Allied Health & Medical Services

Medi-Cal Provider Training 2017

Redding Vacaville Eureka Paradise Chico Citrus Heights Thousand Oaks San Francisco Seaide Ventura Carmel Bishop Tahoe City Bieber Eagleville

Sacramento Solvang Santa Barbara Fort Bragg Mendocino Marin Lone Folsom Elk Grove

San Luis Obispo Huntington Beach Victorville Weed Barstow Baker Adin Salinas Simi Valley San Andreas

Visalia Escondido Orange Torrance Hemet Garden Grove

Ontario Mojave Indio Lancaster

Pasadena Santa Ana Long Beach San Clemente Julian Chula Vista Alpine San Marcos San Diego

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

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

**Free Services for Providers**

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

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

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

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

## Allied Health Common Denials
- **Introduction** ................................................................. 1  
- **Claim Denial Description** ............................................. 3  
- **Denied Claim Follow-Up Options** ................................. 4  
- **CIF Submission Exceptions** .......................................... 5  
- **Denied Claim Follow-Up Procedures** ............................ 6  
- **Common Billing Errors** ................................................. 16  
- **Learning Activities** ....................................................... 19  

## Crossover Claims
- **Introduction** ................................................................. 1  
- **Crossover Claim Description** ........................................ 3  
- **Medicare Health Care Benefits** ..................................... 4  
- **Medicare/Medi-Cal Crossover Claim Policies** ................. 6  
- **Medicare/Medi-Cal Crossover Claim Billing** ..................... 8  
- **Crossover Claim Submission** ......................................... 13  
- **Crossover Claim Follow-Up** .......................................... 26  
- **Crossover Pricing Examples** ......................................... 27  
- **Charpentier Claims** ....................................................... 32  

## Surgical Modifiers
- **Introduction** ................................................................. 1  
- **Description** ................................................................. 3  
- **Surgical Modifier Policies** ............................................. 3  
- **Surgical Procedures with Modifiers** ............................... 4  
- **Other Surgical Modifiers** .............................................. 12  
- **By Report Documentation** ............................................. 20  
- **Common Denials** ......................................................... 21  
- **Learning Activity** .......................................................... 22  

## Appendix
- **Acronyms** ................................................................. 1
Allied Health Common Denials

Introduction

Purpose

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

Module Objectives

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

Resource Information

Medi-Cal Subscription Service (MCSS)

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

Provider Manual References

Part 1
- Aid Codes Master Chart (aid codes)
- Appeal Process Overview (appeal)
- CIF Overview (cif)
- Eligibility: Recipient Identification (elig rec)
- Eligibility: Recipient Identification Cards (elig rec crd)
- Remittance Advice Details (RAD) Codes and Messages: 001 – 099 (remit cd001)
- Remittance Advice Details (RAD) Codes and Messages: 300 – 399 (remit cd300)
- Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999 (remit cd9000)

Part 2
- Appeal Form Completion (appeal form)
- CIF Completion (cif co)
- CMS-1500: Completion (cms comp)
- CMS-1500: Tips for Billing (cms tips)

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

NOTES
Claim Denial Description

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

Free-Form Denial Codes

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

### 10 Most Common Denial Messages

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

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

NOTES

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

January 2016
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.

<table>
<thead>
<tr>
<th>RAD Code</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0002</td>
<td>The recipient is not eligible for benefits under the Medi-Cal program or other special programs.</td>
</tr>
<tr>
<td>0010</td>
<td>This service is a duplicate of a previously paid claim.</td>
</tr>
<tr>
<td>0072</td>
<td>This service is included in another procedure code billed on the same date of service.</td>
</tr>
<tr>
<td>0095</td>
<td>This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.</td>
</tr>
<tr>
<td>0314</td>
<td>Recipient not eligible for the month of service billed.</td>
</tr>
<tr>
<td>0326</td>
<td>Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.</td>
</tr>
<tr>
<td>0525</td>
<td>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.</td>
</tr>
<tr>
<td>9940</td>
<td>NCCI (National Correct Coding Initiative) claim line is billed with multiple NCCI modifiers.</td>
</tr>
<tr>
<td>9941</td>
<td>NCCI (National Correct Coding Initiative) column 2 procedure code is not allowed when column 1 procedure has been paid.</td>
</tr>
<tr>
<td>9942</td>
<td>NCCI (National Correct Coding Initiative) quantity billed is greater than the allowed MUE (Medically Unlikely Edit) quantity.</td>
</tr>
</tbody>
</table>
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
Verify the:
- Provider number
- Recipient number
- “From-Thru” date of service
- Procedure code
- Modifier
- Rendering provider number

NOTES

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

January 2015
Denial Code #2

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.

NOTES

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

January 2014
Denial Code #3

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 or rebill the claim.

Billing tips
- Verify that the recipient has a SOC (Share of Cost) and is eligible for the month of service.
- Verify date of service on the claim is correct.
Denial Code #4

Denied Claim Message

<table>
<thead>
<tr>
<th>RAD CODE: 0369</th>
<th>Medical transportation requires Emergency Statement or TAR (Treatment Authorization Request).</th>
</tr>
</thead>
</table>

Follow-Up Procedure

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

Billing Tips

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

NOTES

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Denial Code #5

Denied Claim Message

| RAD CODE: 0031 | The provider was not eligible for the services billed on the date of service. |

Follow-Up Procedure

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

Billing Tips

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

NOTES
Denial Code #6

Denied Claim Message

| RAD CODE: 0376 | Billed procedure code does not match TAR procedure code. New claim and/or TAR is required. |

Follow-Up Procedure

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

Billing Tips

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

NOTE

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

NOTES
Denial Code #7

Denied Claim Message

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

Follow-Up Procedure

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

Billing Tips

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

NOTES

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
Denial Code #8

Denied Claim Message

| RAD CODE: 0036 | RTD (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 submit a Claims Inquiry Form (CIF) within six months.

Billing Tips

- RTDs automatically deny when 45 days old.

NOTES

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Denial Code #9

Denied Claim Message

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

Follow-Up Procedure

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

Billing Tips

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

NOTE

Refer to the Eligibility: Recipient Identification Cards section of the appropriate Part 1 provider manual.
Denial Code #10

Denied Claim Message

| RAD CODE: 0006 | The date(s) of service reported on the claim is not within the TAR (Treatment Authorization Request) authorized period. |

Follow-Up Procedure

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

Billing Tips

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

NOTES

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

January 2015
## Common Billing Errors

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

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

Answer Key: TAR

January 2016
<table>
<thead>
<tr>
<th>Box #</th>
<th>Field Name</th>
<th>Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>24B</td>
<td>PLACE OF SERVICE</td>
<td>Entering the wrong Place of Service two-digit code</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Billing Tip 1:</strong> Check instructions in the <em>CMS-1500 Completion (cms comp)</em> section of the appropriate Part 2 provider manual for the correct two-digit code. Enter a Medi-Cal local Place of Service code instead of a national Place of Service code.</td>
</tr>
</tbody>
</table>
| 24C  | EMG (OR DELAY REASON)      | **Delay Reason Code:** If there is no emergency indicator in the **EMG** field (Box 24C), and only a delay reason code is placed in this box. Enter the code in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the shaded, top portion of this box. Include the required documentation. Only one delay reason code is allowed per claim. If more than one code is present, the first occurrence is applied to the entire claim. Refer to the *CMS-1500: Submission and Timeliness Instructions (cms sub)* section in the appropriate Part 2 provider manual. **Emergency Code:** Enter an "X" when billing for emergency services. Claims without an "X" in this field may be reduced or denied. Only one emergency indicator is allowed per claim. The emergency indicator must be placed in the unshaded, bottom portion of the **EMG** field (Box 24C). An Emergency Certification Statement is required for all OBRA/IRCA recipients and for any service rendered under emergency conditions that would otherwise have required authorization, including: emergency services by allergists, podiatrists, medical transportation providers, portable imaging providers, psychiatrists and out-of-state providers. For emergencies in which emergency medical transportation was provided, providers must include an emergency statement. The statement must include:  
  - The name of the person or agency that requested the service  
  - The nature of the emergency  
  - The name of the hospital to which a recipient was transported  
  - Clinical information on a recipient’s condition  
  - The reason the services were considered to be immediately necessary (medical necessity)  
  - The name of the physician accepting responsibility for the recipient  
  
A mere statement that an emergency existed is not sufficient. |
<table>
<thead>
<tr>
<th>Box #</th>
<th>Field Name</th>
<th>Error</th>
<th>Billing Tip</th>
</tr>
</thead>
<tbody>
<tr>
<td>24D</td>
<td>PROCEDURES, SERVICES OR SUPPLIES</td>
<td>Omitting modifiers or entering incorrect information when required</td>
<td>Do not use Medicare modifiers. Enter procedure description, if necessary, in the Additional Claim Information field (Box 19).</td>
</tr>
<tr>
<td>31</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER</td>
<td>Submitting unsigned claims or claims with illegible signatures. Using initials or stamped signatures or signature extending outside the box.</td>
<td>Signatures must be written, not printed, in blue or black ink. Do not allow signature to extend outside the box. Stamps, initials or facsimiles are not acceptable.</td>
</tr>
<tr>
<td>32</td>
<td>SERVICE FACILITY LOCATION INFORMATION</td>
<td>Entering the wrong facility ID number for the POS entered in field 24B. Omitting the facility ID number when a facility-related Place of Service code is entered in field 24B.</td>
<td>Enter the facility ID number/NPI in field A or B.</td>
</tr>
<tr>
<td>33</td>
<td>PHYSICIAN, SUPPLIER INFO &amp; PH #</td>
<td>Entering the wrong nine-digit ZIP code according to the 10-digit NPI on file</td>
<td>The nine-digit ZIP code entered in this box must match the biller’s ZIP code on file for claims to be reimbursed correctly.</td>
</tr>
</tbody>
</table>

NOTES

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

January 2015
Learning Activities

Learning Activity 1: Matching Terms Puzzle

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

1. _____ BIC
2. _____ CIN
3. _____ EOB
4. _____ HCP
5. _____ NPI
6. _____ POE
7. _____ RAD
8. _____ RTD
9. _____ Spend Down
10. _____ Authorization Request
11. _____ TCN
12. _____ DHCS

A) Client Index Number
B) Resubmission Turnaround Document
C) Health Care Plan
D) Share of Cost
E) ID card
F) Provider Number
G) Proof of Eligibility
H) TAR Control Number
I) Remittance Advice Details
J) Explanation of Benefits
K) TAR or SAR
L) Department of Health Care Services


January 2015
Learning Activity 2: Word Scramble

Unscramble the following words:

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

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

Introduction

Purpose

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

Module Objectives

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

Resource Information

Medi-Cal Subscription Service (MCSS)

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

Provider Manual References

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

Part 2
CMS-1500 Completion (cms comp)
Medicare/Medi-Cal Crossover Claims: CMS-1500 (medi cr cms)
Medicare/Medi-Cal Crossover Claims: CMS-1500 Billing Examples for Allied Health
(medi cr cms exa)
Medicare/Medi-Cal Crossover Claims: CMS-1500 Billing Examples for Medical Services
(medi cr cms exm)
Medicare/Medi-Cal Crossover Claims: CMS-1500 Pricing Examples for Medical Services
(medi cr cms prm)
Medicare/Medi-Cal Crossover Claims: Inpatient Services (medi cr ip)
Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples (medi cr ip ex)
Medicare/Medi-Cal Crossover Claims: Outpatient Services (medi cr op)
Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples
(medi cr op ex)
Medicare/Medi-Cal Crossover Claims: Outpatient Services Medi-Cal Pricing Examples
(medi cr op pr)
Medicare/Medi-Cal Crossover Claims: UB-04 (medi cr ub)
Medicare Non-Covered Services: Charts Introduction (medi non cha)
Medicare Non-Covered Services: CPT-4 Codes (medi non cpt)
Medicare Non-Covered Services: HCPCS Codes (medi non hcp)
UB-04 Completion: Inpatient Services (ub comp ip)
UB-04 Completion: Outpatient Services (ub comp op)

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

NOTES

January 2017
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.

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

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

**Part A – Inpatient Services**

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

**NOTE**

If a recipient does not have Part A coverage, the Medicare Part A contractor will pay for the services otherwise covered by Part B from funds held in trust for this purpose.

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

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

Part C – Medicare Advantage Plans

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

Part D – Prescription Drugs

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

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

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

Medical Supplies

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

Braille teaser

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

Answer Key: 1) Inpatient; 2) Outpatient, professional
Medicare/Medi-Cal Crossover Claim Policies

Recipient Coverage

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

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Medicare Coverage Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>Subscriber has Part A Medicare coverage with Health Insurance Claim number (HIC) __________. Medicare-covered services must be billed to Medicare before Medi-Cal.</td>
</tr>
<tr>
<td>Part B</td>
<td>Subscriber has Part B Medicare coverage with HIC Number __________. Medicare-covered services must be billed to Medicare before Medi-Cal.</td>
</tr>
<tr>
<td>Parts A and B</td>
<td>Subscriber has Parts A and Part B Medicare coverage with HIC Number __________. Medicare-covered services must be billed to Medicare before Medi-Cal.</td>
</tr>
<tr>
<td>Parts A and D</td>
<td>Subscriber has Parts A and D Medicare coverage with HIC Number __________. Medicare Part A-covered services must be billed to Medicare before billing Medi-Cal.</td>
</tr>
<tr>
<td>Parts B and D</td>
<td>Subscriber has Parts B and D Medicare coverage with HIC Number __________. Medicare Part B-covered services must be billed to Medicare before billing Medi-Cal.</td>
</tr>
<tr>
<td>Parts A, B, and D</td>
<td>Subscriber has Parts A, B and D Medicare coverage with HIC number __________. Medicare Part A and Part B-covered services must be billed to Medicare before billing Medi-Cal.</td>
</tr>
<tr>
<td>Part D</td>
<td>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.</td>
</tr>
</tbody>
</table>

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

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

MEDI-CAL ELIGIBILITY LIMITED TO MEDICARE COINSURANCE, DEDUCTIBLES. PART A, B MEDICARE COVERAGE WITH HIC #________. BILL MEDICARE BEFORE MEDI-CAL.
As with other crossover claims, Medi-Cal pays coinsurance and/or deductibles for both Medicare Part A and Part B services on crossover claims for aid code 80 only QMBs. Medi-Cal payment, combined with the Medicare payment, will not exceed the lower of either the Medicare or Medi-Cal allowed amount. Straight Medi-Cal claims submitted for Medicare denied and non-covered services for aid code 80 only QMBs will be denied.

**Medi-Cal Crossover Claim Reimbursement**

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

**Zero Pay Crossovers**

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

**Brinteaser**

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

1. ________________________________
2. ________________________________

**Answer Key:** 1) Claim is unassigned; 2) Medicare denied 100% of the claim
Non-Crossover Claim Procedures

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

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

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

**Medicare Non-Covered Service**

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

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

**NOTE**

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

**Medicare Denied Service**

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

**Medicare Exhausted Service**

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

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

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

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

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

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

Other Health Coverage – HMO

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

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

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

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

Mailing Instructions

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

<table>
<thead>
<tr>
<th>Inpatient Only</th>
<th>All Other Provider Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduent</td>
<td>Conduent</td>
</tr>
<tr>
<td>P.O. Box 15500</td>
<td>P.O. Box 15700</td>
</tr>
<tr>
<td>Sacramento, CA 95852-1500</td>
<td>Sacramento, CA 95852-1700</td>
</tr>
</tbody>
</table>

Hard Copy Submission Requirements

Inpatient Services

Part A Services Billed to Part A Contractor

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

Follow these instructions to bill for services rendered:

<table>
<thead>
<tr>
<th>Box #</th>
<th>Form Fields</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>TYPE OF BILL</td>
<td>First two digits must be 11 or 18 and values must match the Medicare RA. If first two digits are 12, bill as straight Medi-Cal with other health coverage.</td>
</tr>
<tr>
<td>6</td>
<td>FROM-THROUGH DATES OF SERVICE</td>
<td>From-through dates of service must match the Medicare RA.</td>
</tr>
<tr>
<td>8b</td>
<td>PATIENT NAME</td>
<td>Patient name must match the Medicare RA.</td>
</tr>
<tr>
<td>31</td>
<td>OCCURRENCE CODES &amp; DATES</td>
<td>List the date of the MNSIRA (MMDDYY) with code 50.</td>
</tr>
<tr>
<td>Box #</td>
<td>Form Fields</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
</tbody>
</table>
| 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**  
\[
\text{SUM (Blood deductible + Medicare deductible + Medicare coinsurance)} - \text{SUM (SOC, OHC, Medicare supplemental insurance payments)} = \text{Amount Due}
\]
Example: Inpatient UB-04 Crossover Claim Form
Attach a copy of the MNSIRA showing the Part A payment. The single claim detail level MNSIRA printed with Medicare’s free PCPrint software is required for outpatient claims. For providers who receive an electronic RA, this version is preferred and may also be required in the future for inpatient claims.

### Simplified Medicare RA With Part A Payment

#### Outpatient and Professional Services

**Part B Services Billed to Part A Contractor**

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

<table>
<thead>
<tr>
<th>Box #</th>
<th>Field Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>TYPE OF BILL</td>
<td>First two digits will be 13, 14, 72, 74, 75, 76, or 85 and values must match the <em>Medicare National Standard Intermediary Remittance Advice</em> (MNSIRA).</td>
</tr>
<tr>
<td>8B</td>
<td>PATIENT NAME</td>
<td>Patient name must match the MNSIRA.</td>
</tr>
<tr>
<td>31</td>
<td>OCCURRENCE CODES &amp; DATES</td>
<td>Enter code 50 and the date (MMDDYY) of the MNSIRA.</td>
</tr>
<tr>
<td>39 – 41</td>
<td>VALUE CODES AND AMOUNTS</td>
<td>Enter code 23 and the patient’s SOC for the claim. Leave blank, if not applicable.</td>
</tr>
<tr>
<td>A – D</td>
<td></td>
<td>• Enter code 06 and the blood deductible amount.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enter code 38 and the number of pints of blood.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enter code A1 and the Medicare deductible amount if Medicare is the primary payer. Enter code B1 if Medicare is a secondary payer. Leave blank, if not applicable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enter code A2 and the Medicare coinsurance amount if Medicare is the primary payer. Enter code B2 if Medicare is a secondary payer. Leave blank, if not applicable.</td>
</tr>
<tr>
<td>42</td>
<td>REVENUE CODE</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The Revenue Code must display “001” in column 42, line 23.</td>
</tr>
<tr>
<td>43</td>
<td>DESCRIPTION</td>
<td>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.</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/RATE</td>
<td>Enter the same procedure codes billed to Medicare.</td>
</tr>
<tr>
<td>45</td>
<td>SERVICE DATE</td>
<td>Enter the actual date of service on each detail line.</td>
</tr>
<tr>
<td>47</td>
<td>TOTAL CHARGES</td>
<td>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.</td>
</tr>
<tr>
<td>Box #</td>
<td>Field Name</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>50</td>
<td>PAYER NAME</td>
<td>Payers must be listed in the following order of payment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• OHC, if applicable, except Medicare supplemental insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare supplemental insurance (if applicable)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medi-Cal Outpatient Services</td>
</tr>
<tr>
<td>51</td>
<td>HEALTH PLAN ID</td>
<td>Enter the Medicare contractor ID.</td>
</tr>
<tr>
<td>54 A–C</td>
<td>PRIOR PAYMENTS</td>
<td>Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NOTE</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Medicare payment amount must match the MNSIRA ALLOW/REIM amount not the NET REIMB AMT.</td>
</tr>
<tr>
<td>55</td>
<td>ESTIMATED AMOUNT DUE</td>
<td>• On the corresponding Medicare line, enter the total charges from Box 47, line 23.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• On the corresponding Medi-Cal line, enter the difference of: Blood deductible + Medicare deductible + Medicare coinsurance amounts less SOC, OHC and Medicare supplemental insurance payments.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Submit an original <em>UB-04</em> claim form using the provider NPI in effect appropriate for the date of service on the claim</td>
</tr>
<tr>
<td>76, 77, 78, 79</td>
<td>ATTENDING, OPERATING, &amp; OTHER</td>
<td>Enter appropriate provider NPI.</td>
</tr>
</tbody>
</table>
Crossover Claims

Example: Outpatient UB-04 Crossover Claim
 Include a complete, unaltered and legible copy of the corresponding MNSIRA for each crossover claim.

![Medicare National Standard Intermediary Remittance Advice](image)

**Example: Medicare Remittance Advice Details Form**

**NOTE**

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

Part B Services Billed to Part B Carriers

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

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

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

NOTES

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

January 2017
## CMS-1500 claim form fields for crossovers only:

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

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

Reminders:

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

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

NOTES

__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

January 2014
Crossover Claim Follow-Up

Tracing Claims

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

Claims Inquiry Form (CIF)

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

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

Crossover CIF Billing Tips

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

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

NOTE

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

This section has examples of Medicare/Medi-Cal claims for medical and outpatient services billed on the CMS-1500 and UB-04 claim forms as well as corresponding Remittance Advice Details (RAD) code examples.

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

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

Remittance Advice Details

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

NOTES

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

January 2017
The most common RAD codes and messages related to crossover claims are listed in the following table.

<table>
<thead>
<tr>
<th>RAD Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0002</td>
<td>The recipient is not eligible for benefits under the Medi-Cal program or other special programs.</td>
</tr>
<tr>
<td>0371</td>
<td>Line detail crossover submitted incorrectly on Medi-Cal claim; submit only copy of Medicare claim and EOMB (Explanation of Medicare Benefits) to Crossover Unit, P.O. Box 15700, Sacramento, CA 95852-1700.</td>
</tr>
<tr>
<td>0372</td>
<td>This crossover must be billed with line-specific information. Please resubmit with line item information.</td>
</tr>
<tr>
<td>0395</td>
<td>This is a Medicare non-covered benefit. Rebill Medi-Cal on an original claim form except for aid code “80”, QMB (Qualified Medicare Beneficiary Program) recipients.</td>
</tr>
<tr>
<td>0442</td>
<td>Medicare payment meets or exceeds Medi-Cal maximum reimbursement.</td>
</tr>
<tr>
<td>0443</td>
<td>Medi-Cal payment may not exceed the maximum amount allowed by Medi-Cal.</td>
</tr>
<tr>
<td>0444</td>
<td>For non-physician claims, see Charpentier billing instructions in the provider manual. Medi-Cal automated system payment does not exceed the Medicare allowed amount.</td>
</tr>
<tr>
<td>9019</td>
<td>Information on the claim does not match what is being billed.</td>
</tr>
</tbody>
</table>

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

**Brainteaser**

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

*Answer Key:* amount allowed
Payment Examples

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

0395 Medicare Non-Covered Benefit

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

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

Example: RAD code 0395
0442 Cutback (Zero Pay)

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

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

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

Example: Pricing for 0443 Cutback (with deductible)

Example: RAD code 0443

NOTES
Charpentier Claims

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

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

The following definitions apply to Charpentier rebills:

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

Pricing Information

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

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

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

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

Brainteaser
A Charpentier claim may be billed for?
1. __________  2. ________________  3. ________________________________

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

Introduction

Purpose

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

Module Objectives

- Explain the use of modifiers in the Medi-Cal program
- Demonstrate the correct placement of modifiers on the claim forms
- Review surgical procedure modifiers
- Identify pre-operative and post-operative services policy
- Identify modifiers for Non-Physician Medical Practitioners (NMPs)
- Provide general information regarding anesthesia-related drug and supply modifiers
- Explain “By Report” documentation
- Review Common Denials

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)
Correct Coding Initiative: National (correct)
Correct Coding Initiative: National – Claim Preparation (correct cod)
Hysterectomy (hyst)
Modifiers: Approved List (modif app)
Non-Physician Medical Practitioners (NMP) (non ph)
Non-Physician Medical Practitioner (NMP) Billing Example: CMS-1500 (non ph cms)
Non-Physician Medical Practitioner (NMP) Billing Example: UB-04 (non ph ub)
Sterilization (ster)
Supplies and Drugs (supp drug)
Surgery (surg)
Surgery Billing Examples: CMS 1500 (surg bil cms)
Surgery Billing Examples: UB-04 (surg bil ub)
Surgery: Billing with Modifiers (surg bil mod)
UB-04 Special Billing Instructions for Inpatient Services (ub spec ip)
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 integral part of billing for health care services. Modifiers give additional information for claims processing. The following modifiers are discussed in this training module:

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

  | Anesthesia-related 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: AS, SA, SB, U7, U9 |
  | 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:

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

**Primary Surgeon (Modifier AG)**

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

**Modifier AG Exception**

CPT-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.

**Gender Dysphoria**

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

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

June 2017
NOTE
A service or the frequency of services available to a transgender beneficiary cannot be categorically limited. All medically necessary services must be provided timely. Limitations and exclusions, medical necessity determinations and/or appropriate utilization management criteria that are non-discriminatory may be applied.

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

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

Multiple Surgical Procedure Exceptions
The following medical policies have been established for specific, multiple surgeries when billed for a recipient, by the same provider, for the same date of service.

- Tubal ligations performed at the time of a cesarean section or other intra-abdominal surgery are reimbursable only when billed with CPT-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.
- Intraocular lens with cataract surgery policy is located in the Surgery: Eye and Ocular Adnexa (surg eye) section of the appropriate Part 2 provider manual.
- Insertion of a non-indwelling or temporary indwelling bladder catheter (CPT-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 00100 – 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 Correct Coding Initiative: National (correct) section of the Part 2 provider manual.

Bilateral Procedures (Modifier 50)
Modifier 50 is used when bilateral procedures performed add significant time or complexity to patient care at a single operative session.
### Claim Form Examples Using Modifier 50

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Date of Service</th>
<th>Place of Service</th>
<th>Diagnosis Code</th>
<th>Procedure Code</th>
<th>Charges</th>
<th>Date of Service</th>
<th>Place of Service</th>
<th>Diagnosis Code</th>
<th>Procedure Code</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bunionectomy, RT Foot</td>
<td>28290</td>
<td>10/11/16</td>
<td>AG</td>
<td>10-11116</td>
<td>16171</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bunionectomy, LT Foot</td>
<td>282905</td>
<td>10/11/16</td>
<td>AG</td>
<td>10-11116</td>
<td>16171</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Date of Service</th>
<th>Place of Service</th>
<th>Diagnosis Code</th>
<th>Procedure Code</th>
<th>Charges</th>
<th>Date of Service</th>
<th>Place of Service</th>
<th>Diagnosis Code</th>
<th>Procedure Code</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bunionectomy, RT Foot</td>
<td>28290</td>
<td>10/11/16</td>
<td>AG</td>
<td>10-11116</td>
<td>16171</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bunionectomy, LT Foot</td>
<td>282905</td>
<td>10/11/16</td>
<td>AG</td>
<td>10-11116</td>
<td>16171</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

Multiple Procedures (Modifier 51)

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

Sample: Partial CMS-1500 Claim Form
Surgical Modifiers

Sample: *UB-04 Claim Form*
Reimbursement Rule:

<table>
<thead>
<tr>
<th>CPT-4 Code/Modifier</th>
<th>Reimbursement Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>41150 AG</td>
<td>100% of full-fee rate</td>
</tr>
<tr>
<td>38720 51</td>
<td>50% of full-fee rate</td>
</tr>
<tr>
<td>15120 51</td>
<td>50% of full-fee rate</td>
</tr>
<tr>
<td>31600 51</td>
<td>50% of full-fee rate</td>
</tr>
</tbody>
</table>

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

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

**Assistant Surgeon Modifiers and Descriptions**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Assistant Surgeon</td>
</tr>
<tr>
<td>99</td>
<td>Multiple Modifiers</td>
</tr>
</tbody>
</table>

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

**NOTE**
Not all surgical procedures are reimbursable to an assistant surgeon. To determine if there are any policy restrictions, refer to the TAR and Non-Benefit List: Codes (tar and non cd) section in the appropriate Part 2 provider manual.

**Multiple Modifiers (Modifier 99)**
Under certain circumstances two or more modifiers may be necessary to completely define a service.
- Use modifier 99 with the appropriate procedure code.
- Explain modifier 99 in the Remarks field (Box 80) for UB-04 claims and Additional Claim Information field (Box 19) for CMS-1500 claims.
### Sample: Partial CMS-1500 Claim Form

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Code</td>
<td>Short Description</td>
<td>Service Code</td>
<td>Service Description</td>
<td>Units</td>
<td>Amount</td>
<td>Total Charges</td>
<td>Automatically</td>
<td>Claimant</td>
</tr>
<tr>
<td>01/10/15</td>
<td>2829080</td>
<td>BUNIONECTOMY, RT FOOT</td>
<td>100115</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/10/15</td>
<td>2829099</td>
<td>BUNIONECTOMY, LT FOOT</td>
<td>100115</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/10/15</td>
<td>2809999</td>
<td>EXCISION OF LESION</td>
<td>100115</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Sample: Partial UB-04 Claim Form

```
<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Service Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BUNIONECTOMY, RT FOOT</td>
<td>2829080</td>
<td>100115</td>
</tr>
<tr>
<td>2</td>
<td>BUNIONECTOMY, LT FOOT</td>
<td>2829099</td>
<td>100115</td>
</tr>
<tr>
<td>3</td>
<td>EXCISION OF LESION</td>
<td>2809999</td>
<td>100115</td>
</tr>
</tbody>
</table>
```

### Sample: Partial UB-04 Claim Form

```
<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Service Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BUNIONECTOMY, RT FOOT</td>
<td>2829080</td>
<td>100115</td>
</tr>
<tr>
<td>2</td>
<td>BUNIONECTOMY, LT FOOT</td>
<td>2829099</td>
<td>100115</td>
</tr>
<tr>
<td>3</td>
<td>EXCISION OF LESION</td>
<td>2809999</td>
<td>100115</td>
</tr>
</tbody>
</table>
```
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**

<table>
<thead>
<tr>
<th>PL A</th>
<th>PROCEDURE, SERVICES, OR SUPPLIES</th>
<th>DATES OF SERVICE</th>
<th>E</th>
<th>CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15002  AG</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15003  51</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15003  51</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15003  51</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15003  51</td>
</tr>
</tbody>
</table>

**Preferred Billing Method**

<table>
<thead>
<tr>
<th>PL A</th>
<th>PROCEDURE, SERVICES, OR SUPPLIES</th>
<th>DATES OF SERVICE</th>
<th>E</th>
<th>CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15002  AG</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15003  51</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15003  51</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15003  51</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>02 11 16</td>
<td>21</td>
<td>15003  51</td>
</tr>
</tbody>
</table>

** UB-04 Form**

**Current Billing Method**

<table>
<thead>
<tr>
<th>PL A</th>
<th>PROCEDURE, SERVICES, OR SUPPLIES</th>
<th>DATES OF SERVICE</th>
<th>E</th>
<th>CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>15002 AG</td>
<td>021116</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>15003 AG</td>
<td>021116</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>15003 AG</td>
<td>021116</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>15003 AG</td>
<td>021116</td>
<td>1</td>
</tr>
</tbody>
</table>

**Preferred Billing Method**

<table>
<thead>
<tr>
<th>PL A</th>
<th>PROCEDURE, SERVICES, OR SUPPLIES</th>
<th>DATES OF SERVICE</th>
<th>E</th>
<th>CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>15002 AG</td>
<td>021116</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>1500351</td>
<td>021116</td>
<td>3</td>
</tr>
</tbody>
</table>
Other Surgical Modifiers

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

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

Complex Operative Procedure Modifiers and Descriptions

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased Procedural Services</td>
</tr>
</tbody>
</table>

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
- Very low weight
- Inflammation
- Infections

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

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>62</td>
<td>Two Surgeons</td>
</tr>
<tr>
<td>66</td>
<td>Surgical Team</td>
</tr>
</tbody>
</table>

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

NOTE
Each surgeon would bill with modifier 62.

Surgical Team (Modifier 66)
Indicates the services of all physician members of a surgical team. Anesthesiologists must submit a separate claim for services.

NOTE
CPT-4 instructions for modifier 66 permit each physician of a surgical team to bill separately for their services. However, when billing Medi-Cal, the services of all physician members of team must be billed on a single line of the same claim form.
Operative/Postoperative Modifiers and Descriptions

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>Reduced services</td>
</tr>
<tr>
<td>54</td>
<td>Surgical care only</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative Management only</td>
</tr>
<tr>
<td>58</td>
<td>Staged or related procedure by the same physician during the postoperative period</td>
</tr>
</tbody>
</table>

**Reduced Services (Modifier 52)**

**Operative Postoperative Management (Modifier 54)**
Surgical care only

**Operative Postoperative Management (Modifier 55)**
Postoperative management only

**Staged or Related Procedure Postoperative Period (Modifier 58)**
May be used with CPT-4 codes 15002 – 15429 and 52601 to address subsequent part(s) of a staged procedure.
Additional Operative Procedure Modifiers and Descriptions

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78</td>
<td>NCCI-associated Unplanned return to operating/procedure room by the same</td>
</tr>
<tr>
<td></td>
<td>physician following initial procedure for a related procedure during the</td>
</tr>
<tr>
<td></td>
<td>postoperative period</td>
</tr>
<tr>
<td>79</td>
<td>NCCI-associated Unrelated procedure or service by the same physician during</td>
</tr>
<tr>
<td></td>
<td>the postoperative period</td>
</tr>
</tbody>
</table>

Modifier Descriptions

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

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

Discontinued Procedure Modifiers and Descriptions

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

Brainteasers:
1. A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 10, 2017. The cone biopsy was performed on February 17, 2017. 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 Preoperative Visits Before or on the Day of Surgery
Under most circumstances, including ordinary referrals, the preoperative examination by the operating surgeon or assistant surgeon in the emergency room, hospital or elsewhere on the day of surgery, or one day prior to the day of surgery, is considered a part of the surgical procedure and is not separately reimbursable by Medi-Cal.

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

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

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

Exceptions

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Unrelated E&amp;M service by the same physician during a postoperative period</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable E&amp;M service by the same physician on the same day of the procedure or other service</td>
</tr>
</tbody>
</table>

NOTE
Modifiers 24 and 25 require documentation.
Non-Physician Medical Practitioner (NMP)

Non-Physician Medical Practitioners (NMPs) include:
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)
- Licensed Midwife (LM)

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

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

The following items need to be included on claim forms for reimbursement:
- The NMP’s NPI must be noted in the Remarks field (Box 80) on UB-04 claims or Additional Claim Information field (Box 19) on CMS-1500 claims.
- When billing for assistant surgeon services performed by the PA, services must be billed with modifiers 80 and 99 (multiple modifiers). (99 = 80 + U7).

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

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>Date of Service</th>
<th>CPT Code</th>
<th>Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colposcopy</td>
<td>57452SA</td>
<td>021116</td>
<td>1</td>
<td>27500</td>
</tr>
</tbody>
</table>

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

- JANE SMITH, CNM, NPI 1234567890
- Procedure Code: 0123456789
- Total Charges: 27500
Anesthesia-Related Drugs and Supplies Modifiers

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

Billing Reminders

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

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

- Anesthesia time
- “By Report” procedures/modifiers
- Delay Reason Code used on claim
- Denials from Other Health Coverage (OHC) carriers
- Emergency Statement required
- Medicare Non-Covered or Denied services
- Multiple modifiers
- No price is listed
- Specific surgical procedures
- Sterilization or hysterectomy
- Unlisted injections
- Unlisted services (for example, 36299)
  - No specific CPT-4 description of service
  - Requires a TAR
  - Time involved
  - Nature and purpose of procedure
  - Relation to diagnosis
- Unusual/Complicated procedures

“By Report” Documentation Requirements

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

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

NOTE

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

<table>
<thead>
<tr>
<th>RAD Code</th>
<th>Description</th>
<th>Follow-Up Procedure</th>
</tr>
</thead>
</table>
| 0196     | This procedure requires a modifier; modifier is not present | • Rebill the claim within six months from the month of service  
• Submit a *Claims Inquiry Form (CIF)* within six months from the denial date (date on RAD)  
• Submit an Appeal within 90 days from the denial date (date on RAD) |
| 0326     | Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service | • Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9068     | Submit documentation indicating the procedure performed was unilateral or bilateral | • Rebill the claim within six months from the month of service  
• Submit a *Claims Inquiry Form (CIF)* within six months from the denial date (date on RAD)  
• Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9106     | This modifier requires a breakdown (for example, 99 = 80 + 51) | • Rebill the claim within six months from the month of service  
• Submit a *Claims Inquiry Form (CIF)* within six months from the denial date (date on RAD)  
• Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9118     | This modifier is not payable without a primary surgeon modifier | • Rebill the claim within six months from the month of service  
• Submit a *Claims Inquiry Form (CIF)* within six months from the denial date (date on RAD)  
• Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9940     | NCCI (National Correct Coding Initiative) claim line is billed with multiple NCCI modifiers | • Submit an Appeal within 90 days from the denial date (date on RAD) |
| 9941     | NCCI (National Correct Coding Initiative) column 2 procedure code is not allowed when column 1 procedure has been paid | • Submit an Appeal within 90 days from the denial date (date on RAD) |
Learning Activity

Modifier Review

1. An assistant surgeon was involved in performing the procedure. What modifier should be used to bill for the assistant’s services?
   a. 99
   b. 80
   c. U7

2. Surgical procedures that require two surgeons who perform on distinct anatomical regions on the same recipient, same date of service, may each bill with modifier AG on separate claims.
   a. True
   b. False

3. Procedures billed with modifier 51 are reimbursed at what percentage of the Medi-Cal maximum allowable?
   a. 50%
   b. 100%
   c. Both

4. Is it possible to bill with more than one primary surgical procedure with modifier AG on the same date of service?
   a. Yes
   b. No

5. For dates of service on or after October 1, 2015, providers should use the letter “O” to document the ICD indicator?
   a. True
   b. False

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

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

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

January 2013
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
</tr>
<tr>
<td>MCP</td>
<td>Managed Care Plan</td>
</tr>
<tr>
<td>MAPD</td>
<td>Medicare Advantage Prescription Drug</td>
</tr>
<tr>
<td>MNSIRA</td>
<td>Medicare National Standard Intermediary Remittance Advice</td>
</tr>
<tr>
<td>MREP</td>
<td>Medicare Remit Easy Print Software</td>
</tr>
<tr>
<td>MRN</td>
<td>Medicare Remittance Notice</td>
</tr>
<tr>
<td>MSA</td>
<td>Medi-Cal Savings Account</td>
</tr>
<tr>
<td>NCCI</td>
<td>National Correct Coding Initiative</td>
</tr>
<tr>
<td>NMP</td>
<td>Non-Physician Medical Practitioner</td>
</tr>
<tr>
<td>NF</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>OHC</td>
<td>Other Health Coverage</td>
</tr>
<tr>
<td>OP</td>
<td>Outpatient Services</td>
</tr>
<tr>
<td>PA</td>
<td>Physician Assistant</td>
</tr>
<tr>
<td>PC</td>
<td>Personal Computer</td>
</tr>
<tr>
<td>PDP</td>
<td>Prescription Drug Plan</td>
</tr>
<tr>
<td>PFFS</td>
<td>Private Fee-For-Service</td>
</tr>
<tr>
<td>POE</td>
<td>Proof of Eligibility</td>
</tr>
<tr>
<td>POS</td>
<td>Point of Service</td>
</tr>
<tr>
<td>PPO</td>
<td>Preferred Provider Organization</td>
</tr>
<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
</tr>
<tr>
<td>RA</td>
<td>Remittance Advice</td>
</tr>
<tr>
<td>RAD</td>
<td>Remittance Advice Details</td>
</tr>
<tr>
<td>REIMB</td>
<td>Reimbursable</td>
</tr>
<tr>
<td>RTD</td>
<td>Resubmission Turnaround Document</td>
</tr>
<tr>
<td>SNP</td>
<td>Special Needs Plan</td>
</tr>
<tr>
<td>SOC</td>
<td>Share of Cost</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>TAR</td>
<td>Treatment Authorization Request</td>
</tr>
<tr>
<td>TCN</td>
<td>TAR Control Number</td>
</tr>
<tr>
<td>TSC</td>
<td>Telephone Service Center</td>
</tr>
</tbody>
</table>