CIF Special Billing Instructions for Vision Care

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Claims Inquiry Forms (CIFs) submitted for Share of Cost (SOC) reimbursement and Medicare/Medi-Cal crossover claims for vision care services require unique completion instructions explained in this section. Examples of completed CIFs for these types of inquiries also are included. Refer to the CIF sections in this manual for additional billing information.

Claim Attached to CIF Requires ICD Indicator

CIFs received by the California MMIS Fiscal Intermediary on or after October 1, 2015, require an ICD indicator of "0" in the diagnosis area of the claim only if the initial claim contained an ICD-10-CM diagnosis code. CIFs accompanied by claims (as supporting documentation) without an ICD indicator will not be processed.

To update an attached *CMS-1500* claim:

Insert a "0" in the ICD Ind. area of Box 21

To update an attached UB-04 claim:

Insert a "0" in the white space below DX Box 66

Share of Cost (SOC) Claims

Submitting SOC CIFs

In addition to submission requirements in the *CIF Completion* section in this manual, use the following instructions to request SOC reimbursement for previously paid claims (see *Figure 1* on a following page in this section):

- All services on the CIF must be for SOC reimbursement.
- Share of Cost (SOC) CIFs may contain multiple claim lines, but all lines must be for the same recipient. Use each CIF to submit inquiries for only one recipient.
- Complete Boxes 7, 8, 9, 10 and 13.

Note: The CIF must contain the date of service in Box 13. Providers submitting improperly completed CIFs will receive one of four CIF denial letters, numbers 70 through 73.

- In the Remarks section, state "SOC reimbursement; MC 1054 attached."
- Attach a Share-of-Cost Medi-Cal Provider Letter (MC 1054).

Note: If requesting SOC reimbursement for denied claims or claims not previously submitted, submit the MC 1054 with the new claim.

• If SOC is reduced to other than zero, wait a minimum of 30 days before submitting a CIF.

Note: The Remittance Advice Details (RAD) will not display a specific message for an SOC reduced to zero. The RAD will display message 433 for an SOC reduced to other than zero.

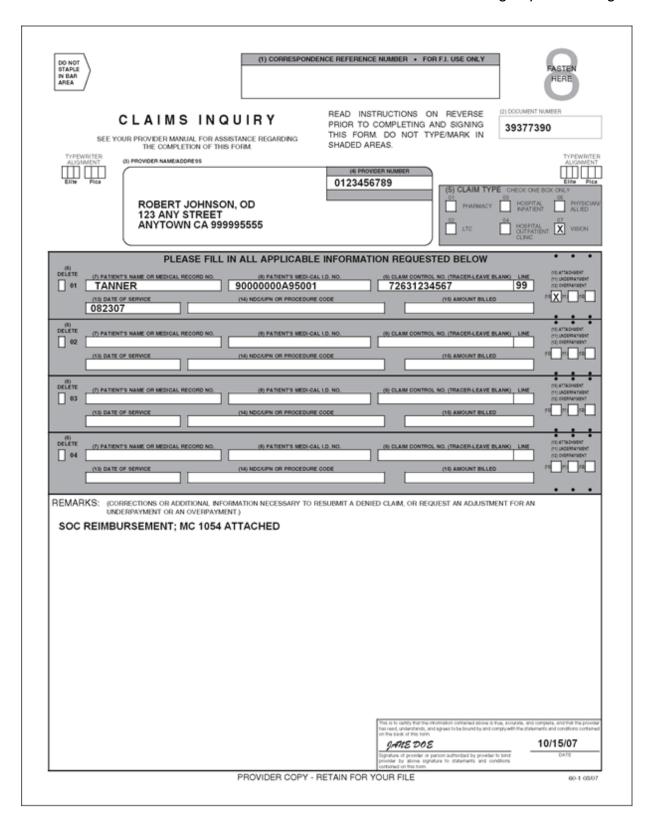


Figure 1: Sample *Claims Inquiry Form* (CIF): SOC Reimbursement for a Previously Paid Claim.

Medicare/Medi-Cal Crossover Claims

Submitting Crossover CIFs

In addition to submission requirements in the *CIF Completion* section of this manual, use the following instructions to complete a CIF for Medicare/Medi-Cal crossover claims. A CIF may be used to request reconsideration of a denied crossover claim (see *Figure 2* on a following page in this section), an adjustment of an underpaid or overpaid Medi-Cal claim, or an adjustment related to a Medicare adjustment. Refer also to the *CIF Submission and Timeliness Instructions* section in this manual for additional requirements.

Note: Charpentier claims must not be submitted on a CIF. Refer to "Charpentier Rebilling" in the *Medicare/Medi-Cal Crossover Claims: Vision Care* section of this manual for specific instructions.

Reconsideration of Denied Crossover Claims

Follow the instructions below to complete a CIF for reconsideration of a denied crossover claim:

- Submit only one crossover claim (that is, only one Claim Control Number [CCN]) for each CIF.
- Enter in Box 9 the 13-digit CCN of the most recently denied crossover claim from the *Remittance Advice Details* (RAD). This number must end with a "99" or "00".
- Mark Attachment in Box 10.
- Attach the following documentation:
 - If Part B services are billed to a Part B carrier, submit a clear copy of one of the following:
 - Original crossover claim form billed to Medi-Cal
 - Claim form billed to Medicare
 - Facsimile of the claim form submitted to Medicare (same format as CMS-1500 with visible background)
 - All claims for Part B services must include a clear copy of both of the following:
 - Medicare Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)
 - Medi-Cal RAD showing the Medi-Cal crossover denial
- In the Remarks section, indicate the denial code and include any additional information needed to correct the claim.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the Remarks section is completed.

Adjustments to Medi-Cal Crossover Payments

Follow the instructions below to complete a CIF for an adjustment to a Medi-Cal crossover payment:

- Submit only one crossover claim (that is, only one Claim Control Number [CCN]) for each CIF.
- Enter in Box 9 the 13-digit CCN of the most recent crossover payment from the *Remittance Advice Details* (RAD). This number must end with a "99" or "00".
- Mark Attachment in Box 10.
- Mark Underpayment in Box 11 or Overpayment in Box 12.
- Attach the following documentation for an adjustment <u>not</u> related to a Medicare adjustment:
 - If Part B services are billed to a Part B carrier, submit a clear copy of one of the following:
 - Original crossover claim form billed to Medi-Cal
 - Claim form billed to Medicare
 - ❖ Facsimile of the claim form submitted to Medicare (same format as CMS-1500 with visible background)
 - All claims for Part B services must include a clear copy of both of the following:
 - ❖ Medicare EOMB/MRN
 - ❖ Medi-Cal RAD showing the Medi-Cal crossover payment
- In the Remarks section, indicate the specific reason for the adjustment and the type of action desired.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the *Remarks* section is completed.

Adjustments Related to Medicare Adjustments

When Medicare automatically crosses over a Medicare adjustment, it does not include the original Medi-Cal Claim Control Number (CCN). As a result, the Medicare adjustment claim number cannot be matched to the originally submitted Medi-Cal crossover claim. These Medicare adjustments will deny as duplicates of the original crossover claim if it was approved and appear as RAD code 010 on a *Remittance Advice Details* (RAD). Therefore, to obtain correct reimbursement, providers must submit all Medicare adjustments on a CIF after they receive a RAD denial.

When completing a CIF for an adjustment as a result of a Medicare adjustment, follow these additional instructions:

- Include only one crossover claim (that is, only one Claim Control Number [CCN]) per CIF.
- Enter in Box 9 the 13-digit CCN of the most recent crossover payment from the *Remittance Advice Details* (RAD). This number must end with a "99" or "00".
- Mark Attachment (Box 10).
- Mark Underpayment (Box 11) or Overpayment (Box 12).
- Attach the following documentation for an adjustment related to a Medicare adjustment:
 - If Part B services are billed to a Part B carrier, submit a clear copy of the Medicare adjusted claim form and one of the following:
 - Original crossover claim form billed to Medi-Cal
 - Original claim form billed to Medicare
 - ❖ Facsimile of the original claim form submitted to Medicare (same format as CMS-1500 with visible background)
 - All claims for Part B services must include a clear copy of both of the following:
 - Original and adjusted Medicare EOMB/MRN
 - ❖ Medi-Cal RAD showing the Medi-Cal crossover payment or denial
- In the *Remarks* section, indicate the specific reason for the adjustment and the type of action desired.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the Remarks section is completed.

Tracing Crossover Claims

A CIF must be submitted to trace a crossover claim. Do not submit a crossover claim (*CMS-1500* and Medicare EOMB/MRN) to trace crossover claims.

Billing Tips for Crossover CIFs

Following these billing tips will help prevent rejections, delays, mispayments, and/or denials of crossover CIFs:

- Only one crossover claim (that is, only one Claim Control Number [CCN]) can be processed on a single CIF. Additional crossover claims submitted on the same CIF will be rejected.
- Always include supporting documentation with a CIF, or the claim will be denied.

Note: For information about claims that are attached to CIFs submitted on or after October 1, 2015, see the "Claim Attached to CIF Requires ICD Indicator" in this section.

- All supporting documentation must be clear, concise and complete.
- Failure to mark *Attachment* (Box 10) may cause the claim to be denied.
- Verify that the CCN in Box 9 of the CIF has 13 digits and ends with "00" or "99".
- If requesting adjustment of a crossover claim, use the approved CCN that is being requested for adjustment.
- If requesting reconsideration of a denied crossover claim, use the CCN that matches the most recently adjudicated claim.
- Failure to mark *Underpayment* (Box 11) or *Overpayment* (Box 12), when applicable, may cause a delay in claim processing.
- Do not mark Underpayment (Box 11) or Overpayment (Box 12) if submitting a CIF for reconsideration of a denial.
- Failure to complete the Remarks section of the CIF may cause claim denial or delayed processing.
- To ensure timeliness requirements are met, refer to the *CIF Submission and Timeliness Instructions* section in this manual.

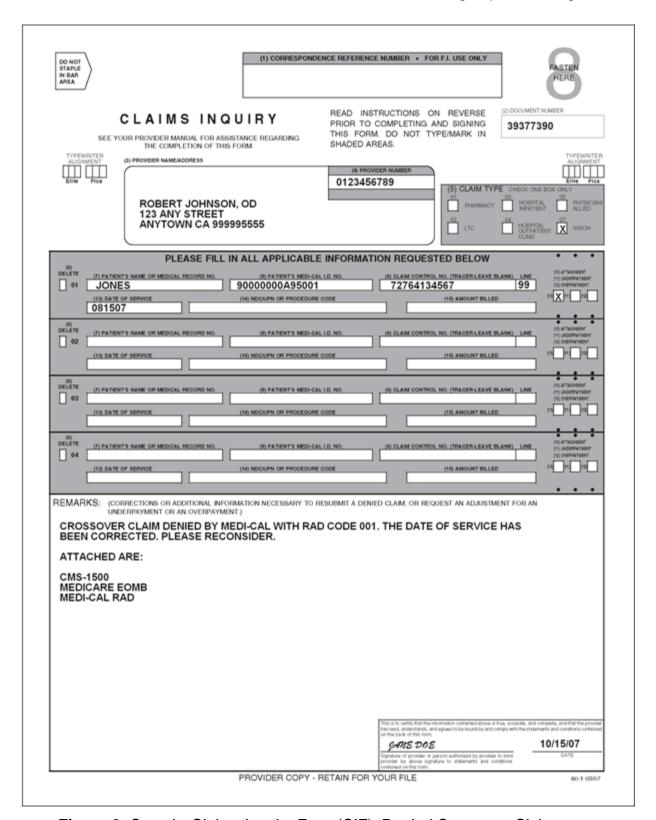


Figure 2: Sample Claims Inquiry Form (CIF): Denied Crossover Claim.

«Legend»

«Symbols used in the document above are explained in the following table.»

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