Medicare/Medi-Cal Crossover Claims: UB-04

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This section contains hard copy submission requirements for Medicare/Medi-Cal crossover claims, specifically Part B services billed to Part A intermediaries submitted on a *UB-04* 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.

Hard Copy Submission Requirements of 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 can be billed to Medi-Cal either electronically or on hard copy. Providers must submit crossover claims to the California MMIS Fiscal Intermediary at the following address:

Attn: Crossover Unit

California MMIS Fiscal Intermediary

P.O. Box 15700

Sacramento, CA 95852-1700

Part B Services Billed to Part A Intermediaries

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

- Original *UB-04* claim (current version only)

  Note: *Type of Bill* field (Box 4) must match what is shown on the *Medicare National Standard Intermediary Remittance Advice* (Medicare RA).

- Copy of the corresponding Medicare RA for each crossover claim (see *Figures 2a* and *2b* in the *Medicare/Medi-Cal Crossover Claims: UB-04 Billing Examples* section of this manual)
  - Must be complete, unaltered and legible
  - The following fields on the Medicare RA must match the corresponding fields on the *UB-04* claim:
    - Date(s) of service ("from-through" dates)
    - Patient last name or Medicare ID number
    - Provider name
    - Billed/Total/Submitted charges
    - HCPCS codes
  - Printouts of electronic RAs are acceptable only in the PC Print single claim detail version of the Medicare RA format. (For examples, refer to the *Medicare/Medi-Cal Crossover Claims: UB-04 Billing Examples* section in this manual.) The following critical fields must be present:
    - Date of RA
    - Intermediary name (this field may be handwritten or typed) and Medicare contractor ID code
    - Provider name
    - Patient last name or Medicare ID number
    - "From-through" dates
    - Billed/total/submitted charges
    - Deductible and/or coinsurance amounts
    - Non-covered/non-allowed charges (if applicable)
    - Denial reason/reason code (Medicare-denied claims only, not crossovers)
    - Type of Bill (TOB)/type of claim/claim type/bill type (such as inpatient, outpatient or Nursing Facility Level B [NF-Bs])

- ❖ At the claim line level:
  - Medicare Billed
  - Medicare Paid
  - Adjustment Group Code
  - Adjustment Reason Code
  - Adjustment Amount

- Timeliness
- Additional *UB-04* claim fields for crossovers only:

  Occurrence Codes and Dates (Boxes 31 thru 33 A thru B).

  Date of RA.

  – Enter code 50 and the date (MMDDYY) of the Medicare RA.

  Value Codes and Amounts (Boxes 39 thru 41 A thru D).

  Blood Deductible.

  – Enter code 06 and the Medicare blood deductible amount.

  – Leave blank if not applicable.

  Patient's Share of Cost.

  – Enter code 23 and the patient's Share of Cost 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.

Description (Box 43).

Enter all claim detail lines (services) that were billed to Medicare on this claim. Crossover claims in excess of 15 claim lines must be billed on two or more claim forms. Refer to "Split Billing: More than 15 Line Items for Part B Services Billed to Part A Intermediaries" in this section.

HCPCS/Rate (Box 44).

Enter the same code billed to Medicare reflected on the Medicare RA.

Service Date (Box 45).

Enter the actual date of service on each detail line.

Total Charges (Box 47).

Enter the total charge for each service billed to Medicare in the *Total Charges* field.

Revenue Code (Box 42), Description (Box 43) and Total Charges (Box 47).

Box 42, Line 23: Enter “001” to indicate that this is the total charge line.

Box 47, Line 23: Enter the total amount of all charges billed to Medicare.

Payer Name (Boxes 50 A thruC).

The payers must be listed in the following order of payment:

1. Other Health Coverage (OHC) (if applicable) except Medicare Supplemental Insurance
2. Medicare
3. Medicare Supplemental Insurance (if applicable)
4. Medi-Cal

<u>Medicare/Medi-Cal Payers</u>

If only Medicare and Medi-Cal are involved, enter “MEDICARE” on line A and “O/P MEDI-CAL” on line B. Enter the facility type as the first two digits in the *Type of Bill* field (Box 4).

Other Health Coverage Payers

If Other Health Coverage (OHC) is primary, enter the name of the OHC on line A, enter "MEDICARE" on line B, and enter "O/P MEDI-CAL" on line C. Enter the facility type code as the first two digits in the *Type of Bill* field (Box 4).

Medicare Supplemental Insurance Payers

If Medicare supplemental insurance is involved, it is secondary to Medicare. Enter "MEDICARE" on line A, enter the name of the Medicare supplemental insurance on line B, and enter "O/P MEDI-CAL" on line C. Enter the facility type code as the first two digits in the *Type of Bill* field (Box 4).

Health Plan ID (Box 51).

Enter the Medicare carrier code.

Prior Payments (Boxes 54 A thru C).

Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50.

ESTIMATED AMOUNT DUE (Boxes 55 A thru C).

Note: Do not enter a decimal point (.) or dollar sign ($).

On the corresponding Medicare line, enter the total charges from Box 47, line 23.

On the corresponding Medi-Cal line, follow the instructions below:

Add the blood deductible (value code 06), Medicare deductible (value code A1 or B1), and Medicare coinsurance (value code A2 or B2). (See Boxes 39 thru 41 and example on the following page.)

For example:

Value Type	**Amount (in dollars)**
Blood Deductible	40.00
Medicare Deductible	60.00
Medicare Coinsurance	20.00
Total (Sum of Blood Deductible, Medicare Deductible and Medicare Coinsurance)	120.00

Add the SOC (Boxes 39-41 [value code 23]), the OHC (Box 54) and the Medicare supplemental insurance (Box 54).

For example:

Value Type	**Amount (in dollars)**
SOC	50.00
OHC	25.00
Supplemental Insurance	25.00
Total (Sum of SOC, OHC and Supplemental Insurance)	100.00

Then subtract that total (100 00) from the deductible(s) and coinsurance total (120 00). The difference equals the Estimated Amount Due. Enter this amount in Box 55 on the Medi-Cal line.

For example:

Value Type	**Amount (in dollars)**
Sum of Deductible + Coinsurance	120.00
Sum of SOC/OHC/Supplemental	100.00
Estimated Amount Due (Sum of SOC/OHC/Supplemental subtracted from Sum of Deductible + Coinsurance)	20.00

NPI (Box 56).

Enter the National Provider Identifier (NPI) number for the billing provider.

Box 57 is required when an NPI is not used in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.

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

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

- Submit an original *UB-04* claim form, not a 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.
- Include all services billed to Medicare on the crossover claim.
- Each crossover claim must match the corresponding Medicare RA.
- A separate copy of the Medicare RA must be submitted with each *UB-04* claim form.
- All copies of Medicare RAs must be complete, legible, unaltered and in the correct format.
- 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 *UB-04* claim form
  - One Medicare RA for multiple *UB-04* claim forms
  - Multiple claims (on one or more RAs) for the same recipient on one *UB-04* claim form
  - Multiple claim lines from more than one RA for the same recipient on one *UB-04* claim form
  - Summary level rather than detail level RA
  - Non-PC Print version of Medicare RA

- Crossover claims for outpatient services in excess of 15 lines must be billed on two or more claim forms. Follow the billing instructions in the *Medicare/Medi-Cal Crossover Claims: UB-04 Billing Examples* section.
- If the recipient has Other Health Coverage (OHC), submit a copy of the RA or denial letter from the insurance carrier.
- Submit Medicare adjustment crossovers on the *Claims Inquiry Form* (CIF). Follow the Medicare/Medi-Cal crossover claims billing instructions in the *CIF Special Billing Instructions for Outpatient Services* section in the appropriate Part 2 Medi-Cal manual.

Split Billing: More Than 15 Line Items for Part B Services Billed to Part A Intermediaries

Medi-Cal cannot process more than 15 lines per claim form for crossover claims. Therefore, outpatient crossover claims billed for more than 15 line items for Part B services billed to Part A Intermediaries require billing on two or more separate *UB-04* claims. This process is called "split billing."

Submit split-billed crossover claims according to the billing instructions under "Part B Services Billed to Part A Intermediaries" on a previous page in this section. In addition, these claims require special billing procedures, as follows:

- Enter the sum of the deductible amounts (reason code PR 1) from the Medicare RA that correspond to the lines billed on the claim using code A1 in the *Value Codes and Amounts* field (Boxes 39 - 41) of each claim.
- Enter the sum of the coinsurance amounts (reason code PR 2 and PR 122) from the Medicare RA that correspond to the lines billed on the claim using code A2 in the *Value Codes and Amounts* field (Boxes 39 - 41) of each claim.
- Enter "001" on line 23 in the *Revenue Code* field (Box 42) and the sum of the charges amounts from the Medicare RA that correspond to the lines billed on the claim in the *Total Charges* field (Box 47) of each claim.

- Enter the sum of the Medicare payment amounts from the Medicare RA that correspond to the lines billed on the claim in the *Prior Payments* field (Box 54) of the Medicare line of each claim.

  Note: The amount entered on each split-billed claim is determined by the provider, but the sum of the amounts on each split-billed claim must equal the summary data on the Medicare RA. Claim lines with no patient responsibility (coinsurance or deductible due) need not be billed to Medi-Cal.

- The following information must be entered in the *Remarks* field (Box 80) on each split-billed claim form, or on an attachment to the claim:
  - On line A:
    - ❖ Enter "Split-Billed."
    - ❖ Enter the number of the claim (for example, "Claim 1 of 2").
    - ❖ Enter "Deductible." Then enter the total deductible amount from value code A1 (Boxes 39 - 41) from all claims or from the summary data on the Medicare RA.
  - On line B, enter the total amount from <u>all claims</u> in the following categories:
    - ❖ Enter "Total Charge =." Then enter the total Medicare billed amount from line 23 of the *Total Charges* field (Box 47) or from the summary data on the Medicare RA.
    - ❖ Enter "Mcare Paid." Then enter the total amount from the "Medicare" line in the *Prior Payments* field (Box 54) from all claims or from the summary data on the Medicare RA.
    - ❖ Enter "Coins." Then enter the total coinsurance of value code A2 (Boxes 39 - 41) <u>from all claims</u> or from the summary data on the Medicare RA.
  - On lines C and D, enter the breakdown for each claim in the same categories as above:
    - ❖ Line C. Enter "Claim 1." Then enter the amounts only for total charges, total Medicare paid and coinsurance. Align the amounts under the corresponding amounts on line B.
    - ❖ Line D. Enter "Claim 2." Then enter the amounts only for total charges, total Medicare paid and coinsurance. Align the amounts under the corresponding amounts on lines B and C.
- A separate copy of the entire Medicare RA must be submitted with each *UB-04* claim. Indicate which detail lines of each Medicare RA correspond to the claim forms. (For example, bracket the appropriate detail lines and write "CLAIM 1 of 2" in the margin.)

‹‹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.