Medicare/Medi-Cal Crossover Claims: CMS-1500

Page updated: November 2023

This section contains billing information, billing tips and Medicare documentation requirements for Medicare/Medi-Cal crossover claims submitted on 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 of Medicare Approved Services
- Crossover *Claims Inquiry Forms* (CIFs)
- *Charpentier* Rebilling
- Billing for Medicare Non-Covered, Exhausted or Denied Services, or Medicare Non-Eligible Recipients

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 must be hard copy billed directly to Medi-Cal. Providers must submit crossover claims to the California MMIS Fiscal Intermediary (FI) 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 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 *CMS-1500* claim (8/05 version only)
  - Original
  - Clear photocopy of the claim submitted to Medicare
  - Facsimile (same format as *CMS-1500* and background must be visible)
- *CMS-1500* claim 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 Identification 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): CMS-1500* section in this manual.)
  - *Insurance Plan Name or Program Name* (Box 11C). Enter the Medicare Carrier Code.

- *Date(s) of Service* field (Box 24A). ‹‹Enter the date of service.
- *Procedures, Services or Supplies* (Box 24D). Enter the appropriate HCPCS code for each line billed, even if Medicare was billed with an NDC/UPC/HRL.››

  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.
- *Rendering Provider Number* field (Box 24J). Enter the NPI number.
- ‹‹*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 last name or Medicare ID number
    - ❖ Provider name
    - ❖ Billed charge(s)
    - ❖ Procedure 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) and code
    - ❖ 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 "Six Month Billing Limit" in the *CMS-1500 Submission and Timeliness Instructions* section of this manual.)››

Psychiatric Services for HCP-Enrolled Recipients

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. To facilitate prompt and appropriate reimbursement, the rendering provider's NPI number must be entered in the *Rendering Provider ID Number* field (Box 24J) of the *CMS-1500* claim.

Reimbursement to Licensed Clinical Social Workers

Medi-Cal reimburses Licensed Clinical Social Workers (LCSWs) for Medicare-approved Part B crossover services. LCSWs must be enrolled in Medicare and complete the appropriate Medi-Cal provider application forms to receive reimbursement for Medicare Part B crossover claims.

Note: Filling out the provider application forms allows LCSWs to bill Medi-Cal only for Medicare Part B crossover services. Nothing in the registration or crossover payment process is to be construed as making LCSWs enrolled Medi-Cal providers for any purpose.

LCSWs currently enrolled as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental services providers must complete the provider application forms in order to bill and receive reimbursement for Medicare Part B crossover services.

The majority of LCSW crossover claims will automatically cross over to Medi-Cal from Medicare. Claims that do not automatically cross over must be hard copy billed on the *CMS-1500* claim.

Reimbursement to Clinical Nurse Specialists

Medi-Cal reimburses Clinical Nurse Specialists (CNS) for Medicare-approved Part B crossover services.

Note: To qualify for enrollment as a Medi-Cal crossover provider, a CNS must be enrolled in the Medicare Program, must be billing as a freestanding CNS provider, be a registered nurse licensed to practice in the State of California and possess Board of Registered Nursing (BRN) certification as a CNS.

The majority of CNS crossover claims automatically cross over to Medi-Cal from Medicare. Claims that do not cross over must be hard copy billed on the *CMS-1500* claim. These Medi-Cal payments are for crossovers only and are not available for straight Medi-Cal. To receive an application to become a CNS crossover-only Medi-Cal provider, call the Telephone Service Center (TSC) at 1-800-541-5555.

Billing Tips: Part B Services Billed to Part B 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 B Medicare Administrative Contractors (MACs):

- Submit the current version of the *CMS-1500* claim form.
- If submitting a *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 MRN must be submitted with each *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 *CMS-1500* claim form
  - One MRN for multiple *CMS-1500* claim forms
  - Multiple claims (on one or more MRNs) for the same recipient on one *CMS-1500* claim form
  - Multiple claim lines from more than one MRN for the same recipient on one *CMS-1500* claim form
- 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, Exhausted or Denied Services, or Medicare Non-Eligible Recipients" on a following page in this section.
- ‹‹Enter the Medi-Cal recipient identification 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,›› *Explanation of Benefits* (EOB)/*Remittance Advice* (RA), or denial letter from the insurance carrier.
- If a provider billed Part B services to a Medicare Part A intermediary, follow the billing instructions in the *Medicare/Medi-Cal Crossover Claims: UB-04* section of the appropriate Part 2 manual.
- 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 *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.

Beds and Mattress HCPCS Codes

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 overlay or mattress	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 cutback 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 cutback 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 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 Other Health Coverage (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.

‹‹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 Other Health Coverage (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 ‹‹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).
  - If a Medi-Cal HCPCS Level III code is used, indicate on the Medicare MRN (beside the line being rebilled) the Medi-Cal *CMS-1500* claim line number that corresponds to the Medicare procedure code.

Note: Complete the claim using the HCPCS code that most closely reflects the items or services rendered and that most closely equates to the Medicare code originally billed to Medicare and to the code shown on the MRN. This certifies that the Medi-Cal code on the claim best reflects the item or service actually rendered to the recipient.

- The following attachments are required for *Charpentier* rebilling:
  - A copy of the *CMS-1500* claim 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.

- 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 Durable Medical Equipment (DME) items over $100 within a calendar month for purchase, or when the cumulative rental of the item exceeds $50 wihtin a fifteen-month period. Under *Charpentier* requirements, DHCS and Managed Care Plan (MCP) must process an authorization request for a dually eligible patient in the same manner as a Medi-Cal-only patient. See Medi-Cal Provider Manual: Durable Medical Equipment (DME): Bill for DME (dura bil) (Refer to the *Durable Medical Equipment (DME): An Overview* section in the appropriate Part 2 manual.) Providers may check with DHCS or the member's managed care plan if they have not received a response to their request for prior approval within 14 business days of the request or within 72 hours for an expedited request.››
  - Enter the 11-digit TAR Control Number from the approved TAR in the *Prior Authorization Number* field (Box 23) on the claim.
  - 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, Exhausted 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 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 form. 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 be billed directly to the California MMIS Fiscal Intermediary 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. If a service or supply is not included in the chart, submit the corresponding Medicare MRN showing the services or supplies that are not allowed by Medicare when billing Medi-Cal. Refer to the *Medicare Non-Covered Services: CPT® Codes* and *Medicare Non-Covered Services: HCPCS Codes* sections in the appropriate Part 2 manual for additional instructions.

Medicare Exhausted Services

Physical therapy and occupational therapy for Medi-Cal patients with Medicare coverage must be billed to the appropriate Medicare carrier or intermediary. After Medicare benefits for physical and occupational therapy have been exhausted, providers may bill Medi-Cal directly and must include a copy of the Medicare MRN that shows the benefits are exhausted.

Adjustment for Underpaid Claim: Benefits Exhausted Prior to Completion of Services

When a recipient's physical or occupational therapy Medicare benefits end in the middle of a service, a crossover claim may be underpaid by Medi-Cal. To request adjustment on a claim payment for this reason only, follow these steps:

- Complete an *Appeal Form* (90-1) requesting adjustment of the Medi-Cal claim that included the exhausted Medicare physical or occupational therapy benefits. Refer to the *Appeal Form Completion* section in this manual.

- Attach the following documentation:
  - Copy of the Medicare claim
  - Medicare MRN for the claim on which benefits became exhausted
  - Medi-Cal RAD showing warrant number, warrant date, the underpayment for the exhausted service (if any)
  - A completed *CMS-1500* claim listing all procedure codes for the claim on which benefits became exhausted, with the usual and customary charge for these services and any other required information such as quantity, Place of Service and diagnosis

Where to Submit Documentation

Send the appropriate documentation to the FI at the following address:

Attn: Appeals Unit
California MMIS Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

Adjustment for Underpaid Claim: Services Rendered After Benefits Exhausted

The instructions for filing these special adjustments do not affect instructions for services rendered after the Medicare benefits have been exhausted. These claims must be billed directly to Medi-Cal on a *CMS-1500* claim and must include a copy of the Medicare MRN showing the benefits that are exhausted.

If a service or supply exceeds Medicare's limitations, supporting documentation must be included with the claim. Refer to "*Charpentier* Rebilling" in this section.

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 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, they do not have to see the crossover claim reflected on the RAD with RAD code 395 before billing the Medicare denied services to Medi-Cal.

To bill for Medicare denied services, follow these steps:

- Submit an original *CMS-1500* claim
  - Complete the claim according to instructions in 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 indicating the denial.
  - If the Medicare denial description is not printed on the front of the Medicare MRN, include a copy of the description from the back of the MRN or the Medicare manual.
- Attach a copy of any Other Health Coverage EOB/MRN 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.

Services Denied When Included in Medicare's Surgical Fee, or Not Separately Payable

Medi-Cal does not pay for an office visit when Medicare has denied payment because the visit was included in the surgical fee. The surgical fee covers reimbursement of office visits on the same day that surgery is performed and during the follow-up period of the surgical procedure. In addition, Medi-Cal does not pay for services denied by Medicare because the procedure is a component part of a group of services. Medi-Cal will deny these claims with RAD code 027: "Services denied by Medicare (included in surgical fee, incidental, or not separately payable) are not payable by Medi-Cal."

Billing Tips: Medicare Non-Covered, Exhausted or Denied Services

The following billing tips will help prevent rejections, delays, mispayments and/or denials of claims for Medicare non-covered, exhausted 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, exhausted or denied services appearing on the same MRN.
- Medicare-approved/covered services must be billed as crossover claims according to the instructions in "Hard Copy Submission Requirements of Medicare Approved Services" in this section.
- Medicare non-covered, exhausted or denied services must be billed as straight Medi-Cal claims. Use the *CMS-1500* claim and attach a copy of the Medicare MRN for the exhausted or 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.

- If a Medicare denial description(s) is not printed on the front of an MRN that shows a Medicare denied service(s), providers must copy the Medicare denial description(s) from the back of the original MRN 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, exhausted 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]* and *Other Health Coverage [OHC]: CPT® and HCPCS Codes* sections in the appropriate Part 2 manual). MRN/EOBs from both must accompany the Medi-Cal claim.
- Since Medicare non-covered, exhausted or denied services are billed as straight Medi-Cal claims, the provider must obtain a *Treatment Authorization Request* (TAR) if the service normally requires prior authorization.

  Note: For timeliness requirements, refer to “Six Month Billing Limit” in 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 non-citizen status)››
- Recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage

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

    Note: For all MRNs showing a Medicare denial, if the Medicare denial description is not printed on the front of the MRN, providers must include a separate copy of the Medicare denial description (from the back of the original MRN 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
- ‹‹Permanent Resident 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.