Medicare/Medi-Cal Crossover Claims: Pharmacy Services

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This section contains billing information, billing tips and Medicare documentation requirements for Medicare/Medi-Cal crossover claims submitted on a *Pharmacy Claim Form* (30-1), *Compound Drug Pharmacy Claim Form* (30-4) or a *CMS-1500* claim. Refer to the *Medicare/Medi-Cal Crossover Claims Overview* section in the Part 1 manual for eligibility information and general guidelines. Refer to the Medicare/Medi-Cal crossover sections in the appropriate Part 2 manual for claim form billing and pricing examples. Information in this section is organized as follows:

- Hard Copy Submission Requirements for Medicare Approved Services
- Crossover *Claims Inquiry Forms* (CIFs)
- Charpentier Rebilling
- Billing for Medicare Non-Covered or Denied Services, or Medicare Non-Eligible Recipients

Hard Copy Submission Requirements For Medicare Approved Services

Where to Submit Hard Copy Crossover Claims

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 must be hard copy billed directly to Medi-Cal. Providers must submit crossover claims to the California MMIS Fiscal Intermediary:

Attn: Crossover Unit
California MMIS Fiscal Intermediary
P.O. Box 1157000
Sacramento, CA 95852-1700

Part B Services Billed to Part B Medicare Administrative Carriers

Hard copy submission requirements for Part B services billed to Part B Medicare Administrative Carriers (MACs) are as follows:

- One of the following formats of the *Pharmacy Claim Form* (30-1), *Compound Drug Pharmacy Claim Form* (30-4) for claims billed to Medicare via the National Council for Prescription Drug Programs (NCPDP) or *CMS-1500* claim for claims not billed to Medicare via NCPDP
  - Original
  - Clear photocopy of the claim submitted to Medicare
  - Facsimile (same format as *Pharmacy Claim Form* [30-1], *Compound Drug Pharmacy Claim Form* [30-4] or *CMS-1500* claim and background must be visible)
- *CMS-1500* fields for crossovers only when not billed to Medicare via NCPDP
  - *Medicaid/Medicare/Other ID* field (Box 1). Enter an "X" in both the Medicare and Medicaid boxes.
  - *Other Insured's Policy or Group Number* field (Box 9A). Enter the Medi-Cal recipient identification number in one of the following formats:
    - ❖ 14-digit Medi-Cal recipient ID number
    - ❖ Nine-digit Client Index Number

- *Claim Codes* field (Box 10D). Enter the patient's Share of Cost for the service (leave blank if not applicable). (Refer to the *Share of Cost* (SOC): *30-1 for Pharmacy* section in this manual.)
- *Procedures, Services or Supplies* (Box 24D). Enter the appropriate HCPCS code for each line billed, even if Medicare was billed with an NDC/UPC/HRI.

Note: When billing Medicare for Medi-Cal medical supply crossover claims, providers should not include the Universal Product Number (UPN), qualifier, unit of measurement qualifier and UPN units. Crossover claims for Medi-Cal medical supply items that require hard copy crossover claims to be submitted to Medi-Cal must contain the UPN and appropriate qualifier listed in the shaded area of Box 24A (*Date of Service*). Claims for contracted medical supplies that do not have the appropriate UPN will be denied. The unit of measure qualifier and quantity *may* be listed in the shaded area of Box 24D (*Procedure Code*); however, hard copy crossover claims without this information will not be denied.

- *Signature of Physician or Supplier field* (Box 31). Enter the Medi-Cal provider identification number.

  Box 31 is required when the National Provider Identifier (NPI) is not used in Box 33A and an identification number other than the NPI is necessary for the receiver to identify the provider.
- *Service Facility Location Information* field (Box 32). A nine-digit ZIP code is encouraged when completing this field. Enter the NPI of the facility where the services were rendered in Box 32A.
- *Billing Provider Info and Phone Number* field (Box 33). A nine-digit ZIP code is encouraged when completing this field. Enter the billing provider's NPI in Box 33A.

Note: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.

- Copy of the corresponding *Medicare Remittance Notice* (MRN) for each crossover claim (see *Figures 1a* and *1b* in the Medicare/Medi-Cal crossover claims billing examples section of the appropriate Part 2 manual.)
  - Must be complete, unaltered and legible
  - The following fields on the MRN must match the corresponding fields on the *CMS-1500* claim:
    - Date(s) of service ("from-through" dates)
    - Patient's last name or Medicare ID number
    - Provider name
    - Billed charge(s)
    - Procedure code(s), unless billing with Medi-Cal local code(s)
  - Originals, photocopies or electronic printouts of MRNs are acceptable in any format as long as the following critical fields can be identified:
    - Date of MRN
    - Carrier name (this field may be handwritten or typed)
    - Provider name
    - Patient last name or Medicare ID number
    - Service dates
    - Billed/charged/submitted
    - Procedure code(s)
    - Allowed
    - Deductible
    - Coinsurance
    - Provider paid/pay provider
- Timeliness (Refer to billing limit information in the *CMS-1500 Submission and Timeliness Instructions* section of this manual.)

Billing Tips: Part B Services Billed to Part B Medicare Administrative Carriers

The following billing tips will help prevent rejections, delays, mispayments and/or denials of crossover claims for Part B services billed to Part B Medicare Administrative Carriers (MACs):

- Submit pharmacy crossovers using NDCs on the *Pharmacy* (30-1) claim.
- Submit compound drug pharmacy crossovers using NDCs on the *Compound Drug Pharmacy* 30-4 claim.
- Providers or submitters who have not yet converted to the NCPDP 1.2 format with Medicare must continue billing the Medi-Cal portion of crossover claims that fail to cross over automatically with the *CMS-1500* paper claim using HCPCS codes (not NDCs).
- If submitting a *Pharmacy* (30-1), *Compound Drug Pharmacy* (30-4) or *CMS-1500* facsimile, the background must be visible.
- Do not highlight any information on the claim or attachments. Highlighting renders the data unreadable by the system and causes a delay in processing the claim.
- Do not write in undesignated white space or the top one inch of the claim form.
- A separate copy of the *Medicare Remittance Notice* (MRN) must be submitted with each *Pharmacy Claim Form* (30-1), *Compound Drug Pharmacy Claim Form* (30-4) and *CMS-1500* claim form.
- MRNs must be complete, legible and unaltered. For example, make sure the date in the upper right-hand corner is legible.
- Crossover claims must not be combined. Examples of common errors that will result in rejections, delays, mispayments and/or denials include:
  - Multiple recipients on one *Pharmacy Claim Form* (30-1), *Compound Drug Pharmacy Claim Form* (30-4) or *CMS-1500* claim form
  - One MRN for multiple *Pharmacy Claim Forms* (30-1), *Compound Drug Pharmacy Claim Forms* (30-4) or *CMS-1500* claim forms

  - Multiple claims (on one or more MRNs) for the same recipient on one *Pharmacy Claim Form* (30-1), *Compound Drug Pharmacy Claim Form* (30-4) or *CMS-1500* claim form
  - Multiple claim lines from more than one MRN for the same recipient on one *Pharmacy Claim Form* (30-1), *Compound Drug Pharmacy Claim Form* (30-4) or *CMS-1500* claim form
- Only use NDC/UPC/HRI codes for specified Medicare-covered drugs.
- Use NDC codes when billing pharmacy crossovers on claim forms 30-1 and 30-4.
- Do not use NDC/UPC/HRI codes for other crossover claims.
- All Medicare-allowed claim lines must be included on the crossover claim and must match each corresponding MRN provided by Medicare.
- Medicare-denied claim lines that appear on the same crossover claim MRN with Medicare-allowed claim lines cannot be paid with the crossover claim. Refer to "Billing for Medicare Non-Covered or Denied Services, or Medicare Non-Eligible Recipients" on a following page in this section.
- Enter the recipient ID number in the *Other Insured's Policy or Group Number* field (Box 9A).
- If the recipient has Other Health Coverage (OHC), submit a copy of the MRN or denial letter from the insurance carrier. Part B pharmacy crossovers billed using a *Pharmacy Claim Form* (30-1) and *Compound Drug Pharmacy Claim Form* (30-4) do not require a copy of the MRN or denial letter from the other insurance carrier.
- If a provider billed Part B services to a Medicare Part A intermediary, follow the billing instructions in "Part B Services Billed to Part A Intermediaries" on a following page in this section.
- Submit Medicare adjustment crossovers on a *Claims Inquiry Form* (CIF). Follow the Medicare/Medi-Cal crossover claims billing instructions in the *CIF Special Billing Instructions* section of this manual.

Part B Services Billed to Part A Intermediaries

Hard copy submission requirements for Part B services billed to Part A intermediaries are as follows:

Medicare-Covered Drugs

- Original *Pharmacy Claim Form* (30-1)
  - Complete according to instructions in the *Pharmacy Claim Form (30-1) Completion* section of this manual.
- Additional 30-1 fields for Medicare-covered drugs only:
  - *Patient's Share* field (Box 28). Enter the patient's Share of Cost for the service (leave blank if not applicable). Refer to the *Share of Cost (SOC): 30-1 for Pharmacy* section in this manual.
  - *Charges* field (Boxes 25, 46 and 67). On each detail line, enter the amount billed to Medicare.
  - *Specific Details/Remarks* field. Enter the total amount of Medicare Deductible, Medicare Coinsurance, and Blood Deductible from the RA minus the amounts entered in the *Other Coverage Paid* field (Box 26) and the *Patient's Share* field (Box 28).

All Other Crossover Claims

- Original *CMS-1500* claim form (02/12 version only)
  - Complete according to instructions in the *CMS-1500 Completion* section of this manual.
- Additional *CMS-1500* fields for crossovers only:
  - *Medicaid/Medicare/Other ID* field (Box 1). Enter an "X" in both the Medicare and Medicaid boxes.
  - *Other Insured's Policy or Group Number* field (Box 9A). Enter the Medi-Cal recipient identification number in one of the following formats:
    - ❖ 14-digit Medi-Cal recipient ID number
    - ❖ Nine-digit Client Index Number
  - *Claim Codes* field (Box 10D). Enter the patient's Share of Cost for the service (leave blank if not applicable).

- *Claim Line* field (Box 24). Complete all required fields including:
  - ❖ *Date(s) of Service* field (Box 24A). On each detail line, enter the actual dates of service.
  - ❖ *Procedures/Services* or *Supplies* field (Box 24D). On each detail line, enter the appropriate HCPCS code that most closely reflects the items/services provided
    - Equates to the Medicare code originally billed to Medicare

Reminder: Include all services billed to Medicare. Do not use NDC/UPC/HRI codes.

Note: When billing Medi-Cal medical supply items to Medicare, do not include the UPN, qualifier, unit of measurement qualifier and UPN units. Crossover claims for contracted medical supply items will require hard copy crossover claims be submitted to Medi-Cal with the UPN and appropriate qualifier listed in the shaded area of the *Date(s) of Service* field (Box 24A). Claims for contracted medical supplies that do not have the appropriate UPN will be denied. The unit of measure qualifier and quantity may be listed in the shaded area of Box 24D (*Procedure Code*); however, hard copy crossover claims without the unit of measure qualifier and quantity will not be denied.

- ❖ Charges field (Box 24F). On each detail line, enter the amount billed to Medicare.

- *Amount Paid* field (Box 29). Enter the sum of the amounts paid by the patient's Share of Cost from Box 10D and Other Health Coverage from Box 11D (leave blank if not applicable).
- *Rsvd for NUCC* Use field (Box 30).
- *Signature of Physician or Supplier* field (Box 31). Enter the Medi-Cal provider identification number. Box 31 is required when the NPI is not used in Box 33A and an identification number other than the NPI is necessary for the receiver to identify the provider.
- *Service Facility Location Information* field (Box 32). A nine-digit ZIP code is encouraged when completing this field. Enter the NPI of the facility where the services were rendered in Box 32A.
- *Billing Provider Info and Phone Number* field (Box 33). A nine-digit ZIP code is encouraged when completing this field. Enter the billing provider's NPI in Box 33A.

Note: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.

- Copy of the corresponding Medicare RA for each crossover claim (see *Figures 2a* and *2b* in the Medicare/Medi-Cal crossover claims billing examples section of this manual.)
  - Must be complete, unaltered and legible
  - The following fields on the RA must match the corresponding fields on the *CMS-1500:*
    - ❖ Date(s) of service ("from-through" dates)
    - ❖ Patient's last name or Medicare ID number
    - ❖ Provider name
    - ❖ Total charge(s)
  - Printouts of electronic RAs are acceptable in any format as long as the following critical fields can be identified:
    - ❖ Date of RA
    - ❖ Intermediary name
    - ❖ Provider name
    - ❖ Patient's last name or Medicare ID number
    - ❖ "From-through" dates
    - ❖ Billed or total charges
    - ❖ Medicare paid amount
    - ❖ Deductible and/or coinsurance amount and/or blood deductible
    - ❖ Non-covered charges (if applicable)
    - ❖ Denial reason (Medicare denied claim only; not crossovers)
- Timeliness (refer to "Billing Limit Exceptions" in the *CMS-1500 Submission and Timeliness Instructions* section of this manual.)

Billing Tips: Part B Services Billed to Part A Medicare Administrative Carriers

The following billing tips will help prevent rejections, delays, and/or denials of crossover claims for Part B services billed to Part A Medicare Administrative Carriers (MACs):

- Submit an original *Pharmacy Claim Form* (30-1) to bill for Medicare-covered drugs only. Submit an original 8/05 version of the *CMS-1500* claim form for other crossover claims.
- Do not submit a *CMS-1500* facsimile.
- Do not highlight any information on the claim or attachments. Highlighting renders the data unreadable by the system. This causes a delay in processing the claim.
- Do not write in undesignated white space or the top one inch of the *Pharmacy Claim Form* (30-1) or *CMS-1500* claim form.
- A separate copy of the Medicare RA must be submitted with each 30-1 or *CMS-1500* claim form.
- All copies of Medicare RAs must be complete, legible and unaltered. For example, make sure the date in the upper right-hand corner is legible.
- Crossover claims must not be combined. Examples of common errors that will result in rejections, delays, mispayments and/or denials include:
  - Multiple recipients on one 30-1 or *CMS-1500* claim form
  - One Medicare RA for multiple 30-1 or *CMS-1500* claim forms
  - Multiple claims (on one or more RAs) for the same recipient on one 30-1 or *CMS-1500* claim form
  - Multiple claim lines from more than one RA for the same recipient on one 30-1 or *CMS-1500* claim form

- Use only NDC/UPC/HRI codes for specified Medicare-covered drugs.
- Do not use NDC/UPC/HRI codes for other crossover claims.
- Include all services billed to Medicare on the crossover claim.
- Each crossover claim must match each corresponding claim submitted to Medicare.
- If Medicare denied the claim, or a provider is billing for Medicare non-covered services, follow the billing instructions under “Billing for Medicare Non-Covered or Denied Services, or Medicare Non-Eligible Recipients” on a following page in this section.
- If the recipient has Other Health Coverage (OHC), submit a copy of the EOB/RA or denial letter from the insurance carrier.
- Submit Medicare adjustment crossovers on a *Claims Inquiry Form* (CIF). Follow the Medicare/Medi-Cal crossover claims billing instructions in the *CIF Special Billing Instructions* section of this manual.

Crossover Claims Inquiry Forms (CIFs)

CIF for all Crossover Claims

Refer to the *CIF Special Billing Instructions* section in this manual to complete a CIF for a Medicare/Medi-Cal crossover claim.

Note: Do not use a CIF to rebill a Charpentier claim. Refer to "Charpentier Rebilling" on a following page in this section.

Reimbursement for Beds and Mattresses

Claims for rentals of low air-loss/air-fluidized bed, nonpowered advanced pressure-reducing overlays or mattresses, or powered air overlays are paid by Medicare on a monthly basis. When claims for these cross over automatically to Medi-Cal, the crossover claim and *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN) reflect only one date of service and a quantity of one. Because Medi-Cal reimburses rental of these items on a daily basis, the crossover claims are processed for only one date of service, instead of one month. To request full reimbursement for these claims, providers must submit a CIF stating the actual "from-through" dates of service and the actual quantity in the Remarks area of the CIF.

‹‹HCPCS Codes for Reimbursement for Beds and Mattresses››

Durable Medical Equipment	HCPCS Code
Low air-loss/air fluidized bed	E0193, E0194
Powered pressure reducing air mattress	E0277
Powered air overlay	E0372
Nonpowered advanced pressure-reducing	E0371, E0373

Charpentier Rebilling

Medi-Cal Reimbursement

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. 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 carriers. 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 cut back by Medicare due to a benefit limitation.
- Both Rates and Benefit Limitation – 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.

All Charpentier rebilled claims must have been first processed as Medicare/Medi-Cal crossover claims.

Cutback

If there is a price on file, claims will be cut back with Remittance Advice Details (RAD) code 444. The message for RAD code 444 reads, "For non-physician claims, see Charpentier billing instructions in the provider manual. Medi-Cal automated system payment does not exceed the Medicare allowed amount."

Medicare Allowed Amount

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

Exceeds Medicare's Allowed Amount

If Medi-Cal's rates and/or limitations are greater than that of Medicare, 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.

Where to Submit Charpentier Rebills

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

California MMIS Fiscal Intermediary
P.O. Box 15700
Sacramento, CA 95852-1700

Submission Requirements

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

- Providers must first bill Medicare and any OHC to which the recipient is entitled.
- The claim must then be billed as a crossover and approved by Medi-Cal.
  - The claim may cross over automatically from the Part B carrier or
  - The crossover claim may be hard copy billed to Medi-Cal by the provider.

Medicare-Covered Drugs

After Medi-Cal processes the crossover claim, complete the *Pharmacy Claim Form (30-1)* according to instructions in the *Pharmacy Claim Form (30-1) Completion* section of this manual. In addition, complete the following 30-1 fields for Charpentier rebills only:

- *Other Coverage Paid* field (Box 26). Enter the sum of previous payments from Medicare, Medi-Cal (crossover claim payment) and any OHC.
- *Specific Details/Remarks* area. Select one of the following phrases, as previously defined:
  - For Rates, enter the words “Medi/Medi Charpentier: Rates”
  - For Benefit Limitations, enter the words “Medi/Medi Charpentier: Benefit Limitation”
  - For Both Rates and Benefit Limitations, enter the words “Medi/Medi Charpentier: Both Rates and Benefit Limitation”

- *Medicare Status* field (Box 10). Select one of the following letters that corresponds to the phrase entered in *Specific Details/Remarks* area:
  - For Rates, enter the letter "R"
  - For Benefit Limitation, enter the letter "L"
  - For Both Rates and Benefit Limitation, enter the letter "T"
- *Product ID* field (Boxes 20, 41 and 62).
  - If multiple claim lines were originally processed by Medicare and fewer claim lines are now being rebilled to Medi-Cal, indicate with an asterisk on the Medicare EOMB/MRN the items or services that are being rebilled to Medi-Cal for Charpentier processing. Also indicate the claim line number that corresponds to the asterisk(s).

    When using an NDC/UPC/HRI, indicate on the Medicare EOMB/MRN (beside the line being rebilled) the Medi-Cal 30-1 claim line number that corresponds to the Medicare procedure code.

    Note: Complete the claim using the NDC/UPC/HRI that most closely reflects the items/services provided and that most closely equates to the Medicare code originally billed to Medicare and to the code shown on the EOMB/MRN. You are certifying that the NDC/UPC/HRI on the claim best reflects the item or service actually rendered to the recipient.

All Other Charpentier Claims

After Medi-Cal processes the crossover claim, complete a *CMS-1500* claim according to the instructions in the *CMS-1500 Completion* section of this manual. In addition, complete the following *CMS-1500* fields for Charpentier rebills only:

- *Is There Another Health Benefit Plan?* field (Box 11D). Enter the sum of previous payments from Medicare, Medi-Cal (crossover claim payment) and any OHC.
- Additional Claim Information field (Box 19). Select one of the following phrases, as previously defined:
  - For Rates, enter the words "Medi/Medi Charpentier: Rates"
  - For Benefit Limitation, enter the words "Medi/Medi Charpentier: Benefit Limitation"
  - For Both Rates and Benefit Limitation, enter the words "Medi/Medi Charpentier: Both Rates and Benefit Limitation"
- *Resubmission Code* field (Box 22). Select one of the following letters that corresponds to the phrase entered in Box 19:
  - For Rates, enter the letter "R"
  - For Benefit Limitation, enter the letter "L"
  - For Both Rates and Benefit Limitation, enter the letter "T"
- *Procedures, Services, or Supplies* field (Box 24D):
  - If multiple claim lines were originally processed by Medicare and fewer claim lines are now being rebilled to Medi-Cal, indicate with an asterisk on the Medicare Remittance Notice (MRN) the items or services that are being rebilled to Medi-Cal for Charpentier processing. Also indicate the claim line number that corresponds to the asterisk(s).
  - Complete the claim using the Medicare procedure code originally billed to Medicare and the code shown on the MRN.

- The following attachments are required for Charpentier rebilling:
  - A copy of the *CMS-1500* submitted to Medicare (An original or facsimile is acceptable.)
  - A copy of the corresponding Medicare MRN (Printouts of electronic MRNs are acceptable.)
  - The Medi-Cal RAD showing the crossover payment
  - Proof of payment or denial from any other health insurance carriers, if applicable
  - *Treatment Authorization Request* (TAR), if applicable
  - Copy of manufacturer catalog page or invoice or any other required pricing documentation, if applicable

Billing Tips: Charpentier Rebills

The following billing tips will help prevent rejections, delays, mispayments and/or denials when rebilling Charpentier claims:

- A Charpentier rebill must not be combined with a crossover claim.
- Use of Charpentier indicators (“R,” “L” or “T”) on claims that are not Charpentier claims will result in processing delays.
- Failure to place a Charpentier indicator (“R,” “L” or “T”) on a legitimate Charpentier claim prevents the system from recognizing the claim as a Charpentier rebill. This may result in processing delays or denial of the claim.
- Claims with incorrectly marked MRNs will be denied with RAD code 066 or 636.

- Providers must obtain an approved TAR if a TAR would be required when billed as a Medi-Cal-only claim.
  - Providers are strongly advised to obtain an approved TAR prior to billing Medicare for all high-dollar Durable Medical Equipment (DME) items. (Refer to the *Durable Medical Equipment* [DME]: *An Overview* section in this manual.)
  - Enter the 10-digit TAR Control Number (TCN) followed by the one-digit Pricing Indicator (PI) from the *Adjudication Response* (AR) in the *Prior Authorization Number* field (Box 23) on the *CMS-1500* claim or the *TAR Control No* field (Boxes 27, 46, 65 and 84) on the 30-1.
  - See the *TAR Overview* section in the Part 1 manual for additional information.
- Providers are not required to submit a copy of the *Medicare Appeal and Decision* form when billing Medi-Cal for the difference between Medicare and Medi-Cal's allowed amount.

Billing For Medicare Non-Covered Or Denied Services, Or Medicare Non-Eligible Recipients

Medicare Reimbursement

Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare carrier or intermediary for processing of Medicare benefits. Medi-Cal recipients are considered Medicare-eligible if they are 65 years or older, blind or disabled, or if the Medi-Cal eligibility verification system indicates Medicare coverage. If Medicare approves the claim, it must then be billed to Medi-Cal as a crossover claim.

Straight Medi-Cal Claims

Providers must bill as a straight Medi-Cal claim if any of the following apply: the services are not covered by Medicare, Medicare benefits have been exhausted, Medicare has denied the claim, or the recipient is not eligible for Medicare. These are not crossover claims. For billing and timeliness instructions, refer to the *CMS-1500* Completion and *CMS-1500 Submission and Timeliness Instructions* sections or the *Pharmacy Claim Form (30-1) Completion and Pharmacy Claim Form (30-1) Submission and Timeliness Instructions* sections in this manual.

Note: Charpentier claims require Medicare status codes. However, in all other circumstances, these codes are optional; therefore, providers may leave the *Resubmission Code* field (Box 22) blank on the *CMS-1500* claim. Refer to the *CMS-1500 Completion* section in this manual for a list of codes entered in Box 22.

Medicare Non-Covered Services

The Department of Health Care Services (DHCS) maintains a list of Medi-Cal codes that may not be billed directly to the California MMIS Fiscal Intermediary as straight Medi-Cal claims for Medicare/Medi-Cal recipients. Refer to the Medicare Covered Services section in this manual for this list. If the supply code on the claim is not listed, bill directly to Medi-Cal.

To bill Medi-Cal for medical supplies known to be Medicare non-covered services, use the 30-1 or *CMS-1500* claim, as appropriate. Do not send these claims to the Crossover Unit.

Medicare Denied Services

Medicare denied services should be billed as straight Medi-Cal claims.

Note: If a claim has been adjudicated as a crossover and any of the service lines reflected on the Medi-Cal RAD have a RAD code 395, they must be billed on a straight Medi-Cal claim. However, because providers have the denial from Medicare on their MRN/RA, they do not have to see the crossover claim reflected on the Medi-Cal RAD with RAD code 395 before billing the Medicare denied services to Medi-Cal.

To bill for Medicare denied services, follow these steps:

- Submit claims for drugs on the current version of the *Pharmacy Claim Form* (30-1). Submit claims for medical supplies on a *CMS-1500* claim.
  - Complete the claim according to instructions in the *Pharmacy Claim Form (30-1) Completion* section or the *CMS-1500 Completion* section of this manual.
  - Do not include any Medicare approved services on the claim. The Medicare approved services must be billed separately as a crossover claim.
- Attach a copy of the Medicare MRN/RA indicating the denial.
  - If the Medicare denial description is not printed on the front of the Medicare MRN/RA, include a copy of the description from the back of the MRN/RA or the Medicare manual.
- Attach a copy of any Other Health Coverage EOB/RA or denial letter if the recipient has cost-avoided Other Health Coverage through any private insurance (refer to the *Other Health Coverage [OHC] Guidelines for Billing* section in the Part 1 manual).
- Do not send these claims to the Crossover Unit.

Billing Tips: Medicare Non-Covered or Denied Services

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

- A single claim form cannot be used when billing for the combination of Medicare-approved or covered services and Medicare non-covered or denied services appearing on the same MRN/RA.
- Medicare-approved/covered services must be billed as crossover claims according to the instructions in "Hard Copy Submission Requirements for Medicare Approved Services" in this section.
- Medicare non-covered or denied services must be billed as straight Medi-Cal claims. Use the 30-1 or *CMS-1500*, as appropriate, and attach a copy of the Medicare MRN/RA for the denied services.

  Exception: Refer to the *Medicare Non-Covered Services: CPT® Codes* and *Medicare Non-Covered Services: HCPCS Codes* sections in the appropriate Part 2 manual for services that do not require an MRN/RA.

- If a Medicare denial description(s) is not printed <u>on the front</u> of an MRN/RA that shows a Medicare denied service(s), providers must copy the Medicare denial description(s) from the back of the original MRN/RA or from the Medicare manual and submit it to Medi-Cal along with their bill for the Medicare denied service(s). This applies to any service(s) denied by Medicare for any reason.
- When billing Medicare non-covered or denied services for a recipient who has Other Health Coverage (OHC) through any private insurance, the provider must also bill the OHC before billing Medi-Cal (refer to the *Other Health Coverage [OHC]* section in the appropriate Part 2 manual). MRN/EOB/RAs from both must accompany the Medi-Cal claim.
- Since Medicare non-covered or denied services are billed as straight Medi-Cal claims, the provider must obtain a *Treatment Authorization Request* (TAR) if the service normally requires authorization.

  Note: For timeliness requirements, refer to the *Pharmacy Claim Form (30-1) Submission and Timeliness Instructions* section or the *CMS-1500 Submission and Timeliness Instructions* section of this manual.

Medicare Non-Eligible Recipients

DHCS requires providers to submit formal documentation indicating a recipient is not eligible for Medicare when billing Medi-Cal for the following recipients:

- Recipients who are 65 years or older (for example, those with alien status)
- Recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage

To bill claims for Medicare non-eligible recipients, use the 30-1 or the *CMS-1500* claim.

Medicare Documentation Requirements

Providers must submit Medicare payment or denial documentation with their claims for all Medi-Cal recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage. Claims either with no documentation or with insufficient or unacceptable Medicare documentation will be denied.

Acceptable Medicare Documentation

Examples of acceptable Medicare documentation include:

- Health insurance (Medicare) card indicating Part A or Part B benefits after the date of service billed
- Any document signed, dated and stamped by a Social Security Administration (SSA) District Office, or any documentation on SSA or Department of Health and Human Services letterhead:
  - Valid for dates of service up to the end of the month of the date on the document, or the date of entitlement

    Note: Handwritten statements are acceptable if they bear an SSA stamp and contain the specific date criteria mentioned above.

- "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
  - Common Working File (CWF) printout
- Screen printout of electronic *Medicare Remittance Notice* (MRN):
  - Date of MRN
  - Carrier name (this field may be handwritten or typed)
  - Provider name
  - Patient last name or Medicare ID number
  - Service date
  - Billed/charge/submitted
  - Procedure code
  - Allowed
  - Deductible
  - Coinsurance
  - Provider paid/pay provider

- Screen printout of electronic Medicare *Remittance Advice* (RA):
  - Date of RA
  - Intermediary name (this field may be handwritten or typed)
  - Provider name
  - Patient last name or Medicare ID number
  - "From-through" dates
  - Billed/total/submitted charges
  - Deductible and/or coinsurance amount(s)
  - Non-covered/non-allowed charges (if applicable)
  - Denial reason/reason code (Medicare denied claims only, not crossovers. For older RAs, there is no date element field in the header; however, there will be a code on the line prior to the patient name.)

Note: For all EOMB/MRN/RAs showing a Medicare denial, if the Medicare denial description is not printed on the front of the EOMB/RA, providers must include a separate copy of the Medicare denial description (from the back of the original EOMB/RA or from the Medicare manual) when billing for a Medicare denied claim.

Non-Acceptable Medicare Documentation

Examples of non-acceptable Medicare documentation include:

- Medicare Eligibility Certification Forms completed by the recipient or any statement from the recipient
- Forms indicating that the recipient's name and SSN do not match or are incorrect
- Alien or "green" cards
- Statements from the provider regarding the recipient's Medicare eligibility
- Documents not dated
- Medicare claim denials due to incomplete, unacceptable or inappropriate information from the provider or recipient
- Medicare denials stating the claim should be resubmitted to Medicare

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.