Medi-Cal Provider Training 2016

Advanced Billing: Inpatient & Outpatient Services

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

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

Free Services for Providers

Provider Seminars and Webinars

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

Regional Representatives

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

Small Provider Billing Unit

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

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

Table of Contents

Inpatient Common Denials

Introduction 1
Claim Denial Description 3
Denied Claim Follow-Up Options 4
CIF Submission Exceptions 5
Denied Claim Follow-Up Procedures 6
Inpatient Common Billing Errors 16
Learning Activities 18

Outpatient Common Denials

Introduction 1
Claim Denial Description 3
Denied Claim Follow-Up Options 4
CIF Submission Exceptions 5
Denied Claim Follow-Up Procedures 6
Outpatient Common Billing Errors 16
Learning Activities 18

Crossover Claims

Introduction 1
Crossover Claim Description 3
Medicare Health Care Benefits 4
Medicare/Medi-Cal Crossover Claim Policies 7
Medicare/Medi-Cal Crossover Claim Billing 10
Crossover Claim Submission 15
Crossover Claim Follow-Up 24
Charpentier Claims 25

Surgical Modifiers

Introduction 1
Description 3
Surgical Modifier Policies 3
Billing Modifiers for Surgical Procedures 4
Other Surgical Modifiers 11
Operative/Postoperative Modifiers 13
Attachments – By Report 19
Learning Activities 20

Appendix

Acronyms 1

Inpatient Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages providers receive when billing on the *UB-04* claim form, providing billing advice and appropriate follow-up procedures for these denials. The module lists Remittance Advice Details (RAD) messages and codes that are used to reconcile accounts. RAD codes appear on the Medi-Cal RAD for claims that are approved, denied, suspended, or adjusted, as well as for Accounts Receivable (A/R) and payable transactions.

Module Objectives

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

Resource Information

Medi-Cal Subscription Service (MCSS)

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

References

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

Provider Manual References

Part 1

Appeal Process Overview (Appeal)
CIF Overview (cif)
Remittance Advice Details (RAD) Codes and Messages: 001 – 099 (remit cd001)
Remittance Advice Details (RAD) Codes and Messages: 100 – 199 (remit cd100)
Remittance Advice Details (RAD) Codes and Messages: 200 – 299 (remit cd200)
Remittance Advice Details (RAD) Codes and Messages: 300 – 399 (remit cd300)
Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999 (remit cd900)
Resubmission Turnaround Document (RTD) Overview (resub)

Part 2

Appeal Form Completion (appeal form)
CIF Special Billing Instructions for Inpatient Services (cif sp ip)
Diagnosis-Related Groups (DRG): Inpatient Services (diagnosis ip)
Sterilization (ster)
UB-04 Completion: Inpatient Services (ub comp ip)
UB-04 Tips for Billing: Inpatient Services (ub tips ip)

Acronyms

A list of current acronyms is located in the *Appendix* section of this 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 RAD codes and messages include billing advice to help providers correct denied claims. It is important to verify information on the original claim against the RAD.

Free-Form Denial Codes

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

10 Most Common Denial Messages

Denial #	RAD Code	Message
1	0010	This service is a duplicate of a previously paid claim.
2	0314	Recipient is not eligible for the month of service billed.
3	0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
4	0005	The service billed requires an approved TAR (*Treatment Authorization Request*).
5	0021	This claim was received after the one-year maximum billing limitation.
6	0076	The submitted documentation was not adequate.
7	0105	This service requires a valid sterilization *Consent Form*.
8	0243	The TAR Control Number submitted on the claim is not found on the TAR master file.
9	0036	RTD (*Resubmission Turnaround Document*) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
10	9968	No Approved TAR on File for APR-DRG Inpatient Admission.

Denied Claim Follow-Up Options

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

Timeliness Policy

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

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

NOTES

CIF Submission Exceptions

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

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

Denied Claim Follow-Up Procedures

Denial Code #1

Denied Claim Message

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

Follow-Up Procedure

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

Billing Tips

- Check the provider number/National Provider Identifier (NPI).
- Verify the recipient's 14-character ID number.
- Check "from-through" dates of service.
- Check records for previous payments. If no payment is found, verify all relevant information.

  Example: Procedure code, modifier and rendering provider number/NPI

NOTES

Denial Code #2

Denied Claim Message

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

Follow-Up Procedure

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

Billing Tips

- Verify the recipient's ID number with a valid Medi-Cal Benefits Identification Card (BIC) prior to rendering service, except in an emergency.
- Verify if the recipient has a Share of Cost (SOC) and is eligible for the month of service.
- Confirm the recipient's eligibility.
- Collect and spend down the SOC.

NOTES

Denial Code #3

Denied Claim Message

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

Follow-Up Procedure

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

Billing Tips

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

NOTES

Denial Code #4

Denied Claim Message

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

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0005 is to obtain an approved TAR and rebill the claim.

Billing Tips

- Verify procedure code.
- Verify “from-through” dates of service.
- Verify authorization information.

NOTES

Denial Code #5

Denied Claim Message

RAD CODE: 0021	This claim was received after the one-year maximum billing limitation.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0021 is to appeal the claim.

Billing Tips

Refer to claim form submission and timeliness instructions in the appropriate Part 2 manual for billing limitations.

- Verify “from-through” dates of service.
- Determine if this service was previously denied for another reason, with a denial date that indicates the claim is current.
- Use the most appropriate delay reason code. Place the code in box 37 of the *UB-04* claim.
- Submit initial claims that are over one year old to:

  Xerox State Healthcare, LLC
  Over-One-Year Attention: Claims Preparation Unit
  P.O. Box 13029
  Sacramento, CA 95813-4029

NOTES

Denial Code #6

Denied Claim Message

RAD CODE: 0076	The submitted documentation was not adequate.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0076 is to rebill the claim.

Billing Tips

Inpatient providers should verify:

- Date of birth
- Admission date
- Discharge date
- The “from” date of service is in chronological sequence with the “thru” date
- Primary procedure code is on file and not missing, invalid or unclear
- Secondary procedure code is on file
- Attending physician provider number

NOTES

Denial Code #7

Denied Claim Message

RAD CODE: 0105	This service requires a valid sterilization *Consent Form*.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0105 is to correct and rebill the claim.

Billing Tips

- The only sterilization consent form accepted by Medi-Cal is the Department of Health Services *Consent Form* (PM 330).
- Claims submitted with a computer-generated form or any other preprinted version of the PM 330 will not be reimbursed.
- Instructions must be followed exactly or the PM 330 will be returned and reimbursement delayed or denied.
- See the *Sterilization* (ster) Part 2 provider manual for instructions on completing the PM 330.

NOTES

Denial Code #8

Denied Claim Message

RAD CODE: 0243	The TAR Control Number submitted on the claim is not found on the TAR master file.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0243 is to correct the TAR number and rebill or submit an appeal within 90 days from the RAD denial date.

Billing Tips

- Verify the TAR Control Number on the claim matches the number on the approved TAR.

NOTES

Denial Code #9

Denied Claim Message

RAD CODE: 0036	RTD (*Resubmission Turnaround Document*) was either not returned or was returned uncorrected; therefore, your claim is formally denied.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0036 is to rebill the claim or CIF with the corrected information within six months or submit an appeal within 90 days from the RAD denial date.

Billing Tips

- Submit missing documentation.
- Submit corrected claim.
- If the RTD form is available, find out what error resulted in a denied claim.

NOTES

Denial Code #10

Denied Claim Message

RAD CODE: 9968	No Approved TAR on File for APR-DRG Inpatient Admission.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 9968 is to rebill the claim.

Billing Tips

- An admit TAR is a TAR that is submitted to request authorization for the entire hospital stay.
- For DRG-reimbursed hospitals, most inpatient stays require only an admit TAR and not a daily TAR.
- Review the *Diagnosis-Related Groups (DRG): Inpatient Services* (diagnosis ip) section of the Part 2 provider manual for exceptions.

NOTES

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.

Box#	Field Name	Error
18 – 24	CONDITION CODES	Omitting codes or entering a Medi-Cal local billing limit exception code (X0, X1 – X9) **Billing Tip:** The delay reason code is entered (Box 37A) of the claim. Enter codes in numeric-alpha order. For example, 80, 82, A1.
39 – 41 (A – D)	VALUE CODES AND AMOUNT (Patient's SOC)	Missing value code information. Entering only the value code and not the amount. Entering only the amount and not the value code. **Billing Tip:** 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.
50 (A – C)	PAYER NAME	Missing all payer information **Billing Tip:** Enter the "I/P" indicator.
54 (A – B)	PRIOR PAYMENTS (Other Coverage)	Missing prior payment or Other Health Coverage not indicated **Billing Tip:** Enter the patient's other health insurance payment. Do not enter Medicare payments in this box.
56	NPI	Missing or incorrect NPI number **Billing Tip:** Enter the NPI.
60 (A – C)	INSURED'S UNIQUE ID	Entering the recipient's Medi-Cal ID number incorrectly **Billing Tip:** Verify the recipient is eligible for the services rendered by using the POS network. Do not enter the Medicare ID number.

Box #	Field Name	Error
63 (A – C)	TREATMENT AUTHORIZATION CODES	Entering EVC number instead of the TAR number **Billing Tip:** The EVC number is only for verifying eligibility and should not be entered on the claim.
66	DX	Missing ICD indicator **Billing Tip:** An ICD Indicator of “0” is required for dates of service/discharge on or after October 1, 2015.
74 (A – B)	PRINCIPAL PROCEDURE CODE AND DATE	Missing or incorrect ICD-10-PCS code or a CPT-4/HCPCS procedure code entered
76	ATTENDING PHYSICIAN ID	Missing or incorrect attending physician’s NPI **Billing Tip:** Do not enter the operating or admitting NPI in this field.
77	OPERATING PHYSICIAN ID	Missing or incorrect operating physician’s Medi-Cal provider number/ID Qualifier/NPI
78 – 79	OTHER (Admitting Physician Provider Number) NPI	Missing or incorrect admitting physician’s NPI
80	REMARKS	Reducing font size or abbreviating terminology to fit in the field **Billing Tip:** 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.

NOTES

Learning Activities

Learning Activity 1: Matching Terms Puzzle

Medi-Cal knowledge: Match the words in the first column to the best available answer in the second column.

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

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

Learning Activity 2: Word Scramble

Unscramble the following words:

1. ematceRitn _____
2. OCS _____
3. alenDsi _____
4. wol-uplFo _____
5. msleTinise _____
6. lmsiaC _____
7. cRiiptene _____
8. ribesbrcSu _____
9. DCI iitdacnro _____

Answer Key: 1) Remittance; 2) SOC; 3) Denials; 4) Follow-up; 5) Timeliness; 6) Claims; 7) Recipient; 8) Subscriber; 9) ICD indicator

Outpatient Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages providers receive when billing on the *UB-04* claim form, provide billing advice and appropriate follow-up procedures for these denials. The module lists *Remittance Advice Details* (RAD) messages and codes that are used to reconcile accounts. RAD codes appear on the Medi-Cal RAD for claims that are approved, denied, suspended, or adjusted, as well as for Accounts Receivable (A/R) and payable transactions.

Module Objectives

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

Resource Information

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Remittance Advice Details (RAD) Codes and Messages: 200 – 299 (remit cd200)
Remittance Advice Details (RAD) Codes and Messages: 300 – 399 (remit cd300)
Remittance Advice Details (RAD) Codes and Messages: 600 – 699 (remit cd600)
Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999 (remit cd900)
Resubmission Turnaround Document (RTD) Overview (resub)

Part 2

Appeal Form Completion (appeal form)
CIF Special Billing Instructions for Outpatient Services (cif sp op)
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)

Acronyms

A list of current acronyms is located in the *Appendix* section of this 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 RAD codes and messages include billing advice to help providers' correct denied claims. It is important to verify information on the original claim against the RAD.

Free-Form Denial Codes

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

10 Most Common Denial Messages

Denial #	RAD Code	Message
1	0010	This service is a duplicate of a previously paid claim.
2	0314	Recipient is not eligible for the month of service billed.
3	0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
4	0145	This procedure is not a Medi-Cal benefit on this date of service.
5	0169	This service is not payable when billed with this diagnosis.
6	0250	Quantity exceeds allowed for per-visit codes, or a claim with the same date of service and the same per-visit code was found in history. Medical justification required.
7	0093	Non-emergency services are not payable for limited service OBRA/IRCA recipients.
8	9898	HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.
9	0036	RTD (*Resubmission Turnaround Document*) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
10	0626	Non-emergency related services are not payable for aid code 55 recipients.

Denied Claim Follow-Up Options

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

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

Timeliness Policy

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

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

NOTES

CIF Submission Exceptions

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

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

Denied Claim Follow-Up Procedures

Denial Code #1

Denied Claim Message

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

Follow-Up Procedure

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

Billing Tips

- Check the provider number/National Provider Identifier (NPI).
- Verify the recipient's 14-character ID number.
- Check "from-through" dates of service.
- Check records for previous payments. If no payment is found, verify all relevant information.

  Example: Procedure code, modifier and rendering provider number/NPI

NOTES

Denial Code #2

Denied Claim Message

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

Follow-Up Procedure

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

Billing Tips

- Verify the recipient's ID number with a valid Medi-Cal Benefits Identification Card (BIC) prior to rendering service, except in an emergency.
- Verify if the recipient has a Share of Cost (SOC) and is eligible for the month of service.
- Confirm the recipient's eligibility.
- Collect and spend down the SOC.

NOTES

Denial Code #3

Denied Claim Message

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

Follow-Up Procedure

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

Billing Tips

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

NOTES

Denial Code #4

Denied Claim Message

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

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0145 is to rebill the claim.

Billing Tips

- Verify procedure code.
- Verify “from-through” dates of service.
- Verify authorization information.

NOTES

Denial Code #5

Denied Claim Message

RAD CODE: 0169	This service is not payable when billed with this diagnosis.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0169 is to rebill the claim with the corrected information.

Billing Tips

- Verify primary diagnosis code.
- Verify procedure code.
- Verify modifier.

NOTES

Denial Code #6

Denied Claim Message

RAD CODE: 0250	Quantity exceeds allowed for per-visit codes, or a claim with the same date of service and the same per-visit code was found in history. Medical justification required.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0250 is to submit an appeal within 90 days or rebill the claim.

Billing Tips

- Provide reason for multiple services done on the same date of service and attach medical justification.

NOTES

Denial Code #7

Denied Claim Message

RAD CODE: 0093	Non-emergency services are not payable for limited service OBRA/IRCA recipients.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0093 is to submit an appeal within 90 days from the RAD denial date.

Billing Tips

- Check the *Emergency Verification* field.
- Attach a copy of the Emergency Verification Statement.
- Refer to the *OBRA and IRCA* section of Part 1 provider manual for billing guidelines.

NOTES

Denial Code #8

Denied Claim Message

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

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 9898 is to submit an appeal within 90 days from the RAD denial date.

Billing Tips

- Verify N4 qualifier is used.
- Verify the five-four-two format.
- Zero fill the five-four-two format if needed.
- Review NDC for transcription errors.

NOTES

Denial Code #9

Denied Claim Message

RAD CODE: 0036	RTD (*Resubmission Turnaround Document*) was either not returned or was returned uncorrected; therefore, your claim is formally denied.

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0036 is to rebill the claim or CIF with the corrected information within six months or submit an appeal within 90 days from the RAD denial date.

Billing Tips

- Submit missing documentation.
- Submit corrected claim.
- If the RTD form is available, find out what error resulted in a denied claim.

NOTES

Denial Code #10

Denied Claim Message

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

Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0626 is to rebill the claim or CIF with the corrected information within six months from the RAD denial date.

Billing Tips

- Verify the correct aid code using the *Aid Codes Master Chart* (aid codes) section of the Part 1 provider manual. Aid code 55 is restricted to pregnancy and emergency services.

NOTES

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.

Box#	Field Name	Error
6	STATEMENT COVERS PERIOD (FROM-THROUGH)	Entering information in this field, which is not required by Medi-Cal for outpatient claims **Billing Tip:** For outpatient "from-through" billing instructions, see the *UB-04 Special Billing Instructions for Outpatient Services* section (ub spec op) of the appropriate Part 2 provider manual.
18 – 24	CONDITION CODES	Omitting codes or entering a Medi-Cal local billing limit exception code (A, 1 – 9) **Billing Tip:** The delay reason code is entered in the unlabeled field (Box 37A) of the claim. Enter codes in numeric-alpha order. For example, 80, 82, X1.
39 – 41 (A – D)	VALUE CODES AND AMOUNT (Patient's SOC)	Missing value code information. Entering only the value code and not the amount. Entering only the amount and not the value code. **Billing Tip:** 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.
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-4 codebook.

Box#	Field Name	Error
44	HCPCS/RATE	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. For Section 340B provider submitting claims for physician administered drugs: omitting the modifier UD. **Billing Tip:** Check instructions in the *UB-04 Completion: Outpatient Services* section of this manual for the appropriate location of modifier UD for Section 340B drugs on the *UB-04*.
46	SERVICE UNITS	Entering the wrong service units as required by the billing code **Billing Tip:** Although this is a seven-digit field, Medi-Cal only allows three digits.
54 (A – B)	PRIOR PAYMENTS (Other Coverage)	Missing prior payment or Other Health Coverage not indicated **Billing Tip:** Enter the patient's other health insurance payment. Do not enter Medicare payments in this box.
60 (A – C)	INSURED'S UNIQUE ID	Entering the recipient Medi-Cal ID number incorrectly **Billing Tip:** Verify the recipient is eligible for the services rendered by using the POS network or Automated Eligibility Verification System (AEVS). Do not enter the Medicare ID number.
63 (A – C)	TREATMENT AUTHORIZATION CODES	Entering Eligibility Verification Confirmation (EVC) number instead of the TAR number **Billing Tip:** The EVC number is only for verifying eligibility and should not be entered on the claim.
66	DX	Missing ICD indicator **Billing Tip:** An ICD Indicator of "0" is required for dates of service on or after October 1, 2015.
80	REMARKS	Reducing font size or abbreviating terminology to fit in the field **Billing Tip:** 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.

Learning Activities

Learning Activity 1: Matching Terms Puzzle

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

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

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

Learning Activity 2: Word Scramble

Unscramble the following words:

1. ematceRitn _____
2. OCS _____
3. alenDsi _____
4. wol-uplFo _____
5. msleTinise _____
6. lmsiaC _____
7. cRiiptene _____
8. ribesbrcSu _____
9. DCI iitdcanro _____

Answer Key: 1) Remittance; 2) SOC; 3) Denials; 4) Follow-up; 5) Timeliness; 6) Claims; 7) Recipient; 8) Subscriber; 9) ICD indicator

Crossover Claims

Introduction

Purpose

The purpose of this module is to familiarize participants with the Medi-Cal claim billing 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
- Identify billing for Medicare non-covered, exhausted and non-eligible recipients
- Discuss automatic crossover billing procedures and billing tips for specific claim types
- Identify completion requirements for crossover inpatient claims, outpatient claims, medical claims and *Claims Inquiry Form* (CIF)
- Provide overview of Charpentier claims

Resource Information

Medi-Cal Subscription Service (MCSS)

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

References

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

Provider Manual References

Part 1

Medicare/Medi-Cal Crossover Claims Overview (medicare)

Part 2

CMS-1500 Completion (cms comp)
Medicare/Medi-Cal Crossover Claims: CMS-1500 (medi cr cms)
Medicare/Medi-Cal Crossover Claims: Inpatient Services (medi cr ip)
Medicare/Medi-Cal Crossover Claims: Outpatient Services (medi cr op)
Medicare/Medi-Cal Crossover Claims: UB-04 (medi cr ub)
Medicare Non-Covered Services: Charts Introduction (medi non cha)
UB-04 Completion: Inpatient Services (ub comp ip)
UB-04 Completion: Outpatient Services (ub comp op)

Acronyms

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

NOTES

Crossover Claim Description

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

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

Medicare/Medi-Cal Crossover Claim Terminology

- **Crossover:** A claim billed to Medi-Cal for the Medicare deductible and/or coinsurance is called a crossover claim. This type of claim has been approved or paid by Medicare.
- **Deductible:** The dollar amount Medicare recipients must pay for Part A or Part B services prior to receiving Medicare benefits.
- **Coinsurance:** The remaining balance of the Medicare Allowed Amount after a Medicare payment.
- **Co-payments:** The amount required by Medicare Part C or D when services are rendered or drugs are purchased. (Providers may choose to waive these co-payments or may deny service if a recipient cannot pay this amount. Medi-Cal does not generally pay for co-payments.)
- **Health Insurance Claim (HIC) number:** The Medicare recipient's identification number.

Brainteaser

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

Answer Key: coinsurance, deductible

Medicare Health Care Benefits

Scope of Coverage

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

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

For a more extensive and current list of Medicare-covered services, refer to the annual *Medicare & You* publication available online at (*www.medicare.gov*).

Part A – Inpatient Services

Medicare provides coverage for inpatient hospital services, skilled nursing facility services, hospice and home health care services under Part A. These services are reflected on the Medicare *Remittance Advice* (RA) and include the following health care services:

- Blood received in the hospital or Skilled Nursing Facility (NF-B)
- Home health services
- Hospice care
- Inpatient hospital care
- Skilled nursing facility (NF-B) care

NOTE

The services listed above are generally covered by Part A. However, if a recipient does not have Part A coverage, the Medicare Part A contractor will pay for the services otherwise covered by Part B from funds held in trust for this purpose.

Providers must bill straight Medi-Cal for inpatient Part B-only type of claims because Medi-Cal does not process these as crossover claims. For inpatient Part B-only services, bill as straight Medi-Cal on the *UB-04* claim form showing the Medicare Part B payment as Other Health Coverage (OHC). Refer to the appropriate Part 2 provider manual for billing instructions.

Part B – Outpatient and Professional Services

Medicare provides coverage for medically necessary, professional services and some preventive outpatient services under Part B eligibility. Outpatient claims (Part B services billed to Part A contractors) are reflected on the *Medicare National Standard Intermediary Remittance Advice* (MNSIRA). Providers are required to submit hard copy outpatient crossover claims with the Medicare electronic *Remittance Advice* (RA) information formatted in the MNSIRA. PCPrint Software is used to access and print the Medicare electronic RA in this format. The software is free and available through the Medicare Part A contractors. Part B (outpatient services) billed to Part B (contractors) medical claims are reflected on the *Medicare Remittance Notice* (MRN).

Part B outpatient and professional services include the following:

- Physician and practitioner services
- Outpatient hospital services (emergency, same-day surgery, outpatient imaging and labs)
- Blood received as an outpatient
- Home health services
- Other medical and health services, such as:
  - Chiropractic services (limited)
  - Clinical trials
  - Diagnostic tests, X-rays, MRIs, CTs and others
  - Durable medical equipment
  - Emergency room and urgent care
  - Kidney dialysis services and supplies
  - Medical transportation
  - Medical supplies, including limited diabetic supplies
  - Mental health care (50 percent reimbursable)
  - Pathology and laboratory services
  - Physical and occupational therapy
  - Prescription drugs (limited)
  - Preventive services (limited)
  - Prosthetics and orthotics
  - Smoking cessation services
  - Speech-language pathology
  - Telemedicine (limited)
  - Transplant services
  - Travel health care (limited)

Brainteaser:

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

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

Part C – Medicare Advantage Plans

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

Part D – Prescription Drugs

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

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

Category	Description
Coughs and colds	Symptomatic relief
Non-prescription drugs	Part D, not Medi-Cal; covers insulin, syringes and smoking cessation products
Prescription vitamins and minerals	Select single vitamins and minerals pursuant to *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.
Weight control	Anorexia, weight loss or weight gain

Medical Supplies

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

NOTES

Medicare/Medi-Cal Crossover Claim Policies

Recipient Coverage

Eligibility

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

Type of Coverage	Medicare Coverage Message
Part A	Subscriber has Part A Medicare coverage with Health Insurance Claim number (HIC) _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Part B	Subscriber has Part B Medicare coverage with HIC Number _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Parts A and B	Subscriber has Parts A and Part B Medicare coverage with HIC Number _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Parts A and D	Subscriber has Parts A and D Medicare coverage with HIC Number _____. Medicare Part A-covered services must be billed to Medicare before billing Medi-Cal.
Parts B and D	Subscriber has Parts B and D Medicare coverage with HIC Number _____. Medicare Part B-covered services must be billed to Medicare before billing Medi-Cal.
Parts A, B and D	Subscriber has Parts A, B and D Medicare coverage with HIC number _____. Medicare Part A and Part B-covered services must be billed to Medicare before billing Medi-Cal.
Part D	Subscriber has Part D Medicare coverage with HIC number _____. Medicare Part D covered drugs need to be billed to Medicare carrier before billing Medi-Cal. Carrier name: _____, Cov: R.

Limited Income Recipient – QMB

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

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

> MEDI-CAL ELIGIBILITY LIMITED TO MEDICARE COINSURANCE, DEDUCTIBLES.
> PART A, B MEDICARE COVERAGE WITH HIC #_____.
> BILL MEDICARE BEFORE MEDI-CAL.

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

Medi-Cal Crossover Claim Reimbursement

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

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 sum total of the claim. 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 the claim.

Zero Pay Crossovers

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

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

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

NOTE

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

Share of Cost

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

Brainteaser

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

Answer Key: restricted, Medicare services only

Medicare/Medi-Cal Crossover Claim Billing

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

Crossover Claim Procedures

Automatically Billed Crossover Claims

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

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

Medicare Contractors

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

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

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

Direct Billed Claims

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

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

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

NOTE

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

Brainteaser

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

1. _____
2. _____

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

Non-Crossover Claim Procedures

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

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

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

Medicare Non-Covered Service

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

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

Medicare Denied Service

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

Medicare Exhausted Service

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

Brainteaser

What are the four types of claims that should not be billed as crossovers?

1. _____
2. _____
3. _____
4. _____

Answer Key: 1) Medicare non-covered services; 2) Medicare denied services; 3) Medicare exhausted services; 4) Medicare non-eligible recipients

Medicare Non-Eligible Recipients

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

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

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

Acceptable documentation for Medicare non-eligible recipients includes the following:

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

Other Health Coverage – HMO

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

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

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

Brainteaser:

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

Answer Key: F

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

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

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

NOTES

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 require a delay reason code in order to receive full reimbursement.

Mailing Instructions

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

Inpatient Only
Xerox State Healthcare, LLC
P.O. Box 15500
Sacramento, CA 95852-1500

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

Hard Copy Submission Requirements

Inpatient Services

Part A Services Billed to Part A Contractor

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

NOTE
Refer to billing instructions regarding implementation of the NPI and *UB-04* claim form.

Follow these instructions to bill for services rendered:

Box #	Form Fields	Instructions
4	TYPE OF BILL	First two digits must be 11 or 18 and values must match the Medicare RA. If first two digits are 12, bill as straight Medi-Cal with other health coverage.
6	FROM-THROUGH DATES OF SERVICE	From-through dates of service must match the Medicare RA.
8b	PATIENT NAME	Patient name must match the Medicare RA.
31	OCCURRENCE CODES & DATES	List the date of the MNSIRA (MMDDYY) with code 50.

Box #	Form Fields	Instructions
39 – 41 A – D	VALUE CODES AND AMOUNTS	• Blood Deductible: Enter code 06 and the Medicare blood deductible amount. Leave blank if not applicable. • Patient's SOC: Enter code 23 and the patients' SOC for the claim. Leave blank if not applicable. • Pints of Blood: Enter code 38 and the number of pints of blood billed. Leave blank if not applicable. • Medicare Deductible: Enter code A1 if Medicare is the primary payer, or B1 if Medicare is a secondary payer. Enter the deductible amount. Leave blank if not applicable • Medicare Coinsurance: Enter A2 if Medicare is the primary payer, or B2 if Medicare is a secondary payer. Enter coinsurance amount. Leave blank if not applicable.
42	REVENUE CODE	The Revenue Code must display "001" in column 42, line 23.
47	TOTAL CHARGES AMOUNT	The Total Charges and amount must match the Medicare RA in column 42, line 23.
50	PAYER NAME	Payers must be listed in the following order of payment: • OHC, if applicable, except Medicare supplemental insurance • Medicare • Medicare supplemental insurance (if applicable) • Medi-Cal Inpatient Services (IP)
51	HEALTH PLAN ID	Enter the Medicare contractor ID.
54 A – C	PRIOR PAYMENTS	Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50. **NOTE** The Medicare payment amount must match the MNSIRA ALLOW/REIM amount not the NET REIMB AMT.
55	EST. AMOUNT DUE	On the corresponding Medicare line, enter the same total charges amount as in Box 47, line 23.
56	NPI	Submit an original *UB-04* claim form using the provider NPI in effect appropriate for the date of service on the claim
57 A – C	OTHER BILLING PROVIDER ID	This field is not required, but can be used for legacy provider ID numbers and atypical providers who do not have an NPI to report (Box 56).
60 A – C	INSURED'S UNIQUE ID	Enter the beneficiaries HIC number on the line that corresponds to the Medicare payer line in Box 50. Enter the Medi-Cal BIC ID number on the line that corresponds to the Medi-Cal IP payer line in Box 50.
76, 77, 78, 79	ATTENDING, OPERATING, & OTHER	Enter appropriate provider NPI.

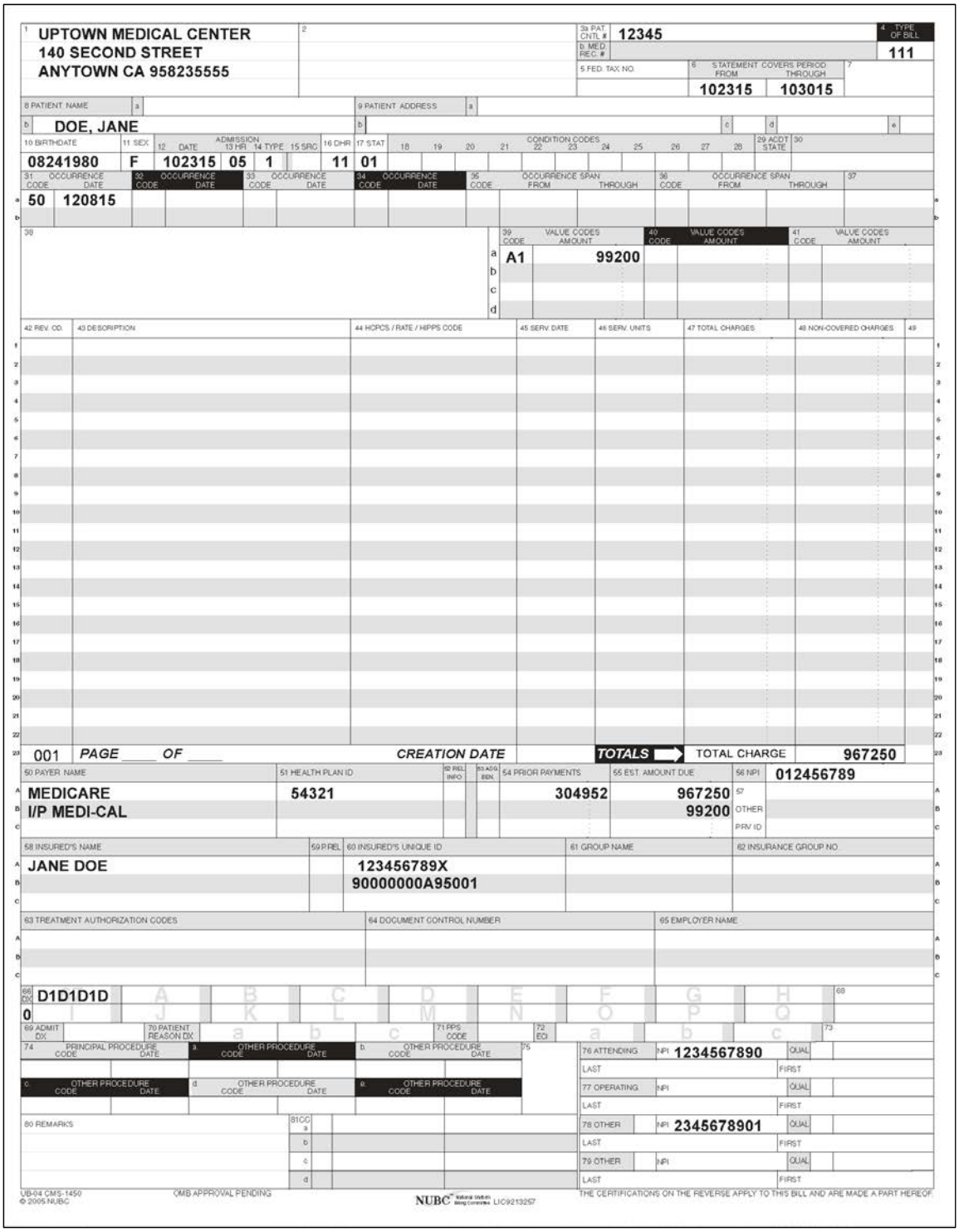
NOTE

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

Calculation

SUM (Blood deductible + Medicare deductible + Medicare coinsurance)
– SUM (SOC, OHC, Medicare supplemental insurance payments)
= Amount Due

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.



Example: Inpatient *UB-04* Crossover Claim Form

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).

NOTE

Refer to billing instructions related to implementation of the NPI and *UB-04* claim form.

UB-04 claim form (applicable fields):

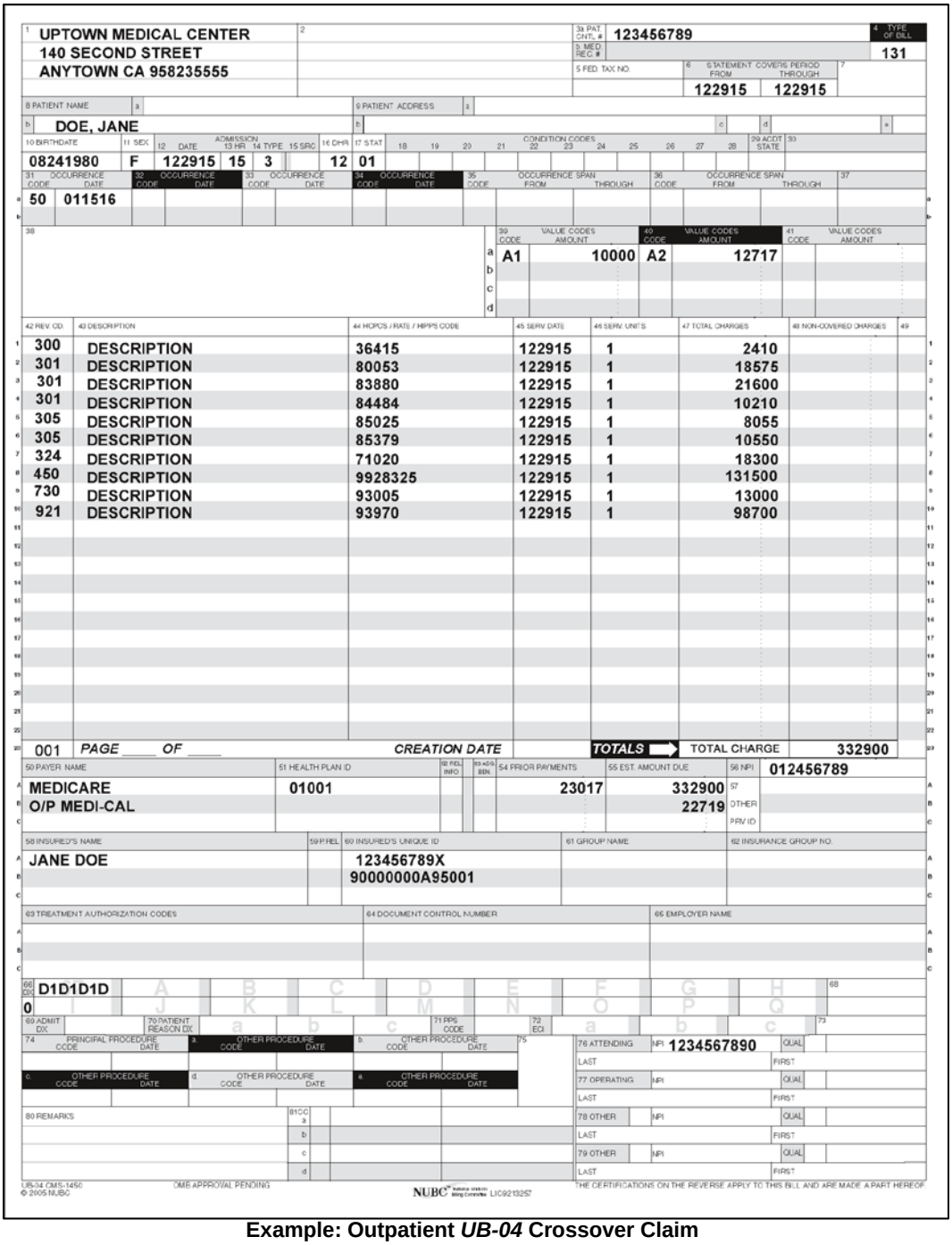
Box #	Field Name	Instructions
4	TYPE OF BILL	First two digits will be 13, 14, 72, 74, 75, 76, or 85 and values must match the *Medicare National Standard Intermediary Remittance Advice* (MNSIRA).
8B	PATIENT NAME	Patient name must match the MNSIRA.
31	OCCURRENCE CODES & DATES	Enter code 50 and the date (MMDDYY) of the MNSIRA.
39 – 41 A – D	VALUE CODES AND AMOUNTS	Enter code 23 and the patient's SOC for the claim. Leave blank, if not applicable. • Enter code 06 and the blood deductible amount. • Enter code 38 and the number of pints of blood. • Enter code A1 and the Medicare deductible amount if Medicare is the primary payer. Enter code B1 if Medicare is a secondary payer. Leave blank, if not applicable. • Enter code A2 and the Medicare coinsurance amount if Medicare is the primary payer. Enter code B2 if Medicare is a secondary payer. Leave blank, if not applicable.
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.
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.

Box #	Field Name	Instructions
50	PAYER NAME	Payers must be listed in the following order of payment: • OHC, if applicable, except Medicare supplemental insurance • Medicare • Medicare supplemental insurance (if applicable) • Medi-Cal Outpatient Services (OP)
51	HEALTH PLAN ID	Enter the Medicare contractor ID.
54 A – C	PRIOR PAYMENTS	Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50. **NOTE** The Medicare payment amount must match the MNSIRA ALLOW/REIM amount not the NET REIMB AMT.
55	ESTIMATED AMOUNT DUE	• On the corresponding Medicare line, enter the total charges from Box 47, line 23. • On the corresponding Medi-Cal line, enter the difference of: Blood deductible + Medicare deductible + Medicare coinsurance amounts less SOC, OHC and Medicare supplemental insurance payments.
56	NPI	Submit an original *UB-04* claim form using the provider NPI in effect appropriate for the date of service on the claim
76, 77, 78, 79	ATTENDING, OPERATING, & OTHER	Enter appropriate provider NPI.

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

NOTE

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



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL. # 123456789
b. MED. REC. #
4 TYPE OF BILL 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 122915 THROUGH 122915
7

8 PATIENT NAME a
b DOE, JANE
9 PATIENT ADDRESS a
b c d e

10 BIRTHDATE 08241980
11 SEX F
12 DATE 122915
ADMISSION 13 HR 15 14 TYPE 3 15 SRC
16 DHR 12
17 STAT 01
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE a 50 011516 b
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT a A1 10000 b c d
40 VALUE CODES CODE AMOUNT A2 12717
41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	300	DESCRIPTION	36415	122915	1	2410		
2	301	DESCRIPTION	80053	122915	1	18575		
3	301	DESCRIPTION	83880	122915	1	21600		
4	301	DESCRIPTION	84484	122915	1	10210		
5	305	DESCRIPTION	85025	122915	1	8055		
6	305	DESCRIPTION	85379	122915	1	10550		
7	324	DESCRIPTION	71020	122915	1	18300		
8	450	DESCRIPTION	9928325	122915	1	131500		
9	730	DESCRIPTION	93005	122915	1	13000		
10	921	DESCRIPTION	93970	122915	1	98700		
23	001	PAGE ____ OF ____	CREATION DATE		TOTALS	TOTAL CHARGE	332900	

50 PAYER NAME
A MEDICARE
B O/P MEDI-CAL
C
51 HEALTH PLAN ID
A 01001
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
A 23017
B
55 EST. AMOUNT DUE
A 332900
B 22719
56 NPI 012456789
57 OTHER PRV ID

58 INSURED'S NAME
A JANE DOE
59 P. REL
60 INSURED'S UNIQUE ID
A 123456789X
B 90000000A95001
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX D1D1D1D
0
A B C D E F G H
I J K L M N O P Q
68

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

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

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

80 REMARKS
81 CC a b c d

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

Example: Outpatient *UB-04* Crossover Claim

Outpatient and Professional Services

Part B Services Billed to Part B Contractor

Refer to billing instructions related to implementation of the National Provider Identifier (NPI) and the *CMS-1500* claim form.

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)

CMS-1500 claim form fields for crossovers only:

Box #	Field Name	Instructions
1	MEDICARE/MEDICAID/TRICARE/ CHAMPVA/GROUP HEALTH PLAN (SSN OR ID)/FECA BLK LUNG (SSN)/ OTHER (ID)	Enter an "X" in both the *Medicare* and *Medicaid* boxes.
1A	INSURED'S ID NUMBER	Enter the recipient's HIC number.
9A	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the 14-character Medi-Cal recipient identification number from the Beneficiary Identification Card.
10D	CLAIM CODES (DESIGNATED BY NUCC)	Enter the patient's SOC for the service (leave blank if not applicable).
11C	INSURANCE PLAN NAME OR PROGRAM NAME	Enter the Medicare Contractor ID.
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only. An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. (The legacy Medi-Cal ID was previously required in this field for crossovers.)
32	SERVICE FACILITY LOCATION INFO.	Enter the full address where services were provided, including the nine-digit ZIP code.
32A	SERVICE FACILITY NPI	Enter the NPI of the Service Facility.
33	BILLING PROVIDER INFORMATION	Enter the full billing address, including the nine-digit ZIP code.
33A	BILLING PROVIDER NPI	Enter the NPI of the Billing Provider.

NOTE

When billing Part B services to a Medicare Part A contractor, follow the billing instructions in the *Medicare/Medi-Cal Crossover Claims: UB-04* section (medi cr ub) of the appropriate Part 2 manual.

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM 06 DD 21 YY 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 90000000A95001

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

c. OTHER ACCIDENT? [ ] YES [ ] NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: 01002

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D1 B. D2D2D2D C. D3D3D3D D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	15	10	01	15	11		99214		1	55 00	1		NPI	
2	10	01	15	10	01	15	11		71020		2	60 00	1		NPI	
3	10	01	15	10	01	15	11		93000		3	50 00	1		NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 165 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use 165 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Smith DATE 10/21/15

32. SERVICE FACILITY LOCATION INFORMATION
JOHN BROWN
651 FIRST STREET
ANYTOWN, CA 958235555

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
JANE SMITH
1027 MAIN STREET
ANYTOWN, CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Example: *CMS-1500* Crossover Claim

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).

NOTE

Refer to billing instructions regarding implementation of the NPI and *UB-04* claim form.

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

Billing Tips

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

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

Crossover Claim Follow-Up

Tracing Claims

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

Claims Inquiry Form (CIF)

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

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

Crossover CIF Billing Tips

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

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

NOTE

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

Charpentier Claims

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

NOTE

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

The following definitions apply to Charpentier rebills:

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

Pricing Information

Cutback

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

Medicare-Allowed Amount

If there is no price on file, Medi-Cal adopts the Medicare-allowed amount and a 444 cutback is not reflected on the RAD.

Exceeds Medicare Rate

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

NOTE

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

Brainteaser

A Charpentier claim may be billed for?

1. _____ 2. _____ 3. _____

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

Charpentier Rebill Procedures

Mailing Instructions

All Charpentier rebills must be mailed to the FI at the following address:

Xerox State Healthcare, LLC
P.O. Box 15700
Sacramento, CA 95852-1700

UB-04 Claim Form Submission Instructions

Providers must use the following submission requirements to be considered for supplemental payment under the Charpentier injunction:

- Providers must first bill Medicare and any OHC for which the recipient is entitled.
- The claim must then be billed as a crossover and approved by Medi-Cal.
- After Medi-Cal processes the crossover claim, complete the *UB-04* claim form.
- Obtain an approved *Treatment Authorization Request* (TAR), if required for a Medi-Cal only claim.
- Complete the following *UB-04* claim form fields for Charpentier rebills only:

Box #	Form Fields	Instructions
18 – 28	CONDITION CODES	Select one of the following alpha-numeric characters that corresponds to the phrase entered in Box 80: • For Rates, enter Z2 • For Benefit Limitation, enter Z1 • For Rates and Benefit Limitations, enter Z3
43	DESCRIPTION	• If multiple claim lines were originally processed by Medicare and fewer claim lines are now being rebilled to Medi-Cal, indicate with an asterisk on the MNSIRA the items or services that are being rebilled to Medi-Cal for Charpentier processing. Also indicate the claim line number that corresponds to the asterisk(s). • If a Medi-Cal Healthcare Common Procedure Coding System (HCPCS) Level III code is used, indicate on the MNSIRA (beside the line being rebilled) the Medi-Cal *UB-04* claim form line number that corresponds to the Medicare procedure code.
54	PRIOR PAYMENTS	Enter the sum of previous payments from Medicare, any other health insurance carriers and Medi-Cal (crossover claim payment).
80	REMARKS	Select one of the following phrases, as previously defined: • For rates, enter Medi/Medi Charpentier: Rates. • For benefit limitation, enter: Medi/Medi Charpentier: Benefit Limitation. • For both rates and benefit limitation, enter: Medi/Medi Charpentier: Both Rates and Benefit Limitation.

NOTE
Complete the claim using the HCPCS code(s) that most closely reflects the items or services rendered, and that most closely equates to the Medicare code originally billed to Medicare and to the code shown on the MNSIRA.

CMS-1500 Claim Form Submission Instructions

Providers must use the following submission requirements to be considered for supplemental payment under the Charpentier injunction:

- Providers must first bill Medicare and any OHC for which the recipient is entitled.
- The claim must then be billed as a crossover and approved by Medi-Cal.
- After Medi-Cal processes the crossover claim, complete a *CMS-1500* claim form.
- Obtain an approved *Treatment Authorization Request* (TAR), if required for a Medi-Cal only claim.
- Complete the following *CMS-1500* claim form fields for Charpentier rebills only:

Box #	Instructions
11D	Enter the sum of previous payments from Medicare, Medi-Cal (crossover claim payment) and any OHC.
19	Select one of the following phrases: • For rates, enter Medi/Medi Charpentier: Rates. • For benefit Limitation, enter: Medi/Medi Charpentier: Benefit Limitation. • For both rates and benefit limitations, enter: Medi/Medi Charpentier: Both Rates and Benefit Limitation.
22	Select one of the following letters that corresponds to the phrase entered in Box 19: • For rates, enter the letter R. • For benefit limitation, enter the letter L. • For rates and benefit limitations, enter the letter T.

Surgical Modifiers

Introduction

Purpose

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

Module Objectives

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

Resource Information

Medi-Cal Subscription Service (MCSS)

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

References

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

Provider Manual References

Part 2

Anesthesia (anest)
CMS-1500 Special Billing Instructions (cms spec)
Modifiers: Approved List (modif app)
Modifiers Used With Procedure Codes (modif used)
Non-Physician Medical Practitioners (NMP) (non ph)
Radiology (radi)
Radiology: Diagnostic (radi dia)
Supplies and Drugs (supp drug)
Surgery (surg)
Surgery Billing Examples: CMS 1500 (surg bil cms)
Surgery Billing Examples: UB-04 (surg bil ub)
Surgery: Billing with Modifiers (surg bil mod)
UB-04 Special Billing Instructions for Inpatient Services (ub spec ip)
UB-04 Special Billing Instructions for Outpatient Services (ub spec op)

Acronyms

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

NOTES

Description

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

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

Anesthesia Drugs & Supplies: UA, UB
Evaluation and Management: 24, 25
General Use: 22, 26, 52, 54, 55, 62, 66, 78, 79, 99
Non-physician Medical Practitioner: U7, SA, SB
Radiology: 26, TC

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

Surgical Modifier Policies

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

Surgical Procedures Codes and Modifiers

Inappropriate Modifier Use

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

Claim Form Placement

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

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10	11	16				21		Procedure code	XX					NPI	
														NPI	

Sample: Partial *CMS-1500* Claim Form

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
	DESCRIPTION	Procedure Code XX	101116		

Sample: Partial *UB-04* Claim Form

Billing Modifiers for Surgical Procedures

Primary Surgeon Modifiers

Codes

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

Modifier Description

Primary Surgeon (Modifier AG)

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

NOTE

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

Multiple Primary Surgeons (Modifier AG)

Two or more surgeons may use modifier AG for the same patient on the same date of service, if the procedures are performed independently and in a different anatomical area or compartment. All claims must include:

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

Multiple Surgical Procedure Exceptions

The following medical policies have been established for specific, multiple surgeries and are not reimbursable when billed for a recipient, by the same provider, for the same date of service.

- Tubal ligations performed at the time of a cesarean section or other intra-abdominal surgery are reimbursable only when billed with CPT-4 code 58611. For more information, refer to the *Hysterectomy* (hyst) and *Sterilization* (ster) sections in the appropriate Part 2 manuals.
- A salpingectomy or oophorectomy (CPT-4 codes 58700, 58720, 58900 – 58943) billed on the same date of service as a hysterectomy (CPT-4 codes 58150 – 58285) is not separately reimbursable.
- A vaginal delivery (CPT-4 codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT-4 codes 59510, 59514, 59618 or 59620) is not reimbursable unless the claim indicates a multiple pregnancy – one child delivered vaginally, and one by cesarean section.
- Intra-ocular lens with cataract surgery policy is located in the *Surgery: Eye and Ocular Adnexa* (surg eye) section of the appropriate Part 2 provider manual.
- Insertion of bladder catheter (CPT-4 codes 51701 and 51702) is not separately reimbursable when billed with CPT-4 codes 10021 – 69979.
- CPT-4 code 36000 (introduction of needle or intracatheter, vein) is not reimbursable when billed by same provider for the same recipient on the same date of service with any CPT-4 code within the ranges of 0100 – 69999 and 96360 – 96549.

National Correct Coding Initiative (NCCI)

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

Bilateral Procedures (Modifier 50)

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

NOTE

Check CPT-4 code for procedure descriptor.

Claim Form Examples Using Modifier 50

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

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. D1D1D1D B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	11	16				21		28290	AG		16171	1		NPI	
2	10	11	16				21		28290	50		16171	1		NPI	
3															NPI	
4															NPI	

OR SUPPLIER INFORMATION

Sample: Partial *CMS-1500* Claim Form

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		BUNIONECTOMY, RT FOOT	28290AG	101116	1	16171		
2		BUNIONECTOMY, LF FOOT	2829050	101116	1	16171		
3								
4								
5								
6								
7								

Sample: Partial *UB-04* Claim Form

66 DX: D1D1D1D
0

68

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

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

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

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

81CC a. b. c. d.

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

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

Multiple Bilateral Procedures

When billing for multiple bilateral procedures performed by the same physician at the same operative session, providers must use modifiers AG, 50, 51 and 99.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
LINES 4 AND 6: MODIFIERS 50 + 51. SEE ATTACHMENT.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. D1D1D1D B. D2D2D2D C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	11	16				21		68720	AG		16171	1		NPI	
2	10	11	16				21		68720	50		16171	1		NPI	
3	10	11	16				21		31200	51		12128	1		NPI	
4	10	11	16				21		31200	99		12128	1		NPI	
5	10	11	16				21		30130	51		10000	1		NPI	
6	10	11	16				21		30130	99		10000	1		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Sample: Partial *CMS-1500* Claim Form

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		DACRYOCYSTORHINOSTOMY	68720AG	101116	1	16171		
2		DACRYOCYSTORHINOSTOMY	6872050	101116	1	16171		
3		ETHMOIDECTOMY	3120051	101116	1	12128		
4		ETHMOIDECTOMY	3120099	101116	1	12128		
5		EXCISION TURBUNATE	3012051	101116	1	10000		
6		EXCISION TURBUNATE	3013099	101116	1	10000		
7								

Sample: Partial *UB-04* Claim Form

66 DX D1D1D1D D2D2D2D B C D E F G H 68
0 I J K L M N O P Q

69 ADMIT DX 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI a b c 73

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

80 REMARKS
LINES 4 AND 6: MODIFIER
99=50+51. SEE ATTACHMENT.

81CC a b c d

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

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

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

Multiple Procedures (Modifier 51)

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

Reimbursement Rule:

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

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

Modifier 51 Versus Modifier 99

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

Assistant Surgeon Modifiers

Codes

Modifier	Description
80	Assistant Surgeon
99	Multiple Modifiers

Modifier Descriptions

Assistant Surgeon (Modifier 80)

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

NOTE

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

Multiple Modifiers (Modifier 99)

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
LINE 2 AND 3: 99=80+51

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. D1D1D1D B. D2D2D2D C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	11	16				21		XXXXX	80		129000	6		NPI	
2	02	11	16				21		XXXXX	99					NPI	
3	02	11	16				21		XXXXX	99					NPI	
4															NPI	

OR SUPPLIER INFORMATION

Sample: Partial *CMS-1500* Claim Form

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		DESCRIPTION	XXXXX80	021116	1			
2		DESCRIPTION	XXXXX99	021116	1			
3		DESCRIPTION	XXXXX99	021116	1			
4								
5								
6								
7								

Sample: Partial *UB-04* Claim Form

66 DX D1D1D1D D2D2D2D B C D E F G H 68
0 I J K L M N O P Q

69 ADMIT DX 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE DATE a. OTHER PROCEDURE CODE DATE b. OTHER PROCEDURE CODE DATE 75

c. OTHER PROCEDURE CODE DATE d. OTHER PROCEDURE CODE DATE e. OTHER PROCEDURE CODE DATE

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

80 REMARKS
LINES 2 AND 3: 99=80+51.

81CC a b c d

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

Sample: Partial *UB-04* Claim Form

Add-On Codes

Codes with “each additional” in the descriptor should not be billed with modifier 99 when performed on the same day or at the same operative session as another surgery. If billing multiple codes that have “each additional” in the descriptor use the *Days or Units* field (Box 24G) on the *CMS-1500* claim form or *Serv. Units* field (Box 46) on the *UB-04* claim form.

CMS-1500 Form

Current Billing Method

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

PHYSICIAN OR SUPPLIER INFORMATION

Preferred Billing Method

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

PHYSICIAN OR SUPPLIER INFORMATION

UB-04 Form

Current Billing Method

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

Preferred Billing Method

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

Other Surgical Modifiers

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

NOTE

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

Complex Operative Procedure Modifiers

Codes

Modifier	Description
22	Increased Procedural Services

Modifier Descriptions

Increased Procedural Services (Modifier 22)

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

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

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

NOTES

Additional Surgeon(s) Modifiers

Codes

Modifier	Description
62	Two Surgeons
66	Surgical Team

Modifier Descriptions

Two Surgeons (Modifier 62)

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

NOTE

Each surgeon would bill with modifier 62.

Surgical Team (Modifier 66)

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

NOTE

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

Operative/Postoperative Modifiers

Codes

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

Modifier Descriptions

Reduced Services (Modifier 52)

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

Operative Postoperative Management (Modifier 54)

Surgical care only

Operative Postoperative Management (Modifier 55)

Post-operative management only

Staged or Related Procedure Postoperative Period (Modifier 58)

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

Additional Operative Procedure Modifiers

Codes

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

Modifier Descriptions

Return to Operating Room (Modifier 78)

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

Return to Operating Room (Modifier 79)

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

Use of Discontinued Procedure Modifiers

Codes

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

NOTE

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

Brainteasers:

1. A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 10, 2016. The cone biopsy was performed on January 17, 2016. What modifier should be used for the cone biopsy? _____
2. An exploratory laparotomy was performed due to a gunshot wound. A few hours later the patient’s blood pressure drops, and the patient is urgently taken back to the operating room to reopen and explore for possible leakage from the surgical site. What modifier should be used for the reopen/explorative procedure? _____

Answer Key: 1) 79; 2) 78

Evaluation and Management (E&M) Modifiers

E&M Examinations

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

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

Postoperative

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

Code Exceptions

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

NOTE

Modifiers 24 and 25 require documentation.

NOTES

Non-Physician Medical Practitioner (NMP)

Non-Physician Medical Practitioners (NMPs) include:

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

Codes

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

Billing Information

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

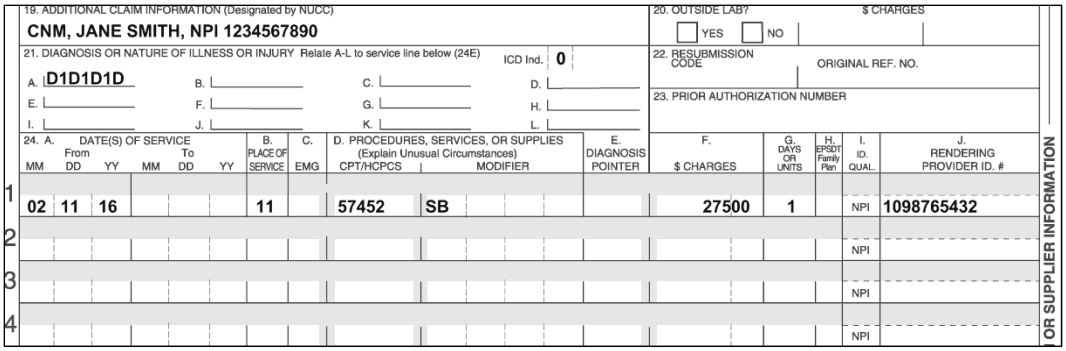
The following items need to be included on claim forms for reimbursement:

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

NOTE

Surgical codes that are reimbursable for NMP services can be found in the *Non-Physician Medical Practitioners* (NMP) section (non ph) of the Part 2 provider manual. Separate reimbursement is not made for physician supervision of an NMP.

NMP Services Claim Examples



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

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. D1D1D1D B. C. D.
E. F. G. H.
I. J. K. L.

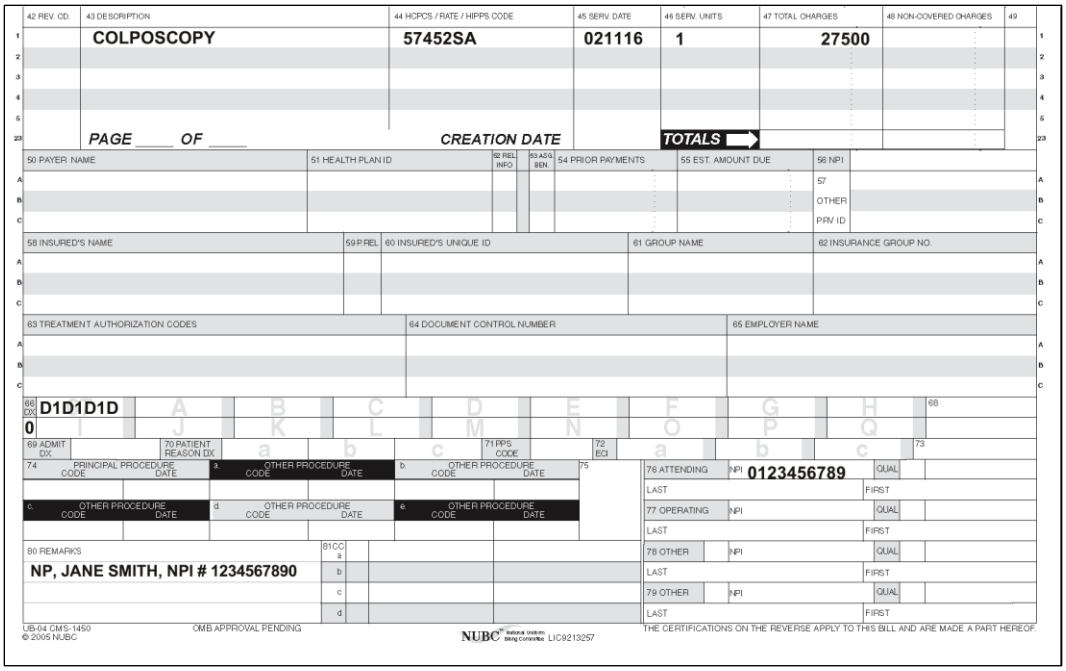
22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	11	16				11		57452	SB		27500	1		NPI	1098765432
2															NPI	
3															NPI	
4															NPI	

I OR SUPPLIER INFORMATION

Sample: Partial *CMS-1500* Claim Form



Sample: Partial *UB-04* Claim Form

Anesthesia Related Drugs and Supplies Modifiers

Codes

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

Billing Reminders

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

HIPPA Code Conversion for Local Modifier ZS

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

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

Claim Completion

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

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

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

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

Attachments – By Report

Attachment Requirements

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

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

Documentation Requirements

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

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

Learning Activities

Modifier Review

1. An assistant surgeon was involved in performing the procedure. What modifier should be used to bill for the assistant's services?
   a. 99
   b. 80
   c. U7
2. Surgical procedures that require two surgeons who perform on distinct anatomical regions on the same recipient, same date of service, may each bill with modifier AG on separate claims.
   a. True ☐
   b. False ☐
3. Procedures billed with modifier 51 are reimbursed at what percentage of the Medi-Cal maximum allowable?
   a. 50%
   b. 100%
   c. Both
4. Is it possible to bill with more than one primary surgical procedure with modifier AG on the same date of service?
   a. Yes
   b. No
5. What modifier do I use if both the professional and technical components were performed after August 1, 2015?
   a. 26
   b. ZS
   c. TC
   d. None
6 For dates of service on or after October 1, 2015, providers should use the letter "O" to document the ICD indicator?
   a. True ☐
   b. False ☐

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

Acronyms

ADHC	Adult Day Health Care
AEVS	Automated Eligibility Verification System
ALLOW	Allowed
AMT	Amount
A/R	Accounts Receivable
BIC	Benefits Identification Card
CCN	Claim Control Number
CCS	California Children's Services
CIF	Claims Inquiry Form
CIN	Client Index Number
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
COBC	Coordination of Benefits Contractor
CPT-4	Current Procedural Terminology, 4th Edition
CWF	Common Working File
DHCS	Department of Health Care Services
DMAC	Durable Medical Equipment Medicare Administrative Contractor
DOB	Date of Birth
DOS	Date of Service
EAPC	Expanded Access to Primary Care
E&M	Evaluation and Management
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ERA	Electronic Remittance Advice
EVC	Eligibility Verification Confirmation
EWC	Every Woman Counts
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
GHI	Group Health Incorporated
GHPP	Genetically Handicapped Persons Program

HCP	Health Care Plan
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIC	Health Insurance Claim
HMO	Health Maintenance Organization
ICD	International Classification of Diseases
ID	Identification
IP	Inpatient Services
IRCA	Immigration Reform and Control Act
LSRS	Laboratory Services Reservation System (LSRS)
LTC	Long Term Care
MAC	Medicare Administrative Contractor
MAPD	Medicare Advantage Prescription Drug
MNSIRA	Medicare National Standard Intermediary Remittance Advice
MREP	Medicare Remit Easy Print Software
MRN	Medicare Remittance Notice
MSA	Medi-Cal Savings Account
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
NDC	National Drug Code
NF	Nursing Facility
NMP	Non-Physician Medical Practitioner
NP	Nurse Practitioner
NPI	National Provider Identifier
OB	Obstetrics
OBRA	Federal Omnibus Budget Reconciliation Act
OHC	Other Health Coverage
OP	Outpatient Services
PA	Physician Assistant
PACT	Planning, Access, Care and Treatment
PDP	Prescription Drug Plan
PFFS	Private Fee-For-Service
POE	Proof of Eligibility
POS	Point of Service
PPO	Preferred Provider Organization
QMB	Qualified Medicare Beneficiary

RA	Remittance Advice
RAD	Remittance Advice Details
REIMB	Reimbursable
RTD	Resubmission Turnaround Document
SNP	Special Needs Plan
SOC	Share of Cost
SSA	Social Security Administration
SSN	Social Security Number
TAR	Treatment Authorization Request
TCN	TAR Control Number
UPN	Universal Product Number