Medicare/Medi-Cal Crossover Claims: CMS-1500 Pricing Examples for Medical Services

Page updated: August 2020

This section illustrates Medi-Cal payment examples of Medicare/Medi-Cal claims for medical services billed on the CMS-1500 claim and correlating *Remittance Advice Details* (RAD) examples. Refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual for billing information.

Welfare and Institutions Code, Section 14109.5, limits Medi-Cal's payment of the deductible and coinsurance to an amount which, when combined with the Medicare payment, should not exceed the amount paid by Medi-Cal for similar services. This limit is applied to the sum-total of the claim. 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 the claim. For examples of Medi-Cal payments, see "Crossover Claim Payment Examples" on a following page in this section.

Payment on Crossover Claims

Medicare deductible and coinsurance amounts that are hard copy billed to the California MMIS Fiscal Intermediary for the Department of Health Care Services (DHCS), are reimbursed in the same manner as if they were automatically transferred from the Part B carrier. Medi-Cal payment is based upon the Medi-Cal allowable amount, minus any payment a provider has received from Medicare and from private insurance.

Payment on Medicare Non-Covered, Exhausted or Denied Services

Medicare non-covered, exhausted (where Medicare service limitations apply) or denied services billed directly by a provider to Medi-Cal are paid based upon the Medi-Cal allowable amount.

Remittance Advice Details

The Medi-Cal *Remittance Advice Details* (RAD) reflects each crossover service processed. For each procedure code listed on the RAD the Medicare Allowed, Medi-Cal Allowed, Computed MCR AMT (Medicare payment) and Medi-Cal Paid amounts will be shown. If Medi-Cal reduces or denies payment consideration for total claim services, an appropriate RAD message will be displayed.

Claims automatically submitted to Medi-Cal by a Part B carrier that result in a zero Medi-Cal payment are not reflected on the *Remittance Advice Details* (RAD). However, automatic crossover claims with one or more procedures processed as a 444 cutback are reflected on the RAD. This alerts providers that they may rebill the 444 cutback procedures. (See "Charpentier Rebilling" in the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual.)

RAD Messages

The most common RAD codes and messages relating to crossovers are listed below (refer to the RAD codes and messages sections in the Part 1 manual for a complete list):

‹‹Most Common RAD Codes and Messages››

RAD Code	Message
002*	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
371*	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
372	This crossover must be billed with line-specific information. Resubmit with line item information.
395	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.
442	Medicare payment meets or exceeds Medi-Cal maximum reimbursement.
443	Medi-Cal payment may not exceed the maximum amount allowed by Medi-Cal.
444**	For non-physician claims, see Charpentier billing instructions in the provider manual. Medi-Cal automated system payment does not exceed the Medicare allowed amount.
9019	Information on the claim does not match what is being billed.

Crossover Claim Payment Examples

The dollar amounts in the following payment examples are for illustration only and do not necessarily represent Medi-Cal or Medicare allowed amounts. Payment of crossover services are made in accordance with *Welfare and Institutions Code*, Section 14109.5.

Medi-Cal payment examples are:

- *Figures 1a and 1b*. 395 Medicare Non-Covered Benefit.
- *Figures 2a and 2b.* 442 Cutback (Zero Pay).
- *Figures 3a and 3b.* 443 Cutback With Deductible.
- *Figures 4a and 4b.* 443 Cutback With No Deductible
- *Figures 5a and 5b.* 444 Cutback (Charpentier Rebill).
- *Figures 6a and 6b.* Medicare Allowed Amount Adopted by Medi-Cal.

395 Medicare Non-Covered Benefits

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT "Medicare Allowed" minus "Deduct" X 80%	COINSUR "Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	BILLED TO MEDI-CAL "Deduct" plus "Coinsur"	MEDI-CAL ALLOWED Medi-Cal price on file or "Medicare Allowed", whichever is less. ("Medicare Allowed" is adopted and shown on the RAD if no Medi-Cal price is on file.)	COMPUTED MEDI-CAL AMOUNT "Medi-Cal Allowed" minus "Computed Medicare Amount"	DEDUCT PLUS COINSUR "Deduct" plus "Coinsur"	PAID AMOUNT The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	RAD CODE
99214	50.00	45.20	0.00	36.16	9.04	9.04	45.20				
93000	50.00	0.00	0.00	0.00	0.00	0.00	0.00				0395
Claim Totals	100.00	45.20	0.00	36.16	9.04	9.04	45.20	9.04	9.04	9.04	

Figure 1a: Sample Pricing for RAD Code 395 (Medicare Non-Covered Benefit)

CA MEDI-CAL
Remittance Advice
Details

TO: JOHN DOE, M.D.
400 CALIFORNIA STREET
ANYTOWN, CA 95344

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE	PAGE: 1 OF 1 PAGES
0123456789	MCARE CROSSOVER	39248026	20000617	12/03/07	

RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	ACCOM/ PROC. CODE	PATIENT ACCOUNT NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
APPROVES (RECONCILE TO FINANCIAL SUMMARY)													
DOE	90000000A90015	4069852123000	073107 073107	073107 073107	92214 93000		0001 0001	45.20	45.20				0395
BLOOD DEDUCT	TOTAL 0.00	4069852123000 0.00	073107 COINS	073107 9 04-	CUTBACK	0 00	SOC	45.20 0 00	45.20	36.16-		9.04	

EXPLANATION OF DENIAL/ADJUSTMENT CODES

0395 THIS IS A MEDICARE NON-COVERED BENEFIT, REBILL MEDI-CAL ON AN ORIGINAL CLAIM FORM, EXCEPT AID CODE 80 – QMB RECIPIENTS.

Figure 1b: RAD Code 395 Example

The Medi-Cal payment on this example is $9.04, which is the lesser of the computed Medi-Cal amount and the deductible plus coinsurance.

Line 2 of this example has a 395 RAD code. This is a Medicare non-covered benefit. To seek Medi-Cal reimbursement for this service, this claim line must be billed separately as a straight Medi-Cal claim. All 395 service lines on a single crossover claim should be billed together as a straight Medi-Cal claim.

Do not rebill any 395 service lines for Qualified Medicare Beneficiary (QMB) recipients, who are not eligible for Medi-Cal.

442 Cutback (Zero Pay)

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT "Medicare Allowed" minus "Deduct" X 80%	COINSUR "Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	BILLED TO MEDI-CAL "Deduct" plus "Coinsur"	MEDI-CAL ALLOWED Medi-Cal price on file or "Medicare Allowed", whichever is less. ("Medicare Allowed" is adopted and shown on the RAD if no Medi-Cal price is on file.)	COMPUTED MEDI-CAL AMOUNT "Medi-Cal Allowed" minus "Computed Medicare Amount"	DEDUCT PLUS COINSUR "Deduct" plus "Coinsur"	PAID AMOUNT The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	RAD CODE
99214	300.00	280.44	0.00	224.35	56.09	56.09	117.60				
71020	15.00	14.57	0.00	11.66	2.91	2.91	11.88				
93000	75.00	72.04	0.00	57.63	14.41	14.41	47.16				
Claim Totals	390.00	367.**05**	0.00	293.64	73.41	73.41	176.64	-117.**00**	73.41	0.00	442

Figure 2a: Sample Pricing for 442 Cutback (Zero Pay)

CA MEDI-CAL
Remittance Advice Details

TO: JOHN DOE, M.D.
400 CALIFORNIA STREET
ANYTOWN, CA 95344

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE	PAGE: 1 OF 1 PAGES
0123456789	MCARE CROSSOVER	39248026	20000617	09/18/07	

RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	ACCOM/ PROC. CODE	PATIENT ACCOUNT NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
APPROVES (RECONCILE TO FINANCIAL SUMMARY)													
DOE	90000000A0010 6	4069852123000	112507 112507 112507	112507 112507 112507	99214 71020 93000		0001 0001 0001	280.44 14.57 72.04	117.60 11.88 47.16				444
BLOOD DEDUCT	TOTAL 0.00	4069852123000 DEDUCT 0 00	120107 COINS	120107 77 01	CUTBACK	77 01	SOC	367.05 0 00	176.64	176.64-			442

EXPLANATION OF DENIAL/ADJUSTMENT CODES

442 MEDICARE PAYMENT MEETS OR EXCEEDS MEDI-CAL MAXIMUM REIMBURSEMENT.

Figure 2b: RAD Code 442 Example

In this example, the amount paid by Medicare exceeded the Medi-Cal maximum reimbursement, resulting in a zero Medi-Cal payment.

Typically, an automatic crossover claim resulting in a zero Medi-Cal payment will not be reflected on the RAD. However, if one or more procedures processes as a 444 cutback, the automatic zero Medi-Cal payment crossover claim will be reflected on the RAD. This alerts providers that they may rebill the 444 cutback procedures (excluding physician services). (Refer to "Charpentier Rebilling" in the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section of the appropriate Part 2 manual.)

443 Cutback With Deductible

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT "Medicare Allowed" minus "Deduct" X 80%	COINSUR "Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	BILLED TO MEDI-CAL "Deduct" plus "Coinsur"	MEDI-CAL ALLOWED Medi-Cal price on file or "Medicare Allowed", whichever is less. ("Medicare Allowed" is adopted and shown on the RAD if no Medi-Cal price is on file.)	COMPUTED MEDI-CAL AMOUNT "Medi-Cal Allowed" minus "Computed Medicare Amount"	DEDUCT PLUS COINSUR "Deduct" plus "Coinsur"	PAID AMOUNT The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	RAD CODE
99201	50.00	34.71	34.71	0.00	0.00	34.71	34.35				
Claim Totals	50.00	34.71	34.71	0.00	0.00	34.71	34.35	34.35	34.71	34.35	443

Figure 3a: Sample Pricing for 443 Cutback (With Deductible)

CA MEDI-CAL
Remittance Advice
Details

TO: BILL SMITH, M.D.
3456 OAK STREET
ANYTOWN, CA 92212

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE	PAGE: 1 OF 1 PAGES
2234567890	MCARE CROSSOVER	39248026	20000617	09/18/07	

RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	ACCOM/ PROC. CODE	PATIENT ACCOUNT NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
APPROVES (RECONCILE TO FINANCIAL SUMMARY)													
DOE	90000000A0010 6	5207859082800	070507	070507	99201		0001	34.71	34.35				
TOTAL		5207859082800	073107	073107				34.71	34.35			34.35	443
BLOOD DEDUCT	0.00	DEDUCT 34.71	COINS	00 00	CUTBACK	0 36	SOC	0 00					

EXPLANATION OF DENIAL/ADJUSTMENT CODES

443 MEDI-CAL PAYMENT MAY NOT EXCEED THE MAXIMUM AMOUNT ALLOWED BY MEDI-CAL.

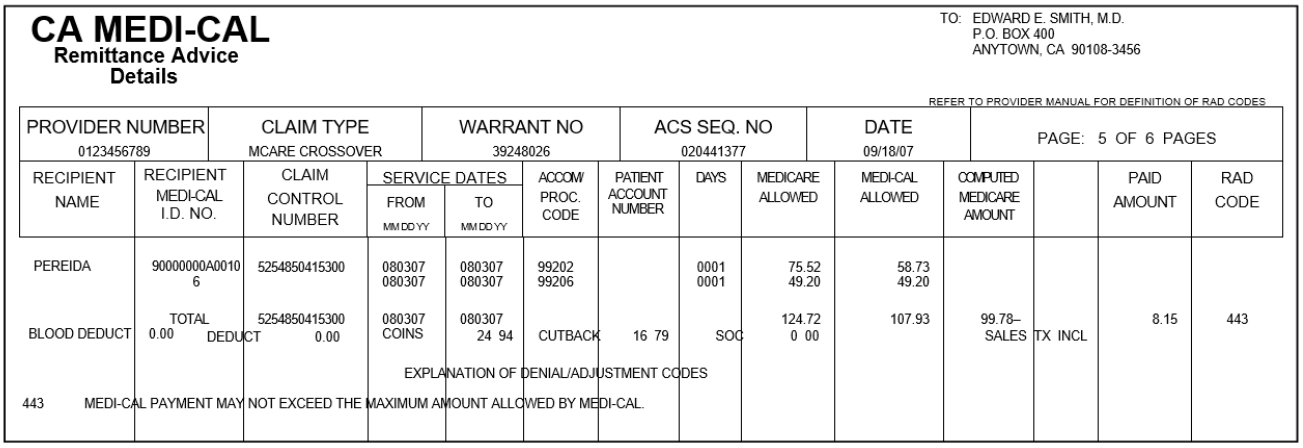
Figure 3b: RAD Code 443 Example

In this example, the deductible and coinsurance amount exceeds the maximum amount allowed by Medi-Cal, resulting in a cutback.

443 Cutback With No Deductible

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT "Medicare Allowed" minus "Deduct" X 80%	COINSUR "Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	BILLED TO MEDI-CAL "Deduct" plus "Coinsur"	MEDI-CAL ALLOWED Medi-Cal price on file or "Medicare Allowed", whichever is less. ("Medicare Allowed" is adopted and shown on the RAD if no Medi-Cal price is on file.)	COMPUTED MEDI-CAL AMOUNT "Medi-Cal Allowed" minus "Computed Medicare Amount"	DEDUCT PLUS COINSUR "Deduct" plus "Coinsur"	PAID AMOUNT The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	RAD CODE
99202	100.00	75.52	0.00	60.42	15.10	15.10	58.73				
99206	75.00	49.20	0.00	39.36	9.84	9.84	49.20				
Claim Totals	175.00	124.72	0.00	99.78	24.94	24.94	107.93	8.15	24.94	8.15	443

Figure 4a: Sample Pricing for 443 Cutback (With No Deductible)



CA MEDI-CAL
Remittance Advice
Details

TO: EDWARD E. SMITH, M.D.
P.O. BOX 400
ANYTOWN, CA 90108-3456

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE	PAGE: 5 OF 6 PAGES
0123456789	MCARE CROSSOVER	39248026	020441377	09/18/07	

RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	ACCOM/ PROC. CODE	PATIENT ACCOUNT NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
PEREIDA	90000000A0010 6	5254850415300	080307 080307	080307 080307	99202 99206		0001 0001	75.52 49.20	58.73 49.20				
BLOOD DEDUCT	TOTAL 0.00 DEDUCT 0.00	5254850415300	080307 COINS	080307 24 94	CUTBACK	16 79	SOC	124.72 0 00	107.93	99.78– SALES	TX INCL	8.15	443

EXPLANATION OF DENIAL/ADJUSTMENT CODES

443 MEDI-CAL PAYMENT MAY NOT EXCEED THE MAXIMUM AMOUNT ALLOWED BY MEDI-CAL.

Figure 4b: RAD Code 443 Example

The Medi-Cal payment on this claim is $8.15, which is the lesser of the computed Medi-Cal amount and the deductible and coinsurance.

444 Cutback (Charpentier Rebill)

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT "Medicare Allowed" minus "Deduct" X 80%	COINSUR "Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	BILLED TO MEDI-CAL "Deduct" plus "Coinsur"	MEDI-CAL ALLOWED Medi-Cal price on file or "Medicare Allowed", whichever is less. ("Medicare Allowed" is adopted and shown on the RAD if no Medi-Cal price is on file.)	COMPUTED MEDI-CAL AMOUNT "Medi-Cal Allowed" minus "Computed Medicare Amount"	DEDUCT PLUS COINSUR "Deduct" plus "Coinsur"	PAID AMOUNT The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	RAD CODE
86000	200.00	113.45	0.00	90.76	22.69	22.69	113.45				444
86001	25.00	11.91	0.00	9.53	2.38	2.38	11.91				444
Claim Totals	225.00	125.36	0.00	100.29	25.07	25.07	125.36	25.07	25.07	25.07	

Figure 5a: Sample Pricing for 444 Cutback (Charpentier Rebill)

CA MEDI-CAL
Remittance Advice Details

TO: HOME LABORATORY
2255 F STREET
ANYTOWN, CA 92345-3000

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE	PAGE: 7 OF 8 PAGES
0123456789	MCARE CROSSOVER	39248026	020226134	09/07/07	

RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	ACCOM/ PROC. CODE	PATIENT ACCOUNT NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
SALAZAR	90000000A00106	5200858954500	080207 080207	080207 080207	86000 86001		0001 0001	113.45 11.91	113.45 11.91				444 444
BLOOD DEDUCT	TOTAL 0.00 DEDUCT 0.00	5200858954500	080207 COINS	080207 25 07	CUTBACK	0 00	SOC	125.36 0 00	125.36	100.29–		25.07	

EXPLANATION OF DENIAL/ADJUSTMENT CODES

444 FOR NON-PHYSICIAN CLAIMS, SEE CHARPENTIER BILLING INSTRUCTION IN THE PROVIDER MANUAL. (MEDI-CAL/MEDICARE REIMBURSEMENT)

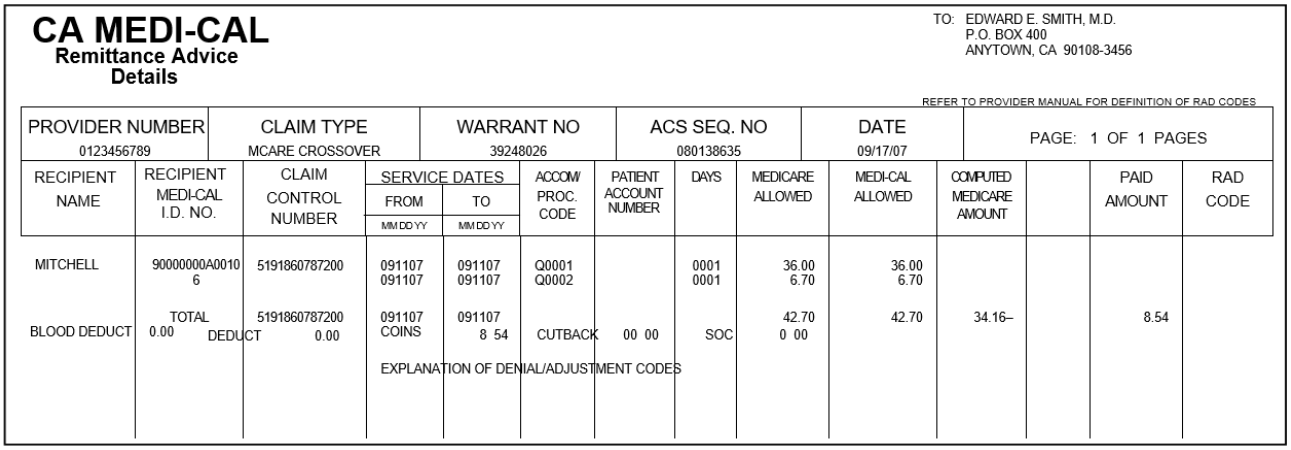
Figure 5b: RAD Code 444 Example

Providers may rebill Medi-Cal for supplemental payment for Medicare/Medi-Cal Part B services, excluding physician services. This supplemental payment applies to crossover claims when Medi-Cal's allowed rates or quantity limitations exceed the Medicare allowed amount. (Refer to "Charpentier Rebilling" in the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual.)

Medicare Allowed Amount Adopted by Medi-Cal

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT "Medicare Allowed" minus "Deduct" X 80%	COINSUR "Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	BILLED TO MEDI-CAL "Deduct" plus "Coinsur"	MEDI-CAL ALLOWED Medi-Cal price on file or "Medicare Allowed", whichever is less. ("Medicare Allowed" is adopted and shown on the RAD if no Medi-Cal price is on file.)	COMPUTED MEDI-CAL AMOUNT "Medi-Cal Allowed" minus "Computed Medicare Amount"	DEDUCT PLUS COINSUR "Deduct" plus "Coinsur"	PAID AMOUNT The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	RAD CODE
Q0001	50.00	36.00	0.00	28.80	7.20	7.20	36.00				
Q0002	10.00	6.70	0.00	5.36	1.34	1.34	6.70				
Claim Totals	60.00	42.70	0.00	34.16	8.54	8.54	42.70	8.54	8.54	8.54	

Figure 6a: Sample Pricing Example for Medicare Allowed Amount Adopted by Medi-Cal



CA MEDI-CAL
Remittance Advice Details

TO: EDWARD E. SMITH, M.D.
P.O. BOX 400
ANYTOWN, CA 90108-3456

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	ACS SEQ. NO	DATE	PAGE: 1 OF 1 PAGES
0123456789	MCARE CROSSOVER	39248026	080138635	09/17/07	

RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	ACCOM/ PROC. CODE	PATIENT ACCOUNT NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT		PAID AMOUNT	RAD CODE
MITCHELL	90000000A0010 6	5191860787200	091107 091107	091107 091107	Q0001 Q0002		0001 0001	36.00 6.70	36.00 6.70				
	TOTAL	5191860787200	091107	091107				42.70	42.70	34.16–		8.54	
BLOOD DEDUCT	0.00	DEDUCT 0.00	COINS	8 54	CUTBACK	00 00	SOC	0 00					

EXPLANATION OF DENIAL/ADJUSTMENT CODES

Figure 6b: RAD Example of Medicare Allowed Amount Adopted by Medi-Cal

Medi-Cal adopts Medicare's allowed amount and shows that amount on the RAD as follows:

- When Medi-Cal has no price on file
- When Medi-Cal's rate is higher than Medicare
- When Medicare paid 100 percent for the service
- Medi-Cal policy for a service requires payment at the Medicare rate

In these instances, Medi-Cal reimburses the full deductible and/or coinsurance billed.

‹‹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.
*	If denial code 002 or 371 is received from Medi-Cal, the claim should be resubmitted to the California MMIS Fiscal Intermediary Crossover Unit with a copy of the Medicare claim, the MRN/RA, and the RAD reflecting the denial. It is not necessary to submit a CIF under these crossover circumstances.
**	Refer to “Charpentier Rebilling” in the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section of this manual.