‹‹Medicare/Medi-Cal Crossover Claims: CMS-1500 Pricing Examples for Pharmacy››

This section illustrates Medi-Cal payment examples of Medicare/Medi-Cal claims for pharmacy services billed on the CMS-*1500* claim and correlating *Remittance Advice Details* (RAD) examples. For pharmacy services billed on the *CMS-1500* claim, refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* section in this manual.

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 are reimbursed in the same manner as if they were automatically transferred from the Part B carrier when billing using the *CMS-1500* claim. Medi-Cal payment is based upon the Medi-Cal allowable amount, minus any payment a provider has received from Medicare and from private insurance and beneficiary Share of Cost.

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 as straight Medi-Cal claims are paid based upon the Medi-Cal allowable amount.

Remittance Advice Details (RAD)

The Medi-Cal *Remittance Advice Details* (RAD) reflects each crossover service processed. In most cases, the procedure code listed on the RAD is the Medi-Cal procedure code. If Medi-Cal is unable to correlate the Medicare procedure code, the Medicare procedure code is reflected on the RAD. In addition, the Medicare Allowed, Medi-Cal Allowed, Computed MCR AMT (Medicare payment) and Medi-Cal Paid amounts are shown. If Medi-Cal reduces or denies payment consideration for total claim services, 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.†››

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):

RAD Messages Table

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 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.

RAD Messages Table (continued)

Code	Message
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.

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 is 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 Benefit

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
E0155	65.00	55.18	0.00	44.14	11.04	11.04	51.18				
E0273	50.00	0.00	0.00	0.00	0.00	0.00	0.00				0395
Claim Totals	115.00	55.18	0.00	44.14	11.04	11.04	51.18	11.04	11.04	11.04	

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

Figure 1b: RAD Code 395 Example.

The Medi-Cal payment on this example is $11.04, 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	COINSUR	BILLED TO MEDI-CAL	MEDI-CAL ALLOWED	COMPUTED MEDI-CAL AMOUNT	DEDUCT PLUS COINSUR	PAID AMOUNT	RAD CODE
				"Medicare Allowed" minus "Deduct" X 80%	"Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	"Deduct" plus "Coinsur"	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.)	"Medi-Cal Allowed" minus "Computed Medicare Amount"	"Deduct" plus "Coinsur"	The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	
L5668LT	300.00	280.44	0.00	224.35	56.09	56.09	117.60				
L8400LT	15.00	14.57	0.00	11.66	2.91	2.91	11.88				
L8420LT	75.00	72.04	0.00	57.63	14.41	14.41	47.16				
L8470LT	20.00	18.00	0.00	14.40	3.60	3.60	18.00				444
Claim Totals	410.00	385.05	0.00	308.04	77.01	77.01	194.64	-113.40	77.01	0.00	442

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

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 process 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).†››

443 Cutback With Deductible

PROC CODE	PROVIDER BILLED	MEDICARE ALLOWED	DEDUCT	COMPUTED MEDICARE AMOUNT	COINSUR	BILLED TO MEDI-CAL	MEDI-CAL ALLOWED	COMPUTED MEDI-CAL AMOUNT	DEDUCT PLUS COINSUR	PAID AMOUNT	RAD CODE
				"Medicare Allowed" minus "Deduct" X 80%	"Medicare Allowed" minus "Deduct" minus "Computed Medicare Amount"	"Deduct" plus "Coinsur"	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.)	"Medi-Cal Allowed" minus "Computed Medicare Amount"	"Deduct" plus "Coinsur"	The lesser of "Computed Medi-Cal Amount" or "Deduct plus Coinsur" (negative = 0)	
E0860V7	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).

Figure 3b: RAD Code 443 Example.

In this example, the deductible and coinsurance amount ($34.71) exceeds the Medi-Cal maximum amount ($34.35), 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
E0135V7	100.00	75.52	0.00	60.42	15.10	15.10	58.73				
K0001V6	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).

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
E0919V6	25.00	11.91	0.00	9.53	2.38	2.38	11.91				444
Claim Totals	25.00	11.91	0.00	9.53	2.38	2.38	11.91	25.07	25.07	25.07	

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

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.

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
K0005	50.00	36.00	0.00	28.80	7.20	7.20	36.00				
K0195	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.

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 when Medi-Cal has no price on file. The full deductible and/or coinsurance are paid.

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.