider.

Incorrectly paid and denied claims can also create incorrect provider reimbursement data and inaccuracies in the health service records that may impact beneficiary share of cost (SOC), access to services and estate recovery.

For assistance in resolving these issues, providers are advised to write to the Correspondence Specialist Unit (CSU) at:

Correspondence Specialist Unit
P.O. Box 13029
Sacramento, CA  95813-4029
RAD Code 0037

| RAD Code: 0037 | Health Care Plan enrollee, capitated service not billable to Medi-Cal. |

Root Cause of Denial

Providers did not verify recipient eligibility prior to rendering services for each recipient who presents a plastic Benefits Identification Card (BIC), Managed Care Plan (MCP) card, Paper Immediate Need or Minor Consent card.

Billing Tips

- Verify the recipient’s eligibility.
- Verify the recipient’s 14-character ID number on the RAD is the same as what was reported on the eligibility response and claim.
- Check the county code.
  - Verify county code in the *MCP: Code Directory* section (mcp code dir) of the Part 1 provider manual.
  - Contact the managed care plan for any specific billing instructions.
  - Bill the Managed Care Plan (MCP).
RAD Code 9898

| RAD Code: 9898 | HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid. |

**Root Cause of Denial**

The HCPCS qualifier and/or NDC/UPN is invalid.

**Billing Tips**

- Verify the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens) is directly following the last digit of the NDC (no space); followed by the two-character unit of measure and numeric quantity.

- Verify the NDC number on the claim is consistent with the 5-4-2 format. Hyphens (-) separate the NDC number into three segments. An 11-digit number must be entered on the claim.

- Verify the NDC is contracted with Medi-Cal.

Refer to the following Part 2 provider manual sections for more information:


- *Drugs: Contract Drugs List Part 5 Authorized Drug Manufacturer Labeler Codes* (drugs cdl p5)

**Notes:**

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
RAD Code 0145

RAD Code: 0145 | This procedure is not a Medi-Cal benefit on this date of service.

Root Cause of Denial

Provider billed for a service that is not a Medi-Cal benefit on the date of service.

Billing Tips

- Verify procedure code and modifier, if required
- Verify the “From-Thru” dates of service
- Verify authorization information
- Verify revenue code

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
B Outpatient Common Denials
Page updated: September 2020

RAD Code 0314

| RAD Code: 0314 | Recipient is not eligible for the month of service billed. |

Root Cause of Denial

The recipient has an unmet SOC on the date of service.

Billing Tips

- Verify if the recipient’s SOC has been met and spent down in the Point of Service (POS) network, ensuring the recipient is eligible for the month of service.
- Verify date of service on the claim is correct.
- Submit an appeal within 90 days from the date on the RAD.
- Attach a copy of the eligibility printout as proof that SOC has been met.

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

9
RAD Code 0225

| RAD Code: 0225 | Incorrect procedure code and or modifier for this service. Resubmit new claim. |

**Root Cause of Denial**

Provider billed with an incorrect procedure code and/or modifier for the service provided.

**Billing Tips**

- Verify:
  - Procedure Code
  - Modifier
  - From thru Dates of service
- Refer to the *Modifiers* section in the Part 2 manual for billing guidelines.

**Notes:**
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
RAD Code 0626

| RAD Code: 0626 | Non-emergency related services are not payable for aid code 55 recipients. |

**Root Cause of Denial**

Provider billed non-emergency services when the recipient is only eligible for pregnancy-related, postpartum and emergency services.

**Billing Tips**

- Verify the recipient’s eligibility prior to rendering services.

**Note:** If the services were emergency-related, refer to the “Emergency Certification” heading in the *UB-04 Completion: Outpatient Services* section (ub comp op) of the Part 2 provider manual.

**Notes:**

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
RAD Code 0021

| RAD Code: 0021 | The claim was received after the one year maximum billing limitation. |

**Root Cause of Denial**

Claims submitted more than 12 months from the month of service must always use delay reason code “10” and must be billed hard copy with the appropriate attachments.

**Billing Tips**

- Refer to the *CMS-1500 Submission and Timeliness Instructions* section – (cms sub) 4 of the Part 2 manual for list of documentation requirements.

- Claims must be submitted to the Over-One Year Claims Unit and must include a copy of the recipient’s proof of eligibility with appropriate documentation attached.

Claims must be submitted to the following special address:

California MMIS Fiscal Intermediary  
Over-One-Year Attention: Claims Preparation Unit  
P.O. Box 13029  
Sacramento, CA 95813-4029

**Notes:**

_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________

12
B  Outpatient Common Denials

Page updated: September 2020

RAD Code 9109

| RAD Code: 9109 | This service is not payable for the diagnosis billed. |

Root Cause of Denial

Provider billed for a diagnosis code that is not payable for this service.

Billing Tips

- Verify procedure code is a valid Medi-Cal benefit via Transaction Services or contact the Telephone Service Center (TSC) at 1-800-541-5555.
- Ensure provider is eligible to bill for the service by verifying provider’s Category of Service with administrator.

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
B Outpatient Common Denials
Page updated: September 2020

RAD Code 9671

| RAD Code: 9671 | Procedure code has not been authorized by CCS/GHPP (California Children's Services/Genetically Handicapped Persons Program). |

Root Cause of Denial

Provider billed procedure and/or diagnosis code(s) not authorized by the California Children’s Services (CCS) and Genetically Handicapped Persons Program (GHPP).

Billing Tips

- Verify procedure code and diagnosis code(s) are valid CCS/GHPP benefits via Transaction Services or contact the Telephone Service Center (TSC) to confirm at 1-800-541-5555.

- Ensure provider is eligible to bill for the service(s) by verifying the CCS/GHPP Service Code Groupings in the California Children’s Services (CCS) Program Service Code Groupings section (cal child serv) of the Part 2 provider manual.

Notes:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

14
Outpatient Common Billing Errors

The following fields must be completed accurately and completely on the UB-04 claim form to avoid suspended or denied claims.

**Note:** The following table is also available in the UB-04 Tips for Billing section (ub tips op) in the appropriate Part 2 Outpatient Services manual.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Statement Covers Period (From-Through)</td>
<td>Entering information in this field, which is not required by Medi-Cal for outpatient claims. <strong>Billing Tip:</strong> For outpatient “From-Through” billing instructions, see the UB-04 Special Billing Instructions for Outpatient Services section in this manual.</td>
</tr>
<tr>
<td>18 thru 24</td>
<td>Condition Codes</td>
<td>Omitting codes or entering a Medi-Cal local billing limit exception code (A, 1 thru 9). <strong>Billing Tip:</strong> The delay reason code is entered in the Unlabeled field (Box 37A) of the claim. <strong>Billing Tip:</strong> Enter codes in numeric-alpha order. For example, 80, 82, X1.</td>
</tr>
<tr>
<td>39 thru 41</td>
<td>Value Codes and Amount (Patient's Share of Cost)</td>
<td>Missing value code information. Entering only the value code and not the amount. Entering only the amount and not the value code. <strong>Billing Tip:</strong> Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. Value code information is required for Medicare crossovers.</td>
</tr>
</tbody>
</table>
### Field of Common Billing Errors (continued)

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Error</th>
</tr>
</thead>
</table>
| 43    | Description | Omitting individual dates of service required after entering description of services rendered.  
**Billing Tip:** The description must identify the particular service code indicated in the HCPCS/Rate field (Box 44). For more information, refer to the specific policy section in this manual or the CPT code book.  
Omitting the product ID qualifier and NDC for physician-administered drugs. Incorrect entry of optional unit of measure and numeric quantity.  
**Billing Tip:** Check instructions in the Physician-Administered Drugs – NDC: UB-04 Billing Instructions (physician ndc ub) and UB-04 Completion: Outpatient Services (ub comp op) sections of the Part 2 provider manual for the appropriate product ID qualifier, NDC, unit of measure qualifier and numeric quantity, and instructions on entering this information. Unit of measure and numeric quantity are optional; however, entering the NDC quantity in the proper format is crucial to the correct payment for a billed NDC. |
### Table of Common Billing Errors (continued)

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Error</th>
</tr>
</thead>
</table>
| 44    | HCPCS/Rate/HiPPS Code | Entering incorrect code for provider type, omitting procedure code or omitting modifier(s). **Billing Tip:** Revenue codes are increasingly required on outpatient claims, including:  
- Adult Day Health Care (ADHC) (all codes)  
- Home and Community-Based Waiver Services (select codes)  
- Hospice (room and board only)  
- EAPC (all codes)  
- EAPC claims must include the required revenue code in the *Revenue Code* field (Box 42) and the HCPCS code, immediately followed by the appropriate modifier, in the *HCPCS/Rate* field (Box 44). Claims submitted without all three will be denied.  
- Organ procurement  
For Section 340B providers submitting claims for physician administered drugs: omitting the modifier UD. **Billing Tip:** Check instructions in the *UB-04 Completion: Outpatient Services* (ub comp op) section of the Part 2 provider manual for the appropriate location of modifier UD for Section 340B drugs on the UB-04. |
<p>| 46    | Service Units | Entering the wrong service units as required by the billing code. <strong>Billing Tip:</strong> Although this is a seven-digit field, Medi-Cal only allows two digits in this field. |</p>
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 A</td>
<td>Payer Name</td>
<td>Entering a Place of Service code. <strong>Billing Tip:</strong> Enter the two-digit facility type and one-character frequency code as specified in the National Uniform Billing Data Element Specifications manual in the <em>Type of Bill</em> field (Box 4). Missing all payer information. <strong>Billing Tip:</strong> Be sure to enter the “O/P” indicator.</td>
</tr>
<tr>
<td>54 A</td>
<td>Prior Payments (Other Coverage)</td>
<td>Missing prior payment or Other Health Coverage not indicated. <strong>Billing Tip:</strong> Be sure to enter the patient’s other health insurance payment. Do not enter Medicare payments in this box.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Missing or incorrect NPI number. <strong>Billing Tip:</strong> Enter the NPI.</td>
</tr>
<tr>
<td>60 A</td>
<td>Insured’s Unique ID</td>
<td>Missing the recipient’s Medi-Cal ID number. <strong>Billing Tip:</strong> Verify that the recipient is eligible for the services rendered by using the POS network or telephone AEVS. Do not enter the Medicare ID number.</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Codes</td>
<td>Entering EVC number instead of the TAR number. <strong>Billing Tip:</strong> The EVC number is only for verifying eligibility. Do not enter this number on the claim.</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>Reducing font size or abbreviating terminology to fit in the field. <strong>Billing Tip:</strong> If additional information cannot be completely entered in this field, attach the additional information to the claim. Reducing font size and abbreviating terminology may result in scanning difficulties and/or medical review denials.</td>
</tr>
</tbody>
</table>
Knowledge Review 1

Fill in the blanks to complete the common RAD messages:

1) 0037: ______________ enrollee, capitated service not billable to Medi-Cal.

2) 0010: This service is a __________________ of a previously paid claim.

3) 0626: Non-emergency related services are ________________ for aid code 55 recipients.

4) 0145: The procedure is not a ______________ benefit on this date of service.

5) 0314: Recipient is not eligible for the ______________ of service billed.

See the Appendix for the Answer Key
## Knowledge Review 2

Match the RAD Denial Codes in the second column to the most appropriate definition.

<table>
<thead>
<tr>
<th>Enter Letter</th>
<th>RAD Code</th>
<th>RAD Code Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RAD 0225</td>
<td>A) Procedure code has not been authorized by CCS/GHPP (California Handicapped Persons Program).</td>
</tr>
<tr>
<td></td>
<td>RAD 0021</td>
<td>B) The claim was received after the one year maximum billing limitation.</td>
</tr>
<tr>
<td></td>
<td>RAD 9671</td>
<td>C) Incorrect procedure code and or modifier for this service. Resubmit new claim.</td>
</tr>
<tr>
<td></td>
<td>RAD 9109</td>
<td>D) HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.</td>
</tr>
<tr>
<td></td>
<td>RAD 9898</td>
<td>E) This service is not payable for the diagnosis billed.</td>
</tr>
</tbody>
</table>

See the Appendix for the Answer Key

## Notes:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Resource Information

References

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

Provider Manual References

Part 1
Appeal Process Overview (appeal)
CIF Overview (cif)
Eligibility: Service Restrictions (elig rstrict)
Remittance Advice Details (RAD) Codes and Messages: RAD Repository

Part 2
Appeal Form Completion (appeal form)
CIF Special Billing Instructions for Outpatient Services (cif sp op)
Physician-Administered Drugs – NDC: UB-04 Billing Instructions (physician ndc ub)
UB-04 Completion: Outpatient Services (ub comp op)
UB-04 Special Billing Instructions for Outpatient Services (ub spec op)
UB-04 Tips for Billing: Outpatient Services (ub tips op)
Crossover Claims

Introduction

Purpose

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

Module Objectives

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

Acronyms

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

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

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

Medicare/Medi-Cal Crossover Claim Terminology

- **Crossover**: A claim billed to Medi-Cal for the Medicare deductible and/or coinsurance is called a crossover claim. This type of claim has been approved or paid by Medicare.

- **Deductible**: The dollar amount Medicare recipients must pay for Part A or Part B services prior to receiving Medicare benefits.

- **Coinsurance**: The remaining balance of the Medicare Allowed Amount after a Medicare payment.

- **Co-payments**: The amount required by Medicare Part C or D when services are rendered or drugs are purchased. (Providers may choose to waive these co-payments or may deny service if a recipient cannot pay this amount. Medi-Cal does not generally pay for co-payments.)

- **Medicare Beneficiary Identifier (MBI)**: The Medicare recipient's identification number.
Medicare Health Care Benefits

Scope of Coverage

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

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

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. PC-Print Software is used to access and print the Medicare electronic RA in this format. The software is free and available through the Medicare Part A contractors. Part B (outpatient services) billed to Part B (contractors) medical claims are reflected on the Medicare Remittance Notice (MRN).

Part C – Medicare Advantage Plans

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

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

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

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

Medical Supplies

Most medical supplies are not covered by Medicare and can be billed directly to Medi-Cal. However, medical supplies listed under the “Medicare Covered Services” heading in the Medical Supplies (mc sup) section of the Part 2 provider manual are covered by Medicare. These supplies must be billed to Medicare prior to billing Medi-Cal.
Medicare/Medi-Cal Crossover Claim Policies

Recipient Coverage

Eligibility

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

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Medicare Coverage Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>Subscriber has Part A Medicare coverage with Medicare Beneficiary Identifier (MBI) _______. Medicare-covered services must be billed to Medicare before Medi-Cal.</td>
</tr>
<tr>
<td>Part B</td>
<td>Subscriber has Part B Medicare coverage with MBI Number _______. Medicare-covered services must be billed to Medicare before Medi-Cal.</td>
</tr>
<tr>
<td>Parts A and B</td>
<td>Subscriber has Parts A and Part B Medicare coverage with MBI Number _______. Medicare-covered services must be billed to Medicare before Medi-Cal.</td>
</tr>
<tr>
<td>Parts A and D</td>
<td>Subscriber has Parts A and D Medicare coverage with MBI Number _______. Medicare Part A-covered services must be billed to Medicare before billing Medi-Cal.</td>
</tr>
<tr>
<td>Parts B and D</td>
<td>Subscriber has Parts B and D Medicare coverage with MBI Number _______. Medicare Part B-covered services must be billed to Medicare before billing Medi-Cal.</td>
</tr>
<tr>
<td>Parts A, B and D</td>
<td>Subscriber has Parts A, B and D Medicare coverage with MBI _______. Medicare Part D covered drugs need to be billed to Medicare carrier before billing Medi-Cal. Carrier name: ________, Cov: R.</td>
</tr>
</tbody>
</table>
Limited Income Recipient – QMB

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

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

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

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

Medi-Cal Crossover Claim Reimbursement

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

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

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

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

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

Share of Cost

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

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

Crossover Claim Procedures

Automatically Billed Crossover Claims

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

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

Medicare Contractors

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

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

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

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

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

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

**Note:** Medicare/Medi-Cal crossover claims for psychiatric services must be hard copy billed if the recipient is enrolled in a health care plan (HCP) that is not capitated for psychiatric services. Refer to Medicare/Medi-Cal Crossover Claims in the appropriate Part 2 provider manual for specific billing instructions.
Non-Crossover Claim Procedures

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

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

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

Medicare Non-Covered Service

DHCS maintains a list of Medicare non-covered services that may be billed directly to the California MMIS Fiscal Intermediary (FI) as straight Medi-Cal claims for Medicare/Medi-Cal recipients. Do not send these claims to the Crossover Unit.

All services or supplies on a straight Medi-Cal claim must be included in the Medicare Non-Covered Services charts for direct billing to Medi-Cal without any Medicare payment or denial documentation. If a service or supply is not included in the chart, but was not covered by Medicare, submit the claim with the corresponding MNSIRA or MRN showing the non-covered services or supplies.

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

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

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

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

Medicare Exhausted Service

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

Medicare Non-Eligible Recipients

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

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

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

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Card</td>
<td>Showing eligibility start date after date of service (DOS)</td>
</tr>
</tbody>
</table>
| Document signed, dated and stamped by Social Security Administration (SSA) or any documentation on SSA or Department of Health and Human Services (HHS) letterhead | - The document is valid only for dates of service up to the end of the month of the date on the document, or the date of entitlement.  
- Handwritten statements are acceptable if they bear an SSA stamp and contain the specific date criteria mentioned above. |
| Common Working File (CWF) printout or Third-Party Query Confidential computer printouts | If the printout says “Not in File as of XX/XX/XX,” it can be accepted for dates of service up to the date printed. |

**Other Health Coverage – HMO**

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

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

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

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

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

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Crossover Claim Submission

Timeliness

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

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

Mailing Instructions

Medicare/Medi-Cal crossover claims for Medicare approved or covered services that do not automatically cross over, or that cross over but cannot be processed and are rejected, may be billed directly to Medi-Cal (electronically or by hard copy). Providers must submit hard copy crossover claims to the FI:

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

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

Inpatient Services

Part A Services Billed to Part A Contractor

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

Follow these instructions to bill for services rendered:

**Part A Services Billed to Part A Contractor Table**

<table>
<thead>
<tr>
<th>Box Number</th>
<th>Form Fields</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>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.</td>
</tr>
<tr>
<td>6</td>
<td>From-Through Dates of Service</td>
<td>From-through dates of service must match the Medicare RA.</td>
</tr>
<tr>
<td>8b</td>
<td>Patient Name</td>
<td>Patient name must match the Medicare RA.</td>
</tr>
<tr>
<td>31</td>
<td>Occurrence Codes &amp; Dates</td>
<td>List the date of the MNSIRA (MMDDYY) with code 50.</td>
</tr>
<tr>
<td>39 thru 41</td>
<td>Value Codes and Amounts</td>
<td>• Blood Deductible: Enter code 06 and the Medicare blood deductible amount. Leave blank if not applicable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient’s SOC: Enter code 23 and the patients’ SOC for the claim. Leave blank if not applicable.</td>
</tr>
<tr>
<td>A thru D</td>
<td></td>
<td>• Pints of Blood: Enter code 38 and the number of pints of blood billed. Leave blank if not applicable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code</td>
<td>The Revenue Code must display “001” in column 42, line 23.</td>
</tr>
</tbody>
</table>
### Part A Services Billed to Part A Contractor Table (continued)

<table>
<thead>
<tr>
<th>Box Number</th>
<th>Form Fields</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>47</strong></td>
<td><strong>Total Charges</strong></td>
<td>The Total Charges and amount must match the Medicare RA in column 42, line 23.</td>
</tr>
<tr>
<td><strong>50</strong></td>
<td><strong>Payer Name</strong></td>
<td>Payers must be listed in the following order of payment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• OHC, if applicable, except Medicare supplemental insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare supplemental insurance (if applicable)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medi-Cal Inpatient Services (IP)</td>
</tr>
<tr>
<td><strong>51</strong></td>
<td><strong>Health Plan ID</strong></td>
<td>Enter the Medicare contractor ID.</td>
</tr>
<tr>
<td><strong>54</strong></td>
<td><strong>Prior Payments</strong></td>
<td>Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50.</td>
</tr>
<tr>
<td>A thru C</td>
<td></td>
<td>Note: The Medicare payment amount must match the MNSIRA ALLOW/REIMB amount not the NET REIMB AMT.</td>
</tr>
<tr>
<td><strong>55</strong></td>
<td><strong>Est. Amount</strong></td>
<td>On the corresponding Medicare line, enter the same total charges amount as in Box 47, line 23.</td>
</tr>
<tr>
<td><strong>56</strong></td>
<td><strong>NPI</strong></td>
<td>Submit an original UB-04 claim form using the provider NPI in effect appropriate for the date of service on the claim.</td>
</tr>
<tr>
<td><strong>57</strong></td>
<td><strong>Other Billing</strong></td>
<td>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).</td>
</tr>
<tr>
<td>A thru C</td>
<td><strong>Provider ID</strong></td>
<td></td>
</tr>
<tr>
<td><strong>60</strong></td>
<td><strong>Insured’s Unique</strong></td>
<td>Enter the beneficiaries MBI number on the line that corresponds to the Medicare payer line in Box 50. Enter the Medi-Cal BIC ID number on the line that corresponds to the Medi-Cal IP payer line in Box 50.</td>
</tr>
<tr>
<td>A thru C</td>
<td><strong>Unique ID</strong></td>
<td></td>
</tr>
<tr>
<td><strong>76, 77, 78, 79</strong></td>
<td><strong>Attending, Operating, &amp; Other</strong></td>
<td>Enter appropriate provider NPI.</td>
</tr>
</tbody>
</table>

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

**Calculation**

\[
\text{SUM (Blood deductible + Medicare deductible + Medicare coinsurance)} - \text{SUM (SOC, OHC, Medicare supplemental insurance payments)} = \text{Amount Due}
\]
Example: Inpatient UB-04 Crossover Claim Form

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Value Codes</td>
<td>99200</td>
</tr>
</tbody>
</table>

C Crossover Claims
Page updated: September 2020
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.

**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):**

<table>
<thead>
<tr>
<th>Box Number</th>
<th>Field Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>First two digits will be 13, 14, 72, 74, 75, 76, or 85 and values must match the *Medicare National Standard Intermediary Remittance Advice (MNSIRA)._</td>
</tr>
<tr>
<td>8B</td>
<td>Patient Name</td>
<td>Patient name must match the MNSIRA.</td>
</tr>
<tr>
<td>31</td>
<td>Occurrence Codes &amp; Dates</td>
<td>Enter code 50 and the date (MMDDYY) of the MNSIRA.</td>
</tr>
<tr>
<td>39 thru 41</td>
<td>Value Codes and Amounts</td>
<td>Enter code 23 and the patient's SOC for the claim. Leave blank, if not applicable.</td>
</tr>
<tr>
<td>A thru D</td>
<td></td>
<td>• Enter code 06 and the blood deductible amount.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enter code 38 and the number of pints of blood.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
</tbody>
</table>
### UB-04 Claim Form (applicable fields) (continued):

<table>
<thead>
<tr>
<th>Box Number</th>
<th>Field Name</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 42         | Revenue Code | Enter the revenue codes that were billed to Medicare on the claim in the same order as they appear on the MNSIRA in column 42, lines 1-22. Crossover claims in excess of 15 claim lines must follow special billing instructions and be split-billed on two or more claim forms.  
  - The Revenue Code must display “001” in column 42, line 23.  
  - Dates of service on or after January 1, 2019, a four-digit revenue code must be included on outpatient claims billed on paper UB-04 claim forms or electronic billing. |
| 43         | Description  | Enter all claim detail lines (services) that were billed to Medicare on the claim in the same order as they appear on the MNSIRA in lines 1-22. Crossover claims in excess of 15 claim lines must follow special billing instructions and be split-billed on two or more claim forms. |
| 44         | HCPCS/Rate   | Enter the same procedure codes billed to Medicare.                                                                                            |
| 45         | Service Date | Enter the actual date of service on each detail line.                                                                                      |
| 47         | Total Charges| Enter the total charge for each service billed to Medicare in lines 1-22. Enter the sum of the line item charges on line 23.                |
Crossover Claims
Page updated: September 2020

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

<table>
<thead>
<tr>
<th>Box Number</th>
<th>Field Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Payer Name</td>
<td>Payers must be listed in the following order of payment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• OHC, if applicable, except Medicare supplemental insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare supplemental insurance (if applicable)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medi-Cal Outpatient Services</td>
</tr>
<tr>
<td>51</td>
<td>Health Plan Id</td>
<td>Enter the Medicare contractor ID.</td>
</tr>
<tr>
<td>54 A thru C</td>
<td>Prior Payments</td>
<td>Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> The Medicare payment amount must match the MNSIRA ALLOW/REIMB amount not the NET REIMB AMT.</td>
</tr>
<tr>
<td>55</td>
<td>Estimated Amount Due</td>
<td>• On the corresponding Medicare line, enter the total charges from Box 47, line 23.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Submit an original UB-04 claim form using the provider NPI in effect appropriate for the date of service on the claim</td>
</tr>
<tr>
<td>76, 77, 78, 79</td>
<td>Attending, Operating, &amp; Other</td>
<td>Enter appropriate provider NPI.</td>
</tr>
</tbody>
</table>
### Example: Outpatient UB-04 Crossover Claim, Part B to Part A Contractor Services

**Description:**
- **UB-04 Crossover Claim:** Part B to Part A Contractor Services

**Details:**
- **UPTOWN MEDICAL CENTER**
  - 140 SECOND STREET
  - ANYTOWN CA 95823555
- **Patient Name:** DOE, JANE
  - **DOB:** 11/01/15
- **UB-04 Claim Number:** 08241980

**Claims:**
- **0300 DESCRIPTION:** 36415
- **0301 DESCRIPTION:** 80053
- **0301 DESCRIPTION:** 83880
- **0301 DESCRIPTION:** 84484
- **0305 DESCRIPTION:** 85025
- **0305 DESCRIPTION:** 85379
- **0450 DESCRIPTION:** 9923825
- **0730 DESCRIPTION:** 93005
- **0921 DESCRIPTION:** 93970

**Totals:**
- **Medicare:**
  - **ID:** 01001
  - **Total Charge:** 332900
- **OHP Medical:**
  - **ID:** 001320
  - **Total Charge:** 23017

**Additional Details:**
- **UB-04 Number:** 08241980
- **UB-04 Status:** 0
- **UB-04 Service Code:** 0
Include a complete, unaltered and legible copy of the corresponding MNSIRA for each crossover claim.

---

**Example:** Medicare Remittance Advice Details Form

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

Part B Services Billed to Part B Carriers

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

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

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

Notes:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Page updated: September 2020
CMS-1500 claim form fields for Crossovers only:

<table>
<thead>
<tr>
<th>Box Number</th>
<th>Field Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare/Medicaid/TRICARE/CHAMPVA/Group Health Plan (SSN or ID)/FECA Blk Lung (SSN)/Other (ID)</td>
<td>Enter an “X” in both the Medicare and Medicaid boxes.</td>
</tr>
<tr>
<td>1A</td>
<td>Insured’s ID Number</td>
<td>Enter the recipient's MBI number.</td>
</tr>
<tr>
<td>9A</td>
<td>Other Insured’s Policy or Group Number</td>
<td>Enter the 14-character Medi-Cal recipient identification number from the Beneficiary Identification Card.</td>
</tr>
<tr>
<td>10D</td>
<td>Claim Codes (Designated by NUCC)</td>
<td>Enter the patient’s SOC for the service (leave blank if not applicable).</td>
</tr>
<tr>
<td>11C</td>
<td>Insurance Plan Name or Program Name</td>
<td>Enter the Medicare Contractor ID.</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier</td>
<td>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.)</td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Info.</td>
<td>Enter the full address where services were provided, including the nine-digit ZIP code.</td>
</tr>
<tr>
<td>32A</td>
<td>Service Facility NPI</td>
<td>Enter the NPI of the Service Facility.</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Information</td>
<td>Enter the full billing address, including the nine-digit ZIP code.</td>
</tr>
<tr>
<td>33A</td>
<td>Billing Provider NPI</td>
<td>Enter the NPI of the Billing Provider.</td>
</tr>
</tbody>
</table>
Example: Billing Medi-Cal for Part B Services Billed to a Part B Contractor

C Crossover Claims

Page updated: September 2020
Crossover Claims

Page updated: September 2020

Example: Simplified Medicare Remittance Notice

![Medicare Remittance Notice](image)

Inpatient Part B-Only Services

Part B-Only Services Billed to a Part A Contractor

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

Reminders:

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

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

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

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Crossover Claim Follow-Up

Tracing Claims

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

Claims Inquiry Form (CIF)

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

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

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

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

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

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

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

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

Remittance Advice Details

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

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

**Notes:**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

32
Payment Examples

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

0395 Medicare Non-Covered Benefit

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

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

![sample RAD code 0395 example]

**Example:** RAD code 0395

![sample RAD code 0395 example]

33
0442 Cutback (Zero Pay)

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

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

![Sample pricing for RAD code 0442](image)

An automatic crossover claim resulting in a zero Medi-Cal payment will not be shown on the RAD form. However, if at least one procedure processes as a 0444 cutback, the automatic zero Medi-Cal payment crossover claim will appear on the RAD form. This indicates to providers that they may rebill the 0444 cutback procedures (excluding physician services). Refer to “Charpentier Rebilling” in the Medicare/Medi-Cal Crossover Claims: CMS-1500 (medi cr cms) section of the Part 2 provider manual for more information.
0443 Cutback with Deductible

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

Example: Pricing for 0443 Cutback (with deductible)

```
<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>PROVIDER BILLED</th>
<th>MEDICARE ALLOWED</th>
<th>DEDUCT</th>
<th>MEDICARE PAYMENT</th>
<th>COINSUR</th>
<th>BILLED TO MEDIC-A</th>
<th>MEDICALE ALLOWED</th>
<th>COMPUTED MEDICALE ALLOWED</th>
<th>DEDUCT PLUS COINSUR</th>
<th>PAID AMOUNT</th>
<th>RAD CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>77657</td>
<td>108.01</td>
<td>108.01</td>
<td>100.00</td>
<td>0.41</td>
<td>1.60</td>
<td>101.60</td>
<td>70.87</td>
<td>64.46</td>
<td>64.46</td>
<td>443</td>
<td></td>
</tr>
</tbody>
</table>
```

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.
Crossovers Claims

Page updated: September 2020

Pricing Information

Cutback

If there is a price on file, crossover claims will be cut back with RAD code 0444: 

For non-physician claims, see Charpentier billing instructions in the provider manual. Medi-Cal automated system payment does not exceed the Medicare allowed amount.

Medicare-Allowed Amount

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

Exceeds Medicare Rate

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

Note: A Charpentier rebill must not be combined with a crossover claim.
Knowledge Review

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

2. What types of services does Medicare Part A cover? _________________________

3. What types of services does Medicare Part B cover? ___________ and ___________

4. Recipients with aid code 80 have coverage that is ________________ to ________________ ____________________ ____________.

5. List two reasons why a crossover claim may not automatically cross over to Medi-Cal:
   a) _________________________________
   b) _________________________________

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

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

8. A Charpentier claim may be billed for?
   a) _________________________________
   b) _________________________________
   c) _________________________________

See the Appendix for the Answer Key.
Resource Information

References

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

Provider Manual References

Part 1
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)
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
- Review surgical procedure modifiers
- Identify pre-operative and post-operative services policy
- Identify modifiers for Non-Physician Medical Practitioners (NMPs)
- Provide general information regarding anesthesia-related drug and supply modifiers
- Explain “By Report” documentation

Acronyms

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

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

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

<table>
<thead>
<tr>
<th>Surgical Modifiers Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia-related Drugs &amp; Supplies</td>
</tr>
<tr>
<td>Evaluation and Management</td>
</tr>
<tr>
<td>General Use</td>
</tr>
<tr>
<td>Non-Physician Medical Practitioner</td>
</tr>
<tr>
<td>Radiology</td>
</tr>
</tbody>
</table>

Use of a modifier with a CPT 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.
Surgical Modifiers
Page updated: September 2020

Claim Form Placement

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

**Sample:** Partial CMS-1500 Claim Form

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AG</td>
<td>Primary Surgeon</td>
</tr>
<tr>
<td>AG</td>
<td>Multiple Primary Surgeons</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Procedure</td>
</tr>
<tr>
<td>51</td>
<td>Multiple Procedures</td>
</tr>
<tr>
<td>99</td>
<td>Multiple Modifiers</td>
</tr>
</tbody>
</table>

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.

**Modifier AG Exception**

CPT 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 when billed for a recipient, by the same provider, for the same date of service.

- Tubal ligations performed at the time of a cesarean section or other intra-abdominal surgery are reimbursable only when billed with CPT code 58611. For more information, refer to the Hysterectomy (hyst) and Sterilization (ster) sections in the appropriate Part 2 manuals.

- A salpingectomy or oophorectomy (CPT codes 58700, 58720, 58900 thru 58943) billed on the same date of service as a hysterectomy (CPT codes 58150 thru 58285) is not separately reimbursable.

- A vaginal delivery (CPT codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT codes 59510, 59514, 59618 or 59620) is not reimbursable unless the claim indicates a multiple pregnancy – one child delivered vaginally and one by cesarean section.

- Intra-ocular lens with cataract surgery policy is located in the Surgery: Eye and Ocular Adnexa (surg eye) section of the appropriate Part 2 provider manual.

- Insertion of a non-indwelling or temporary indwelling bladder catheter (CPT codes 51701 and 51702) is not separately reimbursable when billed with CPT codes 10021 thru 69979.

- CPT code 36000 (introduction of needle or intracatheter, vein) is not reimbursable when billed by same provider for the same recipient on the same date of service with any CPT code within the ranges of 00100 thru 69999 and 96360 thru 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 Correct Coding Initiative: National (correct) section of the Part 2 provider manual.
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.

Claim Form Examples Using Modifier 50

**Sample:** Partial *CMS-1500* Claim Form

![Partial CMS-1500 Claim Form](image)

**Sample:** Partial *UB-04* Claim Form

![Partial UB-04 Claim Form](image)

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

![Partial UB-04 Claim Form: Remarks field](image)
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.

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.

Sample: Partial CMS-1500 Claim Form
Sample: UB-04 Claim Form
Reimbursement Rule:

Reimbursement Rule Table

<table>
<thead>
<tr>
<th>CPT Code/Modifier</th>
<th>Reimbursement Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>41150 AG</td>
<td>100% of full-fee rate</td>
</tr>
<tr>
<td>38720 51</td>
<td>50% of full-fee rate</td>
</tr>
<tr>
<td>15120 51</td>
<td>50% of full-fee rate</td>
</tr>
<tr>
<td>31600 51</td>
<td>50% of full-fee rate</td>
</tr>
</tbody>
</table>

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.

Usage of Modifier 51 and Modifier 99

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

Assistant Surgeon Modifiers and Descriptions

<table>
<thead>
<tr>
<th>Assistant Surgeon Modifiers and Descriptions Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifier</td>
</tr>
<tr>
<td>80</td>
</tr>
<tr>
<td>99</td>
</tr>
</tbody>
</table>

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 are reimbursable to an assistant surgeon. To determine if there are any policy restrictions, refer to the TAR and Non-Benefit List: Codes (tar and non cd) section in the appropriate Part 2 provider manual.

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.
Sample: Partial *CMS-1500* Claim Form

![CMS-1500 Sample Claim Form](image_url)

Sample: Partial *UB-04* Claim Form

![UB-04 Sample Claim Form](image_url)

Sample: Partial *UB-04* Claim Form

![UB-04 Sample Claim Form](image_url)
**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**

<table>
<thead>
<tr>
<th>Current Billing Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>02/11/2018</td>
</tr>
<tr>
<td>02/11/2018</td>
</tr>
<tr>
<td>02/11/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Billing Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>02/11/2018</td>
</tr>
<tr>
<td>02/11/2018</td>
</tr>
</tbody>
</table>
### 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.

### Gender Dysphoria

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

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

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

Complex Operative Procedure Modifiers and Descriptions Table

<table>
<thead>
<tr>
<th>Prior surgery</th>
<th>Marked scarring</th>
<th>Very low weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distorted anatomy</td>
<td>Adhesions</td>
<td>Inflammation</td>
</tr>
<tr>
<td>Irradiation</td>
<td>Infections</td>
<td></td>
</tr>
</tbody>
</table>

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.

Additional Surgeon(s) Modifiers

Two Surgeons (Modifier 62)
Identifies a surgical procedure that requires two surgeons that perform on distinct parts of a procedure.

Note: Each surgeon would bill with modifier 62.

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 instructions for modifier 66 permit each physician of a surgical team to bill separately for their services. However, when billing Medi-Cal, the services of all physician members of team must be billed on a single line of the same claim form.
Operative/Postoperative Modifiers and Descriptions

Reduced Services (Modifier 52)
For use with surgery codes: 66820, 66821, 66830, 66840, 66850, 66920, 66930, 66940 and 66982 thru 66985. Requires “By Report” documentation.

Operative Postoperative Management (Modifier 54)
Surgical care only

Operative Postoperative Management (Modifier 55)
Postoperative management only

Staged or Related Procedure Postoperative Period (Modifier 58)
May be used with CPT codes 15002 thru 15429 and 52601 to address subsequent part(s) of a staged procedure.

Additional Operative Procedure Modifiers and Descriptions

Modifier Descriptions

Return to Operating Room (Modifier 78)
Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period.

Return to Operating Room (Modifier 79)
Unrelated procedure or service by the same physician during the postoperative period.

Discontinued Procedure Modifiers and Descriptions

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>Discontinued procedure; requires “By Report” documentation</td>
</tr>
<tr>
<td>73</td>
<td>Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia; to be reported by hospital outpatient department or surgical clinic only. Requires “By Report” documentation.</td>
</tr>
<tr>
<td>74</td>
<td>Discontinued outpatient hospital/ambulatory surgery center (ASC) after administration of anesthesia; to be reported by hospital outpatient department or surgical clinic only. Requires “By Report” documentation.</td>
</tr>
</tbody>
</table>
Knowledge Review

1. A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 10, 2018. The cone biopsy was performed on February 17, 2018. 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? ___________

See the Appendix for the Answer Key
Evaluation and Management (E&M) Modifiers

E&M Examinations

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

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

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

Policy for Postoperative Visits
Office visits, hospital visits, consultations and ophthalmological exams related to a surgery and billed during a follow-up period of the surgery, are not separately reimbursable if billed by the surgeon or assistant surgeon.

Exceptions Table

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 NCCI-associated</td>
<td>Unrelated E&amp;M service by the same physician during a postoperative period</td>
</tr>
<tr>
<td>25 NCCI-associated</td>
<td>Significant, separately identifiable E&amp;M service by the same physician on the same day of the procedure or other service</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery (major surgery only, day before or day of procedure)</td>
</tr>
</tbody>
</table>

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Note: Effective for dates of service on or after March 1, 2019, billing CPT codes 92002 thru 92014 (general ophthalmological services) and 99201 thru 99499 (Evaluation and Management [E&M] services) with modifier 24, 25 or 57 overrides the requirement of documenting medical justification when billed in conjunction with a surgical procedure.

Non-Physician Medical Practitioner (NMP)

Non-Physician Medical Practitioners (NMPs) include:

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

Modifier Description Table

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

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.

**Non-Medical Practitioner Claim Examples**

**Sample:** Partial CMS-1500 Claim Form
Anesthesia-Related Drugs and Supplies Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UA</td>
<td>Used for surgical or non-general anesthesia-related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code.</td>
</tr>
<tr>
<td>UB</td>
<td>Used for surgical or general anesthesia-related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code.</td>
</tr>
</tbody>
</table>
Billing Reminders

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

By Report Documentation

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

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

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

- Patient’s name
- Date of service
- Procedure code
- Operative report stating the time involved, the nature and purpose of procedure/service and how it relates to diagnosis
- Estimated follow-up days
- Size, number and location of lesions (if applicable)

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

Modifier Review

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

6. When billing for Physician Assistant (PA), what modifier should be used?
   a. 80
   b. U7
   c. 99 = (U7 + 80)
   d. None

See the Appendix for the Answer Key
Resource Information

References

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

Provider Manual References

Part 2

Anesthesia (anest)
CMS-1500 Special Billing Instructions (cms spec)
Correct Coding Initiative: National (correct)
Correct Coding Initiative: National – Claim Preparation (correct cod)
Hysterectomy (hyst)
Modifiers: Approved List (modif app)
Non-Physician Medical Practitioners (NMP) (non ph)
Non-Physician Medical Practitioner (NMP) Billing Example: CMS-1500 (non ph cms)
Non-Physician Medical Practitioner (NMP) Billing Example: UB-04 (non ph ub)
Sterilization (ster)
Supplies and Drugs (supp drug)
Surgery (surg)
Surgery Billing Examples: CMS 1500 (surg bil cms)
Surgery Billing Examples: UB-04 (surg bil ub)
Surgery: Billing with Modifiers (surg bil mod)
UB-04 Special Billing Instructions for Inpatient Services (ub spec ip)
# Appendix

## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHC</td>
<td>Adult Day Health Care</td>
</tr>
<tr>
<td>APR DRG</td>
<td>All Patient Refined Diagnosed Related Groups</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory Surgery Center</td>
</tr>
<tr>
<td>BIC</td>
<td>Benefits Identification Card</td>
</tr>
<tr>
<td>CA-MMIS</td>
<td>California Medicaid Management Information System</td>
</tr>
<tr>
<td>CCN</td>
<td>Claims Control Number</td>
</tr>
<tr>
<td>CCR</td>
<td><em>California Code of Regulations</em></td>
</tr>
<tr>
<td>CCS</td>
<td>California Children’s Services</td>
</tr>
<tr>
<td>CCS/GHPP</td>
<td>California Children’s Services and Genetically Handicapped Persons Program</td>
</tr>
<tr>
<td>CIF</td>
<td><em>Claims Inquiry Form</em></td>
</tr>
<tr>
<td>CNM</td>
<td>Certified Nurse Midwife</td>
</tr>
<tr>
<td>CSU</td>
<td>Correspondence Specialist Unit</td>
</tr>
<tr>
<td>DRG</td>
<td><em>Diagnosis-Related Groups</em></td>
</tr>
<tr>
<td>E&amp;M</td>
<td>Evaluation and Management</td>
</tr>
<tr>
<td>EOMB</td>
<td>Explanation of Medicare Benefits</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnostic and Treatment</td>
</tr>
<tr>
<td>GHPP</td>
<td>Genetically Handicapped Persons Program</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>LM</td>
<td>Licensed Midwife</td>
</tr>
<tr>
<td>MCP</td>
<td>Managed Care Plan</td>
</tr>
<tr>
<td>NCCI</td>
<td>National Correct Coding Initiative</td>
</tr>
<tr>
<td>NDC</td>
<td>National Drug Code</td>
</tr>
<tr>
<td>NMPs</td>
<td>Non-Physician Medical Practitioners</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>OHC</td>
<td>Other Health Coverage</td>
</tr>
<tr>
<td>POS</td>
<td>Point of Service</td>
</tr>
<tr>
<td>RA</td>
<td>Remittance Advice</td>
</tr>
<tr>
<td>RAD</td>
<td>Remittance Advice Details</td>
</tr>
<tr>
<td>SOC</td>
<td>Share of Cost</td>
</tr>
<tr>
<td>TAR</td>
<td>Treatment Authorization Request</td>
</tr>
<tr>
<td>TSC</td>
<td>Telephone Service Center</td>
</tr>
<tr>
<td>UPN</td>
<td>Universal Product Number</td>
</tr>
</tbody>
</table>
## Module A Answer Key

### Knowledge Review

<table>
<thead>
<tr>
<th>Enter Letter</th>
<th>RAD Code</th>
<th>RAD Code Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>RAD 0005</td>
<td>A) Cost center code missing/invalid.</td>
</tr>
<tr>
<td>E</td>
<td>RAD 0010</td>
<td>B) The service billed requires an approved TAR (Treatment Authorization Request).</td>
</tr>
<tr>
<td>C</td>
<td>RAD 0314</td>
<td>C) Health Care Plan enrollee, capitated service not billable to Medi-Cal.</td>
</tr>
<tr>
<td>A</td>
<td>RAD 9286</td>
<td>D) The claim was received after the one year maximum billing limitation.</td>
</tr>
<tr>
<td>D</td>
<td>RAD 0021</td>
<td>E) This service is a duplicate of a previously paid claim.</td>
</tr>
<tr>
<td>F</td>
<td>RAD 0076</td>
<td>F) The submitted documentation was not adequate.</td>
</tr>
<tr>
<td>H</td>
<td>RAD 9952</td>
<td>G) Type of Bill Code for APR-DRG Claim Invalid or Missing.</td>
</tr>
<tr>
<td>I</td>
<td>RAD 0037</td>
<td>H) Type of Admit missing or invalid.</td>
</tr>
<tr>
<td>G</td>
<td>RAD 9128</td>
<td>I) Health Care Plan enrollee, capitated service not billable to Medi-Cal.</td>
</tr>
<tr>
<td>J</td>
<td>RAD 9291</td>
<td>J) Total Charges billed are invalid.</td>
</tr>
</tbody>
</table>
Module B Answer Key

Knowledge Review 1

Fill in the blanks to complete the common RAD messages:

Question 1: 0037: _______________ enrollee, capitated service not billable to Medi-Cal.
Answer: Health Care Plan

Question 2: 0010: This service is a ____________________ of a previously paid claim.
Answer: duplicate

Question 3: 0626: Non-emergency related services are ________________ for aid code 55 recipients.
Answer: not payable

Question 4: 0145: The procedure is not a ____________ benefit on this date of service.
Answer: Medi-Cal

Question 5: 0314: Recipient is not eligible for the _______________ of service billed.
Answer: month
## Knowledge Review 2

Match the RAD Denial Codes in the second column to the most appropriate definition.

<table>
<thead>
<tr>
<th>Enter Letter</th>
<th>RAD Code</th>
<th>RAD Code Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>RAD 0225</td>
<td>A) Procedure code has not been authorized by CCS/GHPP (California Handicapped Persons Program).</td>
</tr>
<tr>
<td>B</td>
<td>RAD 0021</td>
<td>B) The claim was received after the one year maximum billing limitation.</td>
</tr>
<tr>
<td>A</td>
<td>RAD 9671</td>
<td>C) Incorrect procedure code and or modifier for this service. Resubmit new claim.</td>
</tr>
<tr>
<td>E</td>
<td>RAD 9109</td>
<td>D) HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.</td>
</tr>
<tr>
<td>D</td>
<td>RAD 9898</td>
<td>E) This service is not payable for the diagnosis billed.</td>
</tr>
</tbody>
</table>
Module C Answer Key

Knowledge Review 1

Question 1: A crossover claim is a claim billed to Medi-Cal for the Medicare ____________ and ________________.
Answer 1: coinsurance, deductible

Question 2: What types of services does Medicare Part A cover? _________________
Answer 2: Inpatient

Question 3: What types of services does Medicare Part B cover? __________ and __________
Answer 3: Outpatient, professional

Question 4: Recipients with aid code 80 have coverage that is ________________ to ________________ ________________ ________________.
Answer 4: restricted, Medicare services only

Question 5: List two reasons why a crossover claim may not automatically cross over to Medi-Cal:
Answer 5:
   a) Claim is unassigned
   b) Medicare denied 100% of the claim

Question 6: Which OHC code is used to identify a Medicare HMO?__________
Answer 6: F

Question 7: Combined Medicare/Medi-Cal payment for all services of a claim may not exceed the __________ ________ by Medi-Cal for all services.
Answer 7: amount allowed

Question 8: A Charpentier claim may be billed for?
Answer 8:
   a) rates
   b) limitations
   c) rates and limitations
Module D Answer Key

Knowledge Review

Question 1: A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 10, 2018. The cone biopsy was performed on February 17, 2018. What modifier should be used for the cone biopsy? ___________
Answer 1: 79

Question 2: An exploratory laparotomy was performed due to a gunshot wound. A few hours later the patient’s blood pressure drops, and the patient is urgently taken back to the operating room to reopen and explore for possible leakage from the surgical site. What modifier should be used for the reopen/explorative procedure? ____________
Answer 2: 78

Modifier Review

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

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

Question 3: Procedures billed with modifier 51 are reimbursed at what percentage of the Medi-Cal maximum allowable?
Answer 3: C

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

Question 5: For dates of service on or after October 1, 2015, providers should use the letter “O” to document the ICD indicator?
Answer 5: B

Question 6: When billing for Physician Assistant (PA), what modifier should be used?
Answer 6: B