

Medi-Cal Billing and Reconciliation Webinar

Codes 18,19 & 20

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Trainer ID: T



Purpose

The purpose of this training is to provide participants with an overview of Code 18, Code 19, and Code 20 billing requirements that is used by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Services (IHS)/Memorandum of Agreement (MOA) Clinic Providers.

Objectives

- Define Billing Codes 18, 19, and 20
- Explain each code and how it is billed
- Review billing examples
- Review Top Ten Denials
- Answer questions at the end of this training

Resources

- Medi-Cal website: www.medi-cal.ca.gov
 - Provider Manual
 - Provider Bulletins
 - Medi-Cal Subscription Service
 - Medi-Cal Learning Portal
- Telephone Service Center (TSC): 1-800-541-5555
- Regional Provider Representative
- DHCS (Clinics@dhcs.ca.gov)

Provider Manual References

Part 2 - Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): [Rural](#)

Part 2 - Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): [Billing Codes](#)

Part 2 - Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): [Billing Examples](#)

Part 2 - Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, [Clinics](#)

Part 2 - Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: [Billing Codes](#)

[Part 2 - Medicare/Medi-Cal Crossover Claims: medi cr op ex, page 6](#)

Managed Care Differential Rate – Code 18

FQHC, RHC, and IHS/MOA Providers

- Code 18 – Managed Care Differential Rate

Description

- RHC, FQHC, and HIS/MOA facilities use per-visit code 18 when billing for services rendered to enrollees of Medi-Cal managed care plans (and the service is covered by the plan).
- The rate for this code approximates the difference between payments received from the managed care plan(s).
- Rendered on a per-visit basis and the Prospective Payment System (PPS) rate.
- The current billing requirement for code 01 will apply when code 18 is billed.

Dual Eligible – (Medicare Prime and Medi-Cal Managed Care Secondary) Code 18

Description

- RHC and FQHC providers bill per-visit code 18 for **Medi-Cal Managed Care** recipients.
- Primary Payer - Medicare will be either traditional or managed care and is the primary payer.
- Secondary Payer - Medi-Cal managed care plan is the secondary payer

Capitated Medicare Advantage Plan- Code 20

RHC and FQHC Providers

- Code 20 - Capitated Medicare Advantage Plans

Description

RHC and FQHC providers bill code 20 for [straight Medi-Cal recipients](#) enrolled in a capitated Medicare Advantage HMO plan.

- Primary Payer - Bill the Medicare Advantage Plan that will reimburse you on a capitation basis.
- Secondary Payer - Bill Medi-Cal code 20 for a recipient who has straight Medi-Cal and is not enrolled in a Medi-Cal managed care plan.

Special Billing Requirements for Code 18 and 20 After Billing Medicare

Normally, claims submitted to Medi-Cal for RHC and FQHC services must include proof of Medicare denial in the form of an Explanation of Medicare Benefits (EOMB), Medicare Remittance Notice (MRN), or Remittance Advice (RA).

Medicare HMO's do not provide EOMBs, MRNs, or RAs, therefore requiring you to provide specific documentation when billing your claim in Remarks or on an attachment.

Billing Requirements for Codes 18 and 20

- Enter three key facts in Remarks, Fld., 80, on the UB04 claim form
 1. Whether the facility is an RHC or FQHC
 2. That the recipient is a managed care recipient
 3. One of the following: No EOMB / No MRN / No RA

OR

- On an 8 ½” x 11” attachment to the claim, specify the following:
- FQHC (or RHC) Medi-Cal patient enrolled in a capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO.

Billing Requirements for Codes 18 and 20 (cont)

FQHC/RHC

Code 18 and 20

- Requires justification for absence of Medicare EOMB/MRN/RA
- Deductible is not included
- Do not complete Condition Codes Fields 18 - 28 for Medicare Status
- Bill your PPS Rate established for each code

Billing Examples

Managed Care Differential Rate – 18 RHC, FQHC, IHS

1 UPTOWN MEDICAL CENTER													2													3a PAT. CNTRL #			4 TYPE OF BILL																						
140 SECOND STREET																										b. MED. REC. #			711																						
ANYTOWN CA 958235555																										5 FED. TAX NO.			6 STATEMENT COVERS PERIOD FROM			7 THROUGH																			
8 PATIENT NAME						a						9 PATIENT ADDRESS						a																																	
b DOE JOHN													b													c			d			e																			
10 BIRTHDATE			11 SEX		12 DATE		ADMISSION 13 HR		14 TYPE		15 SRC		16 DHR		17 STAT		18		19		20		21		CONDITION CODES 22			23			24			25			26			27			28			29 ACCT STATE			30		
08241980			M												80																																				
31 OCCURRENCE CODE			DATE			32 OCCURRENCE CODE			DATE			33 OCCURRENCE CODE			DATE			34 OCCURRENCE CODE			DATE			35 OCCURRENCE CODE			FROM			THROUGH			36 OCCURRENCE CODE			FROM			THROUGH			37									
a																																																			
b																																																			
38													39 VALUE CODES CODE			AMOUNT			40 VALUE CODES CODE			AMOUNT			41 VALUE CODES CODE			AMOUNT																							
a																																																			
b																																																			
c																																																			
d																																																			
42 REV. CD.			43 DESCRIPTION						44 HCPCS / RATE / HIPPS CODE						45 SERV. DATE			46 SERV. UNITS			47 TOTAL CHARGES			48 NON-COVERED CHARGES			49																								
1			MANAGED CARE DIFFERENTIAL RATE						18						060111			1			45.00						1																								
2																											2																								

Managed Care Differential Rate - 18

23	001	PAGE ____ OF ____	CREATION DATE				TOTALS	45 00	23		
A	50 PAYER NAME O/P MEDI-CAL		51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 45 00	56 NPI 0123456789	A		
B							57 OTHER	B			
C							PRV ID	C			
A	58 INSURED'S NAME		59 P.FEL	60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME		62 INSURANCE GROUP NO.	A		
B									B		
C									C		
A	63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME			A	
B										B	
C										C	
A	66 DX 4139	A	B	C	D	E	F	G	H	68	
B		J	K	L	M	N	O	P	Q		
C											
A	69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73
B	74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING NPI	QUAL		
C								LAST	FIRST		
A	c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING NPI	1234567890	QUAL	
B								LAST	FIRST		
C								78 OTHER NPI	QUAL		
A	80 REMARKS		81CC a					LAST	FIRST		
B			b					79 OTHER NPI	QUAL		
C			c					LAST	FIRST		
A			d					LAST	FIRST		

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NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



Managed Care Differential Rate - 18

Billing Tips

- Bill PPS Rate for code 18 in FLD's 47 and 55
- Include condition code 80 in FLD 18
- Explanation of Benefits is not required with your claim
- Claim may be billed electronic. Hard copy billing not required.

Medi-Cal Managed Care Secondary Code 18 - RHC, FQHC

1 UPTOWN MEDICAL CENTER													2						3a PAT. CNTL.#			4 TYPE OF BILL					
140 SECOND STREET																			b. MED. REC.#			711					
ANYTOWN CA 958235555																			5 FED. TAX NO.			6 STATEMENT COVERS PERIOD FROM THROUGH			7		
8 PATIENT NAME						a						9 PATIENT ADDRESS						a									
b						DOE JOHN						b						c			d			e			
10 BIRTHDATE			11 SEX		12 DATE			ADMISSION 13 HR 14 TYPE 15 SRC			16 DHR		17 STAT		18 19 20 21 22 23 24 25 26 27 28						29 ACDT STATE			30			
08241980			M																								
31 OCCURRENCE CODE DATE			32 OCCURRENCE CODE DATE			33 OCCURRENCE CODE DATE			34 OCCURRENCE CODE DATE			35 OCCURRENCE SPAN CODE FROM THROUGH			36 OCCURRENCE SPAN CODE FROM THROUGH			37									
a			b			c			d			e			f			g									
38													39 VALUE CODES CODE AMOUNT			40 VALUE CODES CODE AMOUNT			41 VALUE CODES CODE AMOUNT								
a													b			c			d								
b													c			d			e								
c													d			e			f								
d													e			f			g								
42 REV. CD.		43 DESCRIPTION						44 HCPCS / RATE / HIPPS CODE						45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49					
1		CAPITATED MEDICARE						18						060111		1		45.00				1					
2																						2					

Medi-Cal Managed Care Secondary Code 18 RHC, FQHC

23	001	PAGE ____ OF ____	CREATION DATE				TOTALS	45 00	23		
A	50 PAYER NAME O/P MEDI-CAL		51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 45 00	56 NPI 0123456789	A		
B							57 OTHER	B			
C							PRV ID	C			
A	58 INSURED'S NAME		59 P.PREL	60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME		62 INSURANCE GROUP NO.	A		
B									B		
C									C		
A	63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME		A		
B									B		
C									C		
A	86 DX 4139	A	B	C	D	E	F	G	H	88	
B		J	K	L	M	N	O	P	Q		
C											
A	69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73
B	74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING NPI	QUAL		
C								LAST	FIRST		
A	c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING NPI	1234567890	QUAL	
B											
C											
A	80 REMARKS										
B											
C											
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OMB APPROVAL PENDING											
ALL AND ARE MADE A PART HEREOF.											

Box 80 REMARKS :
FQHC Medi-Cal patient enrolled in a capitated Medicare Advantage HMO and no EOMB received from Capitated HMO



Medi-Cal Managed Care Secondary Code 18 - RHC, FQHC

Billing Tips

- Leave Condition Codes FLD's 18 - 28 Blank
- Leave FLD 39 Blank - Do not include share of cost
- Enter PPS Rate for code 18 in FLD's 47 and 55
- Claim may be billed electronic. Hard copy billing not required.
- Enter comment in FLD 80 (Remarks FLD) or on an 8 ½" X 11" attachment due to no EOMB, MRN, or RA will be available to you to attach to the claim.

Example:

FQHC (or RHC) Medi-Cal patient enrolled in a capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO.

Capitated Medicare Advantage Plan- Code 20 - RHC, FQHC

1 UPTOWN MEDICAL CENTER													2													3a PAT. CNTL.#			4 TYPE OF BILL					
140 SECOND STREET																										b. MED. REC.#			711					
ANYTOWN CA 958235555																										5 FED. TAX NO.			6 STATEMENT COVERS PERIOD FROM THROUGH			7		
8 PATIENT NAME a													9 PATIENT ADDRESS a																					
b DOE JOHN													b													c			d			e		
10 BIRTHDATE			11 SEX		12 DATE			ADMISSION 13 HR 14 TYPE 15 SRC			16 DHR		17 STAT		18 19 20 21 22 23 24 25 26 27 28 29 ACDT STATE 30																			
08241980			M																															
31 OCCURRENCE CODE DATE			32 OCCURRENCE CODE DATE			33 OCCURRENCE CODE DATE			34 OCCURRENCE CODE DATE			35 OCCURRENCE SPAN CODE FROM THROUGH			36 OCCURRENCE SPAN CODE FROM THROUGH			37																
a			b															a																
b																		b																
38													39 VALUE CODES CODE AMOUNT			40 VALUE CODES CODE AMOUNT			41 VALUE CODES CODE AMOUNT															
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b													b			c			d															
c													c			d			e															
d													d			e			f															
42 REV. CD.		43 DESCRIPTION											44 HCPCS / RATE / HIPPS CODE			45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49										
1		CAPITATED MEDICARE											20			060111		1		45.00				1										
2																								2										

Capitated Medicare Advantage Plan- Code 20 - RHC, FQHC

23	001	PAGE	OF	CREATION DATE	TOTALS	45 00	23				
A	50 PAYER NAME O/P MEDI-CAL		51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 45 00	56 NPI 0123456789			
B							57 OTHER				
C							PRV ID				
A	58 INSURED'S NAME		59 P.FEL	60 INSURED'S UNIQUE ID 90000000A95001		61 GROUP NAME	62 INSURANCE GROUP NO.				
B											
C											
A	63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME					
B											
C											
A	86 DX 4139	A	B	C	D	E	F	G	H	68	
B		J	K	L	M	N	O	P	Q		
C											
A	69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73
B	74 PRINCIPAL PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING NPI	QUAL		
C								LAST	FIRST		
A	c	OTHER PROCEDURE CODE	DATE	d	OTHER PROCEDURE CODE	DATE	e	77 OPERATING NPI	1234567890	QUAL	
B											
C											
A	80 REMARKS										
B											
C											
UB-04 CMS-1450 © 2005 NUBC										OMB APPROVAL PENDING	
										ALL AND ARE MADE A PART HEREOF.	

Box 80 REMARKS :
 FQHC Medi-Cal patient enrolled in a capitated Medicare Advantage HMO and no EOMB received from Capitated HMO



Capitated Medicare Advantage Plan- Code 20 RHC, FQHC

Billing Tips

- Leave Condition Codes FLD's 18 - 28 Blank
- Leave FLD 39 Blank - Do not include share of cost
- Enter PPS Rate for code 20 in FLD's 47 and 55
- Claim may be billed electronic. Hard copy billing not required.
- Enter comment in FLD 80 (Remarks FLD) or on an 8 ½" X 11" attachment due to no EOMB, MRN, or RA will be available to you to attach to the claim.

Example:

FQHC (or RHC) Medi-Cal patient enrolled in a capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO.

Healthy Families Visit – Code 19

RHC, FQHC, IHS/MOA

Description

The Code 19 was created for Rural Health Clinics, Federally Qualified Health Centers, and Indian Health Services providers who render services to Children's Health Insurance Program (CHIP) recipients who are enrolled in Healthy Families Plans (HFP's).

The provider will bill the Healthy Families Health plan, and if applicable bill the Managed Care Plan and any other Third Party Payer Source. Upon receipt of payment bill the Medi-Cal Fiscal Intermediary for your Code 19 rate.

Effective Date

- Code 19 became effective October 1, 2009
- Retroactive period was October 1, 2009 through June 30, 2012
- Clinics and Centers had until June 30, 2012 to submit their claims without experiencing any cut backs in payment for timeliness.
- Submission of claims would not be cut back for timeliness during this timeframe.
- EPC was established for the claims during retroactive period and Xerox started processing these claims March 2, 2012

Aid Codes

The following aid codes identify recipients with CHIP who are enrolled in the Healthy Families Plan.

- 0C - Access for Infants and Mothers (AIM)
Infants enrolled in Healthy Families
- 8X - CHDP Gateway Healthy Families
- 9H - Healthy Families Child

Healthy Families Visit – Code 19

1 UPTOWN MEDICAL CENTER		2		3a PAT. CNTL. # 123456789		4 TYPE OF BILL 751	
140 SECOND STREET				b. MED. REC. #			
ANYTOWN CA 958235555				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 091510 THROUGH 101510	
8 PATIENT NAME a		9 PATIENT ADDRESS a					
b DOE JANE		b		c		d	
10 BIRTHDATE 08242000		11 SEX F		ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT		CONDITION CODES 22 23 24 25 26 27 28	
31 OCCURRENCE CODE DATE 100110		32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE	
35 OCCURRENCE SPAN CODE FROM THROUGH		36 OCCURRENCE SPAN CODE FROM THROUGH		37			
38 HEALTHY FAMILIES WRAP P.O. BOX 15600 SACRAMENTO, CA 95852-1600		39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT	
42 REV. CD. 1 520		43 DESCRIPTION HEALTHY FAMILIES DIFFERENTIAL		44 HCPCS / RATE / HIPPS CODE 19		45 SERV. DATE 100110	
46 SERV. UNITS 1		47 TOTAL CHARGES 75 00		48 NON-COVERED CHARGES		49	

Healthy Families Visit – Code 19

23	001	PAGE	OF	CREATION DATE	TOTALS	75.00	23				
A	50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 AS G BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0123456789	
B	O/P MEDI-CAL							75.00	57		
C									OTHER		
A	58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.			
B				BIC/CIN #							
C											
A	63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME			
B											
C											
A	66 DX	67	A	B	C	D	E	F	G	H	68
B		49311	J	K	L	M	N	O	P	Q	
C											
A	69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PP'S CODE	72 ECI	a	b	c	73
B	74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING NPI	QUAL		
C								LAST	FIRST		
A	c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING NPI	1234567890	QUAL	
B								LAST	FIRST		
C								78 OTHER NPI	QUAL		
A	80 REMARKS		81CC a					LAST	FIRST		
B			b					79 OTHER NPI	QUAL		
C			c					LAST	FIRST		
A			d					LAST	FIRST		
B											
C											

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CHIP Recipients Enrolled in Healthy Families Plans

Billing Tips

Code 19 – Children’s Health Insurance Program (CHIP) Healthy Family Program Visit

- Bill this code after billing Healthy Families
- The rate to bill is established by Audits and Investigations
- Bill with the recipients BIC/CIN ID number
- ID Number starts with a 9 and ends in alpha character. Must be 9 digits
- ID Number starting with an 8 and having 8 digits is not acceptable
- May be billed by RHC, FQHC, and IHS/MOA providers with rate established
- Claim may be billed electronic. Hard copy billing not required.

Part 2, rural ex, pages 4 & 5

Medicare / Medi-Cal Crossover Claim - Code 02 RHC,FQHC,IHS

- Code 02 can be billed by an RHC, FQHC, or IHS/MOA provider who has this code established.
- In order to bill code 02 it means the clinic has received payment from straight Medicare or a Medicare Advantage Plan and **is being paid on a fee-for-service basis.**

Medicare / Medi-Cal Crossover Claim - Code 02 RHC,FQHC,IHS

1 UPTOWN MEDICAL CENTER													2		3a PAT. CNTL.#			123456789			4 TYPE OF BILL																							
140 SECOND STREET													b. MED. REC.#						711																									
ANYTOWN CA 958235555													5 FED. TAX NO.			6 STATEMENT COVERS PERIOD FROM THROUGH			7																									
8 PATIENT NAME						a						9 PATIENT ADDRESS						a																										
b						DOE JANE						b						c						d						e														
10 BIRTHDATE			11 SEX	12 DATE			ADMISSION 13 HR			14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES			22	23	24	25	26	27	28	29 ACDT STATE	30															
08241980			F																																									
31 OCCURRENCE CODE			DATE			32 OCCURRENCE CODE			DATE			33 OCCURRENCE CODE			DATE			34 OCCURRENCE CODE			DATE			35 OCCURRENCE SPAN CODE			FROM			THROUGH			36 OCCURRENCE SPAN CODE			FROM			THROUGH			37		
a																																												
b																																												
38													39 VALUE CODES CODE			AMOUNT			40 VALUE CODES CODE			AMOUNT			41 VALUE CODES CODE			AMOUNT																
a																																												
b																																												
c																																												
d																																												
42 REV. CD.		43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE				45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49																				
1		CROSSOVER CLAIM										02				110307		1		75 00																								
2																																												

Medicare / Medi-Cal Crossover Claim - Code 02 RHC,FQHC,IHS

23 001 PAGE ____ OF ____		CREATION DATE				TOTALS →		75 00		23	
50 PAYER NAME O/P MEDI-CAL			51 HEALTH PLAN ID		82 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 75 00		56 NPI 0123456789
58 INSURED'S NAME			59 P.REL	60 INSURED'S UNIQUE ID 90000000A95001			61 GROUP NAME		62 INSURANCE GROUP NO.		
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME			
66 DX 4118		A		B		C		D		E	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73		68	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75		76 ATTENDING NPI		QUAL	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE		75		77 OPERATING NPI		QUAL	
80 REMARKS			81 CC a		b		78 OTHER NPI		QUAL		
			c		d		79 OTHER NPI		QUAL		

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Medicare / Medi-Cal Crossover Claim - Code 02

Billing Tips

- Bill code 02 claims hard copy
- Attach copy of EOMB / MRN/ RA to your claim
- Bill PPS Rate established for code 02
- Do not complete Condition Codes Fld's 18 - 28 for Medicare Status

Quick Reference Billing Tool

Code	Primary	Secondary
02	Straight Medicare or Medicare Advantage Plan paying the clinic on a Fee-for-Service basis	Straight Medi-Cal . Patient is not in a Medi-Cal managed care plan. Bill Medi-Cal for the PPS rate.
18	Medi-Cal managed care plan pays clinic on a Fee for Service or on a capitation basis. Recipient does not have Medicare.	Bill Medi-Cal for the PPS Rate known as the wrap around rate.
18	Medicare is either traditional Medicare or managed care Medicare.	Recipient in Medi-Cal managed care plan . Bill Medi-Cal for the PPS rate.
20	Medicare Advantage Plan reimbursing on a capitation basis.	Straight Medi-Cal. Recipient does not have a Medi-Cal managed care plan. Bill Medi-Cal for the PPS rate.
19	Healthy Families	Medi-Cal for wrap around rate. Bill PPS rate.

Top Ten Denials

1 RAD Code 0250

Quantity exceeds allowed for per-visit codes, or a claim with the same date of service and the same per-visit code was found in history. Medical justification required.

Prevention Tips

- Provide medical justification in the remarks field of the UB04 claim form (Box 80) or on an attachment.

Note: You can have 2 medical visits or a medical visit and dental visit on the same date of service. However, your medical justification will need to indicate this information.

2 RAD Code 0008

The provider of service is not eligible for the type of services billed.

Prevention Tips

- Verify correct claim form is used for services.
- Verify provider number is correct.
- Verify that code being billed has been added for you to bill.
- You will be notified by Audits and Investigations when a PPS code has been added to your NPI for your clinic.
- You may also call the Telephone Servicer Center and they will advise if it on file for your clinic.

3 RAD Code 0314

Recipient is not eligible for the month of service billed.

Prevention Tips

- Verify that the recipient has a SOC (Share of Cost) and is eligible for the month of service.
- Share of cost can be cleared and obligated to the recipient

4 RAD Code 0036

RTD (Resubmission Turnaround Document) was either not returned or uncorrected; therefore, your claim is formally denied.

Prevention Tips

- Correct your claim and rebill either hard copy or electronic if still within 6 months following the month of service.
- Submit a CIF within 6 months from the last RAD date
- Submit an Appeal within 90 days from the last RAD date

5 RAD Code 0250

Quantity exceeds allowed for per-visit codes, or a claim with the same date of service and the same per-visit code was found in history. Medical justification required.

Prevention Tips

- Provide medical justification in the remarks field of the UB04 claim form (Box 80) or on an attachment.
- Note: You can have 2 medical visits or a medical visit and dental visit on the same date of service. However, your medical justification will need to indicate this information.

6 RAD Code 0010

This service is a duplicate of a previously paid claim.

Prevention Tips

Check records for previous payment. If no payment is found, verify:

- Provider number
- Recipient number
- “From-thru” date of service
- Procedure code
- Modifier
- Rendering provider number

7 RAD Code 0046

SSN (Social Security Number) is not permitted for billing Medi-Cal

Prevention Tips

- Medi-Cal requires a 9 digit BIC/CIN number when billing for Medi-Cal recipients.
- If you don't have the BIC number you can run eligibility with a social security number and if the BIC number comes back you can use the BIC number to determine eligibility.
- Take the last four numbers to determine the issue date. Once this is done you can verify eligibility once more using the issue date and then bill Medi-Cal.
- If recipient is a Healthy Families recipient with an 8 digit number this will not be a valid ID number to bill with.

8 RAD Code 0657

Recipient not eligible for Medi-Cal benefits until payment/denial information is given from other insurance carrier.

Prevention Tips

- Be sure when billing for codes 18 and 20 that you include the following statement in remarks (FLD 80) or on an attachment:

FQHC (or RHC) Medi-Cal patient enrolled in a capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO.

9 RAD Code 0640

Recipient is not eligible for Medi-Cal benefits without complete denial of coverage from the Medicare Health Maintenance Organization (HMO), Competitive Medical Plan (CMP) or Health Care Prepayment Plan (HCPP). Medi-Cal is not obligated for plan services when the recipient chooses not to go to a plan provider.

Prevention Tips

- Verify eligibility prior to rendering services to ensure recipient is covered.
- Be sure to include the following statement in remarks or on an attachment:

FQHC (or RHC) Medi-Cal patient enrolled in a capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO.

10 RAD Code 9939

The provider type or recipient aid code is not payable for Healthy Families PPS (Prospective Payment System).

Prevention Tips

- Verify that you have code 19 on file and have a rate established prior to billing.
- Code 19 only covers recipients with the following aid codes:
0C, 8X, and 9H
- * Verify eligibility to ensure the recipient is a Healthy Families recipient.

Follow Up on Denied Claims

- Correct your claim and rebill if you are still within 6 months following the month of service.
- Correct your claim and submit a CIF if you are within 6 months from your last RAD date.
- Correct your claim and submit an Appeal if you are within 90 days from your last RAD date.

Summary

- Defined Codes 18, 19, and 20
- Defined Code 02
- Explained specific billing requirements
- Reviewed claim examples
- Reviewed Top Ten Denials

Any questions?

Thank You.

Please Complete Your Evaluation.

FHQC, RHC, IHS/MOA

Presented by: Theresa Cox

Trainer ID: T

Class #:

