

Medi-Cal Provider Training 2016

Advanced Billing: Long Term Care





The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP's easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at <http://www.medi-cal.ca.gov/education.asp>.

Free Services for Providers

Provider Seminars and Webinars

Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives

The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit

The four SPBU Specialists are dedicated to providing one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the SPBU Billing Assistance and Training Program, call 916-636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

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LTC (25-1) Claim Completion

Introduction

Purpose

The purpose of this module is to explain the basic requirements for completing the *Payment Request for Long Term Care (25-1)* claim form. Common billing errors, billing tips and claim timeliness will be explained.

Module Objectives

- Identify the Medi-Cal provider manual section that describes the *Payment Request for Long Term Care (25-1)* claim form
- Identify general billing guidelines for the *Payment Request for Long Term Care (25-1)* claim form
- Review completion requirements for the *Payment Request for Long Term Care (25-1)* claim form
- Highlight common billing errors and how to avoid them
- Discuss billing tips

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

CMC Enrollment Procedures (cmc enroll)

Part 2

Accommodation Codes for Long Term Care (accom cd ltc)

Forms Reorder Request: Guidelines (forms reo)

Other Health Coverage (OHC) (oth hlth)

Payment Request for Long Term Care (25-1) Completion (pay ltc comp)

Payment Request for Long Term Care (25-1): Submission and Timeliness Instructions (pay ltc sub)

Payment Request for Long Term Care (25-1): Tips for Billing (pay ltc tips)

Share of Cost (SOC): 25-1 for Long Term Care (share ltc)

TAR Completion for Long Term Care (tar comp ltc)

Other References

Medi-Cal website: (www.medi-cal.ca.gov)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

LTC (25-1) Claim Description

The *Payment Request for Long Term Care (25-1)* is used to submit claims for the following services:

- Nursing Facility Level A (NF-A)
- Nursing Facility Level B (NF-B)

LTC (25-1) Claim Completion Guidelines

Claim Form Submission Method

The DHCS Fiscal Intermediary (FI) uses Optical Character Recognition (OCR) equipment to scan all submitted paper billing forms. Accuracy, completeness and clarity are important. Claim forms cannot be processed if applicable information is not supplied or is illegible. To ensure that claim forms are scanned and processed efficiently, providers must adhere to standard requirements.

Paper Format

The following guidelines apply to claim forms submitted by mail:

Form Completion Instructions

- Submit the original claim form. The FI does not accept carbon copies, photocopies, computer-generated claim form facsimiles or claim forms created on laser printers. Keep a photocopy of the original claim in the patient's record.
- Separate individual claim forms. Do not staple original claims together. Stapling original claims together indicates the second claim is an attachment, not an original claim to be processed separately. Bar codes are also used to separate claims and indicate the beginning of another claim.
- Remove all perforated sides and separate each individual form. Leave a ¼-inch border on both the right and left sides after removing the perforation.
- Do not fold or crease claim forms.
- Enter all dates without slashes. Do not use punctuation, including decimal points (.), dollar signs (\$) or plus (+) or minus (-) signs when entering amounts.

LTC (25-1) Claim Form Completion

DO NOT
STAPLE IN
BAR AREA

1 CLAIM CONTROL NUMBER . FOR F.I. USE ONLY

1

FASTEN
HERE

6

PROVIDER'S NAME, ADDRESS, ZIP CODE

1A

2 Provider Number

2

128 Zip Code

PAYMENT REQUEST FOR LONG TERM CARE

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE
REGARDING THE COMPLETION OF THIS FORM

PLEASE TYPE ALL REQUIRED INFORMATION

← Typewriter Alignment →

3	PATIENT NAME	5 MEDICAL ID NUMBER	6 YR OF BIRTH	7 SEX	8 TAR CONTROL NO	9 MEDICAL RECORD NO	10 ATTEND. M.D. PROVIDER NUMBER				
11	12 DATE OF SERVICE FROM	13 THRU	14 PATIENT STATUS	15 ACCOM CODE	16 PRIM DX CODE	17 GROSS AMOUNT	18 PATIENT LIABILITY/ MEDICARE DEDUCT	18A MEDICARE TYPE	19 OTHER COVERAGE	20 NET AMOUNT BILLED	21 M.D. CERT
22	PATIENT NAME		24 MEDICAL ID NUMBER	25 YR OF BIRTH	26 SEX	27 TAR CONTROL NO	28 MEDICAL RECORD NO	29 ATTEND. M.D. PROVIDER NUMBER			
30	31 DATE OF SERVICE FROM	32 THRU	33 PATIENT STATUS	34 ACCOM CODE	35 PRIM DX CODE	36 GROSS AMOUNT	37 PATIENT LIABILITY/ MEDICARE DEDUCT	38 MEDICARE TYPE	39 OTHER COVERAGE	40 NET AMOUNT BILLED	41 M.D. CERT
42	PATIENT NAME		43 MEDICAL ID NUMBER	44 YR OF BIRTH	45 SEX	46 TAR CONTROL NO	47 MEDICAL RECORD NO	48 ATTEND. M.D. PROVIDER NUMBER			
49	50 DATE OF SERVICE FROM	51 THRU	52 PATIENT STATUS	53 ACCOM CODE	54 PRIM DX CODE	55 GROSS AMOUNT	56 PATIENT LIABILITY/ MEDICARE DEDUCT	57 MEDICARE TYPE	58 OTHER COVERAGE	59 NET AMOUNT BILLED	60 M.D. CERT
61	PATIENT NAME		62 MEDICAL ID NUMBER	63 YR OF BIRTH	64 SEX	65 TAR CONTROL NO	66 MEDICAL RECORD NO	67 ATTEND. M.D. PROVIDER NUMBER			
68	69 DATE OF SERVICE FROM	70 THRU	71 PATIENT STATUS	72 ACCOM CODE	73 PRIM DX CODE	74 GROSS AMOUNT	75 PATIENT LIABILITY/ MEDICARE DEDUCT	76 MEDICARE TYPE	77 OTHER COVERAGE	78 NET AMOUNT BILLED	79 M.D. CERT
80	PATIENT NAME		81 MEDICAL ID NUMBER	82 YR OF BIRTH	83 SEX	84 TAR CONTROL NO	85 MEDICAL RECORD NO	86 ATTEND. M.D. PROVIDER NUMBER			
87	88 DATE OF SERVICE FROM	89 THRU	90 PATIENT STATUS	91 ACCOM CODE	92 PRIM DX CODE	93 GROSS AMOUNT	94 PATIENT LIABILITY/ MEDICARE DEDUCT	95 MEDICARE TYPE	96 OTHER COVERAGE	97 NET AMOUNT BILLED	98 M.D. CERT
99	PATIENT NAME		100 MEDICAL ID NUMBER	101 YR OF BIRTH	102 SEX	103 TAR CONTROL NO	104 MEDICAL RECORD NO	105 ATTEND. M.D. PROVIDER NUMBER			
106	107 DATE OF SERVICE FROM	108 THRU	109 PATIENT STATUS	110 ACCOM CODE	111 PRIM DX CODE	112 GROSS AMOUNT	113 PATIENT LIABILITY/ MEDICARE DEDUCT	114 MEDICARE TYPE	115 OTHER COVERAGE	116 NET AMOUNT BILLED	117 M.D. CERT
118	119 PROV. REF. NO.	120 DATE BILLED									
PLEASE DO NOT MARK IN SHADED AREAS											
EXPLANATIONS: (REFERENCE SPECIFIC AREAS)											
F.I. USE ONLY											

126A

127

X

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM

25-1C 08/16

Sample: Payment Request for Long Term Care (25-1).

LTC (25-1) Field Descriptions: 1 – 4

The following table is a field-by-field description of the LTC 25-1 claim form:

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
1	CLAIM CONTROL NUMBER For FI use only. Do not mark in this area. A unique 13-digit number, assigned by the FI to track each claim, will be entered here when the FI receives the claim.	Same as Medi-Cal	Same as Medi-Cal
1A	PROVIDER'S NAME, ADDRESS Enter your name and address (of the facility) if this information is not pre-imprinted. Please confirm that this information is correct before submitting claims. ZIP CODE (Box 128) Enter the nine-digit ZIP code of the facility. NOTE The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.	Same as Medi-Cal	Same as Medi-Cal
2	PROVIDER NUMBER Enter the National Provider Identifier (NPI) if not pre-imprinted. Be sure to include all 10 characters of the NPI. Do not submit claims using a Medicare provider number (if different from the Medi-Cal number). Claims from providers and/or billing services that bill with anything other than the NPI/provider number will be denied.	Same as Medi-Cal	Same as Medi-Cal
3	DELETE If an error has been made for a particular patient, enter an "X" in this space to delete both the upper and lower lines. Enter the correct billing information on another line. When the <i>Delete</i> field is marked "X," the information on both lines will be ignored by the system and will not be entered as a claim line.	Same as Medi-Cal	Same as Medi-Cal
4	PATIENT NAME Enter the patient's name with commas between each segment of the patient's name: last, first, middle initial (without a period). Avoid nicknames or aliases. For example, for a patient named James T. Smith Jr., enter: SMITH, JAMES, T, JR	Same as Medi-Cal	Same as Medi-Cal

LTC (25-1) Field Descriptions: 5 – 10

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
5	MEDI-CAL ID NUMBER Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC).	Same as Medi-Cal	Same as Medi-Cal
6	YEAR OF BIRTH Enter the patient's year of birth in a two-digit format (YY) from the BIC. If the recipient is 100 years of age or older, enter the recipient's age and the full four-digit year of birth (CCYY) in the <i>Explanations</i> field (Box 126A).	Same as Medi-Cal	Same as Medi-Cal
7	SEX Use the capital letter "M" for male or "F" for female. Obtain the sex indicator from the BIC.	Same as Medi-Cal	Same as Medi-Cal
8	TAR CONTROL NUMBER For services requiring a <i>Treatment Authorization Request (TAR)</i> , enter the nine-digit TAR Control Number (TCN). It is not necessary to attach a copy of the TAR to the claim. Recipient information on the TAR must match the claim. Be sure the billed dates fall within the TAR-authorized dates.	Leave Blank	Leave Blank
9	MEDICAL RECORD NUMBER This is an optional field that will help providers easily identify a recipient on <i>Resubmission Turnaround Documents (RTD)</i> and <i>Remittance Advice Details (RAD)</i> . Enter the patient's medical record number, account number or other identifier in this field (maximum of five characters-either numbers or letters may be used). Whatever you enter here will appear on the RTD and RAD. Refer to the <i>Resubmission Turnaround Document (RTD) Completion</i> and <i>Remittance Advice Details (RAD)</i> sections in the <i>Part 2 Long Term Care</i> manual for more information.	Same as Medi-Cal	Same as Medi-Cal
10	ATTENDING M.D. PROVIDER NUMBER Enter the physician's NPI/provider number. Be sure the attending physician's NPI number is entered on: <ul style="list-style-type: none"> • An admit claim • An initial Medi-Cal claim for a Medicare/Medi-Cal crossover patient • A claim when there is a change in the attending physician's NPI/ provider number 	Same as Medi-Cal	Same as Medi-Cal

LTC (25-1) Field Descriptions: 11 – 13

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
11	<p>BILLING LIMIT EXCEPTIONS (DELAY REASON CODE) If there is an exception to the six-month billing limitation from the month of service, enter the appropriate delay reason code and include the required documentation. See the <i>Payment Request for Long Term Care (25-1): Submission and Timeliness Instructions</i> section (pay ltc sub) in the Part 2 <i>Long Term Care</i> manual for a complete listing of delay reason codes. The appropriate documentation must be supplied to justify the exception to the billing limitations.</p>	<p>Enter delay reason code 7 in this box if the Medi-Cal claim is submitted more than six months from the month of service. Attach a copy of the Medicare EOMB/RA.</p>	<p>Same as Part A coinsurance</p>
12, 13	<p>DATE OF SERVICE Enter the period billed using a six-digit MMDDYY (month/day/year) format for the <i>From</i> and <i>Thru</i> dates. Bill only one calendar month of service at a time. Be sure the authorization dates on the TAR cover the period billed. For example, April 5, 2016 is written "040516".</p> <p>NOTE When a patient is discharged, the thru-date of service must be the discharge date. When a patient expires, the thru-date of service must be the date of death.</p>	<p>Same as Medi-Cal</p> <p>NOTE Dates of service reflect only those days covered by coinsurance. A TAR is not required.</p>	<p>Only a one-month period may be billed on any one billing line. If the Part B Medi-Cal crossover service involves only one day, enter the same date in both the <i>From</i> and <i>Thru</i> boxes. If the services were performed over a range of dates in the same month, the "From" date is the first service date and the "Thru" date is the last service date as it appears on the Medicare claim form.</p>

LTC (25-1) Field Descriptions: 14 – 15

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description																																
14	<p>PATIENT STATUS Enter the appropriate patient status code from the list below:</p> <table border="0"> <thead> <tr> <th><u>CODE</u></th> <th><u>PATIENT STATUS</u></th> </tr> </thead> <tbody> <tr><td>00</td><td>Still under care</td></tr> <tr><td>01</td><td>Admitted</td></tr> <tr><td>02</td><td>Expired</td></tr> <tr><td>03</td><td>Discharged to acute hospital</td></tr> <tr><td>04</td><td>Discharged to home</td></tr> <tr><td>05</td><td>Discharged to another LTC facility</td></tr> <tr><td>06</td><td>Leave of absence to acute hospital (bed hold)</td></tr> <tr><td>07</td><td>Leave of absence to home</td></tr> <tr><td>08</td><td>Leave of absence to acute hospital/discharged</td></tr> <tr><td>09</td><td>Leave of absence to home/discharged</td></tr> <tr><td>10</td><td>Admitted/expired</td></tr> <tr><td>11</td><td>Admitted/discharged to acute hospital</td></tr> <tr><td>12</td><td>Admitted/discharged to home</td></tr> <tr><td>13</td><td>Admitted/discharged to another LTC facility</td></tr> <tr><td>32</td><td>Transferred to LTC status in same facility</td></tr> </tbody> </table> <p>The patient status code must agree with the accommodation code. (For example, if the status code indicates leave days, the accommodation code must also indicate leave days.)</p> <p>NOTE The FI does not require a copy of the <i>Notification of Patient Admission, Discharge or Death</i> form (MC-171) to be attached to the <i>Payment Request for Long Term Care (25-1)</i> claim form.</p>	<u>CODE</u>	<u>PATIENT STATUS</u>	00	Still under care	01	Admitted	02	Expired	03	Discharged to acute hospital	04	Discharged to home	05	Discharged to another LTC facility	06	Leave of absence to acute hospital (bed hold)	07	Leave of absence to home	08	Leave of absence to acute hospital/discharged	09	Leave of absence to home/discharged	10	Admitted/expired	11	Admitted/discharged to acute hospital	12	Admitted/discharged to home	13	Admitted/discharged to another LTC facility	32	Transferred to LTC status in same facility	Same as Medi-Cal	Same as Medi-Cal
<u>CODE</u>	<u>PATIENT STATUS</u>																																		
00	Still under care																																		
01	Admitted																																		
02	Expired																																		
03	Discharged to acute hospital																																		
04	Discharged to home																																		
05	Discharged to another LTC facility																																		
06	Leave of absence to acute hospital (bed hold)																																		
07	Leave of absence to home																																		
08	Leave of absence to acute hospital/discharged																																		
09	Leave of absence to home/discharged																																		
10	Admitted/expired																																		
11	Admitted/discharged to acute hospital																																		
12	Admitted/discharged to home																																		
13	Admitted/discharged to another LTC facility																																		
32	Transferred to LTC status in same facility																																		
15	<p>ACCOMMODATION CODE Enter the appropriate accommodation code for the type of care billed, as listed in the <i>Accommodation Codes for Long Term Care</i> section (accom cd ltc) in the Part 2 <i>Long Term Care</i> manual.</p> <p>NOTE The FI does not require that a copy of the <i>Certification for Special Program Services</i> form (HS 231) be attached to the LTC 25-1 claim form. The HS 231 form should be attached to the LTC TAR sent to the TAR Processing Center.</p>	Same as Medi-Cal	Leave Blank																																

LTC (25-1) Field Descriptions: 16 – 17

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
16	<p>PRIMARY DX (DIAGNOSIS) CODE Enter the primary ICD-10-CM diagnosis code for the following:</p> <ul style="list-style-type: none"> • Admit claims • Initial Medi-Cal claim for Medicare/Medi-Cal crossover patient • Change in diagnosis <p>All claims require an ICD indicator of "0" when billing any diagnosis code. Enter an ICD indicator for each claim.</p> <p>NOTE ICD-10-CM diagnosis codes must be three, four, five, six or seven digits, with the fourth through seventh digits included, if present. The vertical line serves as the decimal point. Do not enter the decimal point when entering this code.</p> <p>Current copies of the ICD-10-CM diagnosis codes may be ordered from:</p> <p>PMIC 4727 Wilshire Boulevard, Suite 300 Los Angeles, CA 90010 1-800-633-7467 www.pmiconline.com</p>	Same as Medi-Cal	Leave Blank
17	<p>GROSS AMOUNT When billing for full Medi-Cal coverage, compute the gross amount by multiplying the number of days by the appropriate Medi-Cal daily rate for the accommodation code listed. When entering the gross amount, do not use the symbols (\$) or (.). The pre-imprinted vertical line serves as the decimal point. Use this method when entering all dollar amounts on the LTC 25-1 claim form.</p>	Multiply the per-diem rate allowed by Medicare, by the total coinsurance days being billed and enter the total.	Enter the amount allowed by Medicare for these services directly from the Medicare EOMB/RA.

LTC (25-1) Field Descriptions: 18 – 18A

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
18	<p>PATIENT LIABILITY/MEDICARE DEDUCT</p> <p>Enter the recipient's net Share of Cost (SOC) liability. The recipient's net SOC liability is the amount billed to the recipient. The recipient's net SOC liability is determined by subtracting from the recipient's original SOC (listed on the Medi-Cal eligibility verification system) the amount expended by the recipient that qualifies under Medi-Cal rules to reduce the patient's SOC liability.</p> <p>For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items not covered by Medi-Cal. A description of non-covered services is included in the <i>Share of Cost (SOC): 25-1 for Long Term Care</i> section (share ltc) of the Part 2 <i>Long Term Care</i> manual.</p> <p>The "PATIENT LIABILITY" (SOC) entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the DHS 6114 form, Item 15 (See the <i>Share of Cost (SOC): 25-1 for Long Term Care</i> section [share ltc] in the Part 2 <i>Long Term Care</i> manual for an example). When billing the recipient for less than the SOC amount indicated by the Medi-Cal eligibility verification system, explain why in the <i>Explanations</i> field.</p>	<p>Same as Medi-Cal</p> <p><u>EXCEPTION:</u> May leave blank if SOC is zero.</p>	<p>Medicare Deductible: For a Part B crossover claim, this field is for Medicare deductible information only. Enter the deductible found on the Medicare EOMB/RA. If the Medicare deductible has already been met, leave this area blank.</p> <p>Share of Cost (SOC): For Part B crossover claims, do not include SOC (patient liability) information in this box. When the Medi-Cal eligibility verification system shows the recipient has an SOC, enter that information in the <i>Explanations</i> field of the claim. Refer to the <i>Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples</i> section (medi cr ltc ex) in the Part 2 <i>Long Term Care</i> provider manual.</p>
18A	<p>MEDICARE TYPE</p> <p>Leave blank for Medi-Cal-only claims.</p>	<p>Enter the capital letter "A" to indicate that the claim is for a Part A coinsurance billing.</p> <p>NOTE A copy of the Medicare EOMB/RA must be attached to the payment request form.</p>	<p>Enter the capital letter "B" to indicate that the claim is for a Part B coinsurance billing.</p> <p>NOTE A copy of the Medicare EOMB/RA must be attached to the payment request form.</p>

LTC (25-1) Field Descriptions: 19 – 116

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
19	<p>OTHER COVERAGE Enter the amount paid by the other insurance carrier(s) for the period billed, if applicable. Other Health Coverage (OHC) includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs.</p> <p>NOTE If the Medi-Cal eligibility verification system indicates a scope of coverage code "L" for the recipient, providers must bill other insurance carriers prior to billing Medi-Cal. For more information about OHC, refer to the <i>Other Health Coverage</i> (OHC) section (oth hlth) in the Part 2 <i>Long Term Care</i> provider manual.</p>	Enter the amount actually paid by the Medicare intermediary for the coinsurance days being billed. Attach a copy of the EOMB/RA to the payment request form.	Enter the amount Medicare paid for service(s) as shown on the Medicare EOMB/RA. Attach a copy of the EOMB/RA to the payment request form. Do not attach a copy of the <i>UB-04</i> claim form. If there is a "contract adjusted amount" on the EOMB/RA, add this figure to the Medicare paid amount and enter the total in the <i>Other Coverage</i> field.
20	<p>NET AMOUNT BILLED Enter the amount requested for this billing. To compute the net amount, subtract patient liability and OHC (if any) from the gross amount billed. If the net amount billed computes to \$00.00, enter the amount as "0000." Do not leave blank.</p> <ul style="list-style-type: none"> • Gross Amount • Patient Liability • Other Coverage • Net Amount 	Enter the total amount billed to Medi-Cal (coinsurance) as shown on the EOMB/RA from the Medicare Intermediary, less any patient liability applied to this billing line.	Enter the portion to be billed to Medi-Cal (coinsurance plus any Medicare deductible as shown on EOMB/RA from the Medicare Intermediary, minus any patient liability as shown in the <i>Explanations</i> field).
21	M.D. CERTIFICATION	Not required	Not required
22 – 116	<p>ADDITIONAL CLAIM LINES The payment request form may be used to bill services for as many as six patients. Bill only one month's services on each line.</p>	Same as Medi-Cal	Same as Medi-Cal

LTC (25-1) Field Descriptions: 117 – 127

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
117	<p>ATTACHMENTS Enter an "X" if attachments are included with the claim. Leave blank if not applicable.</p> <p><u>Reminder:</u> If this box is not marked, attachments may not be seen by the examiner, which may cause the claim to be denied. For more information regarding attachment submission, refer to the Billing Instructions of the <i>California Medicaid (Medi-Cal) Companion Guide Transaction Information</i> on the Medi-Cal website (www.medi-cal.ca.gov).</p>	Same as Medi-Cal	Same as Medi-Cal
118	<p>PROVIDER REFERENCE NUMBER Enter any number, up to seven digits, to identify this claim form in your filing system. Any combination of alpha or numeric characters may be used. The FI will reference this number on any forms sent to you that pertain to the billing data on the form. It will not be included on the RAD.</p>	Same as Medi-Cal	Same as Medi-Cal
119	<p>DATE BILLED In six-digit format, enter the date the claim is submitted for Medi-Cal payment.</p>	Same as Medi-Cal	Same as Medi-Cal
120 – 126	<p>FI USE ONLY Leave blank.</p>	Same as Medi-Cal	Same as Medi-Cal
126A	<p>EXPLANATIONS Use this area for procedures that require additional information or justification. It is essential to clearly indicate the billing line number in this area.</p>	<p>Same as Medi-Cal Use for explanations of SOC adjustments</p>	<p>Same as Medi-Cal Enter Medi-Cal SOC amount here.</p>
127	<p>SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER (REPRESENTATIVE) The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only. An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file with the FI.</p>	Same as Medi-Cal	Same as Medi-Cal

Required Claim Form Information

Form Fields	Medi-Cal Per Diem	Part A Coinsurance	Part B Crossover
3 (DELETE BOX)	When necessary	When necessary	When necessary
4 (PATIENT NAME)	Required	Required	Required
5 (RECIPIENT ID NO.)	Required	Required	Required
6 (YEAR OF BIRTH)	Required	Required	Required
7 (SEX)	Required	Required	Required
8 (TAR CONTROL NO.)	Required	Leave blank	Leave blank
9 (MEDICAL RECORD NO.)	Optional	Optional	Optional
10 (ATTENDING M.D. NO.)	Required for admit/change	Required for admit/change	Valid Medi-Cal NPI is required
11 (REASON CODE)	When necessary	When necessary	When necessary
12, 13 (DATE OF SERVICE)	Required	Required	Required
14 (PATIENT STATUS)	Required	Required	Leave blank
15 (ACCOMMODATION CODE)	Required	Required	Leave blank
16 (PRIMARY DX CODE)	Required for admit/change	Required for admit/change	Leave blank
17 (GROSS AMOUNT)	Required	Required	Required
18 (PATIENT LIABILITY MEDICARE DEDUCT.)	Medi-Cal liability SOC amount or "0". Do not leave blank.	Medi-Cal liability (SOC) when not zero.	Medicare deductible only. Enter SOC in <i>Explanations</i> area of claim.
18A (MEDICARE TYPE)	Leave blank	Required (A)	Required (B)
19 (OTHER COVERAGE)	Blank unless other health insurance billed	Required	Required
20 (NET AMT. BILLED)	Required	Required	Required

Additional Forms (Attachments)

Medi-Cal Claim Attachment Control Form (ACF)

An ACF validates the process of linking paper attachments to electronic claims.

For each electronically submitted claim requiring an attachment, a single and unique ACF must be submitted via mail or fax. Providers are required to use the 11-digit Attachment Control Number (ACN) from the ACF to populate the PWK segment of the 837 HIPAA transaction.

Attachments must be mailed or faxed to the FI at the following address:

Xerox State Healthcare, LLC
 P.O. Box 526022
 Sacramento, CA 95852
 Fax: 1-866-438-9377

NOTE

The method of transmission, by mail or by fax, must be indicated in the appropriate PWK segment and must match the method of transmission used.

Refer to the *California Medicaid (Medi-Cal) Companion Guide Transaction Information* available on the Medi-Cal website (www.medi-cal.ca.gov) for instructions on how to submit attachments to 837 v.5010A1 claims.

Attachment Policies

- All attachments must be received within 30 days of the electronic claim submission.
- The original ACF must accompany the attachments.
- To ensure accurate processing, only one ACN value (found on the ACF) will be accepted per single electronic claim and only one set of attachments will be assigned to a claim.

Denied Claim Reasons

- If an 837 v.5010A1 electronic transaction is received that requires an attachment and there is no ACN, the claim will be denied.
- If no ACF or a non-original ACF is submitted, the attachments or documentation will be returned with a reject letter to the provider or submitter.
- No photocopies of the ACF will be accepted.
- ACF with attachments must be mailed.

ACF Order/Reorder Instructions

To place an order for ACFs or to reorder forms, follow the instructions below:

- To order ACF documents, call Telephone Service Center (TSC) at 1-800-541-5555.
- To reorder forms, complete and mail the hard copy reorder form.

ACFs and envelopes will be provided FREE of charge to all providers submitting 837 v.5010A1 electronic transactions. For further information, refer to the Medi-Cal website (www.medi-cal.ca.gov) or call TSC.

<p style="font-size: 8px; color: red;">DO NOT STAPLE IN BAR AREA</p>										
<p>MEDI-CAL CLAIM ATTACHMENT CONTROL FORM STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES</p>										
<p>ATTACHMENT CONTROL NUMBER 99999999999</p> <p>PROVIDER NUMBER : (REQUIRED)</p> <p>PROVIDER NAME : _____</p> <p>PROVIDER ADDRESS : _____</p> <p style="text-align: center; font-size: 12px; color: red; opacity: 0.5;">VOID</p> <p style="text-align: center; font-size: 8px; color: red;">(PLEASE PRINT IN BLACK OR BLUE INK TO COMPLETE THIS FORM)</p>	<p style="font-size: 8px; color: red;">DO NOT WRITE IN THIS SPACE</p>									
<p style="font-size: 8px; color: red;">FOR F.I. USE ONLY</p> <table style="width: 100%; border: 1px solid black;"> <tr> <td style="text-align: center; font-size: 8px;">1</td> <td style="text-align: center; font-size: 8px;">2</td> <td style="text-align: center; font-size: 8px;">3</td> <td style="text-align: center; font-size: 8px;">4</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p style="font-size: 8px; color: red;">RETURN THIS FORM WITH ATTACHMENTS TO:</p> <p style="text-align: center; color: red;">FISCAL INTERMEDIARY P.O. BOX 526022 SACRAMENTO, CA 95852</p>	
1	2	3	4							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
<p>PROVIDER SIGNATURE DATE</p> <p>X _____</p>										
<p>USE THIS FORM AS A COVER SHEET FOR PAPER DOCUMENTATION TO SUPPORT THE ELECTRONICALLY SUBMITTED CLAIM. FOR FURTHER INFORMATION REGARDING USE OF THE ATTACHMENT CONTROL FORM SEE THE PROVIDER MANUAL.</p>										
<p>FORM NUMBER ACF-001</p>										

Sample: Medi-Cal Claim Attachment Control Form



Xerox State Healthcare, LLC
820 Stillwater Road
West Sacramento, CA 95605

Date:

ATTACHMENT CONTROL FORM REJECT LETTER

This letter is to inform you that the coversheet or Attachment Control Form (ACF) you submitted does not meet Medi-Cal standards. It has been rejected for the following reason(s):

- _____ **Invalid ACF**
(Only original ACFs provided by California Department of Health Services will be accepted)
- _____ **Missing ACF**
(Paper attachments submitted without ACF)
- _____ **Supporting documentation missing**
(ACF received without paper attachments)
- _____ **Invalid Attachment Control Number (ACN) on ACF**
(Pre-imprinted CANNOT be altered or unreadable)
- _____ **Other:** _____

Please resubmit your electronic claim if:

The resubmitted ACF has an Attachment Control Number (ACN) that differs from your original electronic claim form or;

More than 30 days have passed since you originally submitted your electronic claim.

Mail Attachments to - Fiscal Intermediary
P.O. Box 526022
Sacramento, CA 95852

If you have any questions regarding this notice or submitting attachments, please call the Telephone Service Center at 1-800-541-5555.

Sincerely,

Sample: Attachment Control Form Rejection Letter

Common Billing Errors

The following fields must be completed accurately and completely on the LTC 25-1 claim form to avoid claim suspense or denial. The following table can be found in the *Payment Request for Long Term Care (25-1): Tips for Billing* section (pay ltc tips) in the Part 2 *Long Term Care* provider manual.

Field(s)	Description	Error
Explanations	MEDICARE PART B, DUPLICATE CLAIM	<p>Billing two Part B Medicare claim lines for the same recipient with overlapping dates of service.</p> <p>Billing Tip: Enter the reason for the overlapping dates of service in the <i>Explanations</i> field. For example, "Line 1: This is not a duplicate claim. This claim is for speech therapy. Line 2: The physical therapy claim (same recipient for overlapping dates of service was billed on an earlier date [give specific date]). A copy of the claim is attached."</p>
Explanations	SHARE OF COST	<p>Failure to identify the reason for reduction in a recipient's SOC.</p> <p>Billing Tip: Identify the SOC for the patient, minus the non-covered services in the <i>Explanations</i> field. For example, "Share of Cost 300.00 (-) non-covered services 27.70 = Pat Liab/Medicare Deduct 272.30."</p>
11, 30, 49, 68, 87, 106	BILLING LIMIT EXCEPTIONS	<p>Omitting valid delay reason codes for claims submitted more than six months from the date of service.</p> <p>Billing Tip: Enter the delay reason code in the designated field.</p>
14, 33, 52, 71, 90, 109	PATIENT STATUS	<p>Entering the patient status code in the wrong field.</p> <p>Billing Tip: Enter the status code in the <i>Patient Status</i> field.</p>
15, 34, 53, 72, 91, 110	ACCOMMODATION CODE	<p>Entering the accommodation code in the wrong field.</p> <p>Billing Tip: Enter accommodation code in <i>Accommodation Code</i> field.</p>

Common Billing Errors (Continued)

Field(s)	Description	Error
19, 38, 57, 76, 95, 114	OTHER HEALTH COVERAGE	<p>Claim submitted to Medi-Cal with a billing limit exception code or delay reason code or attachment indicating that the claim was submitted to Medicare and/or OHC more than one year from the month of service.</p> <p>Billing Tip: Bill Medicare or the OHC within one year of the month of service to meet Medi-Cal timeliness requirements. Submit claim to the FI within 60 days of Medicare or OHC carrier's resolution. Use the OHC <i>Explanation of Benefits</i> date or Medicare <i>Remittance Advice</i> (RA) date to calculate timeliness.</p>
12,13, 31, 32, 50, 51, 69, 70, 88, 89, 107, 108	DATE OF SERVICE (FROM – THRU)	<p>From – Thru dates of service do not correspond with the authorized from-through dates of service on the TAR.</p> <p>Billing Tip: Verify that the dates of service on the claim match the approved dates on the TAR, or obtain a revised TAR.</p>
14, 15, 33, 34, 52, 53, 71, 72, 90, 91, 109, 110	PATIENT STATUS/ ACCOMMODATION CODE	<p>Entering an accommodation code and status code combination that is inappropriate.</p> <p>Billing Tip: Confirm that the patient status code agrees with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days).</p>

Learning Activities

Learning Activity 1: Review

Use the information below to complete the following LTC 25-1 claim form for a Medi-Cal claim.

Patient Information

- Patient (Recipient): Sharon Sharealike
- Birth date: March 3, 2004
- Address: 123 Summertime Street, Anywhere, CA 98870-4567
- Medi-Cal ID Number: 912345678A4365

Service Provided

- • TAR Control Number: 12345678911
- • Attending Physician ID: 1234567897
- • Date of Service: 05/01/15

Billing Information

- • Date Billed: 06/01/15
- • Gross Amount: \$450.00
- • Patient Liability: \$50.00
- • OHC Payment: \$100.00
- • Net Amount Billed: \$300.00
- • Billing Limit Exceptions (Delay Reason Code): "7" in Box 11

NOTES

Learning Activity 1: Answer Key

DO NOT
STAPLE IN
BAR AREA

1 CLAIM CONTROL NUMBER . FOR F.I. USE ONLY

FASTEN
HERE

PROVIDER'S NAME, ADDRESS, ZIP CODE

**123 SUMMERTIME STREET
ANYWHERE, CA 98870-4567**

2 Provider Number

PAYMENT REQUEST FOR LONG TERM CARE
STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE
REGARDING THE COMPLETION OF THIS FORM

PLEASE TYPE ALL REQUIRED INFORMATION

← Typewriter Alignment →

DELETE	PATIENT NAME	4 MEDICAL ID NUMBER	5 YR OF BIRTH	6 SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER				
1	SHAREALIKE, SHARON	912345678A4365	04		12345678911		1234567897				
BILL'G LIMIT EXCEPTIONS	DATE OF SERVICE FROM	THRU	14 PATIENT STATUS	15 ACCOM CODE	16 PRIM DX CODE	17 GROSS AMOUNT	18 PATIENT LIABILITY/ MEDICARE DEDUCT	19 MEDICARE TYPE	20 OTHER COVERAGE	21 NET AMOUNT BILLED	M.D. CERT
7	05/01/15					450 00	50 00		100 00	300 00	
2											
3											
4											
5											
6											
ATTACH. MENTS	PROV. REF. NO.	DATE BILLED	F.I. USE ONLY								
117		06/01/15									

PLEASE DO NOT MARK IN SHADED AREAS

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM

127

X _____

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM

25-1C 08/16

Review Exercise

1. To receive 100 percent of the Medi-Cal maximum reimbursement, claims should be submitted within _____ from the _____ of service.
2. Place the delay reason code in the appropriate field.
3. If the subscriber/recipient has OHC, Medicare and Medi-Cal, what is the order in which you bill?

4. Patient status codes must agree with the accommodation code on each claim.
True False
5. What is the "Patient Liability"?

Learning Activity 2

Unscramble the following words:

1. TCL _____
2. RSNUIGN FIYCAILT _____
3. TAHELH ACRE _____
4. PISNIAYCH _____
5. TATNANTED _____
6. PIETATN _____
7. MALIDEC- _____
8. TIBLYIIILEG _____
9. OCS _____
10. OIREDVPR _____
11. NIP _____
12. CDI IITRDCOAN _____

Answer Key: 1) six months, month; 2) 7, Box 11; 3) OHC, Medicare then Medi-Cal; 4) True; 5) Share of Cost

Answer Key: 1) LTC; 2) Nursing Facility; 3) Health Care; 4) Physician; 5) Attendant; 6) Patient; 7) Medi-Cal; 8) Eligibility; 9) SOC; 10) Provider; 11) NPI; 12) ICD indicator

LTC Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages when billing with the *Payment Request for Long Term Care (25-1)* claim form for Long Term Care services, providing billing advice and appropriate follow-up procedures for denials. The module lists *Remittance Advice Details (RAD)* messages and codes that are used to reconcile accounts. RAD codes appear on the Medi-Cal RAD for claims that are approved, denied, suspended or adjusted, as well as for Accounts Receivable (A/R) and payable transactions.

Module Objectives

- Identify the 10 most common claim denial messages for Long Term Care (LTC) claims
- Show common billing errors that cause denials
- Offer billing tips to prevent claim denials
- Give the appropriate follow-up procedures for listed claim denials
- Highlight the correct provider manual section for each denial

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

Eligibility: Recipient Identification Cards (elig rec crd)

Eligibility Medicare/Medi-Cal Crossover Claims Overview (medicare)

Remittance Advice Details (RAD) Codes and Messages: 001 – 099 (remit cd001)

Remittance Advice Details (RAD) Codes and Messages: 100 – 199 (remit cd100)

Remittance Advice Details (RAD) Codes and Messages: 200 – 299 (remit cd200)

Remittance Advice Details (RAD) Codes and Messages: 300 – 399 (remit cd300)

Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999 (remit cd9000)

Share of Cost (SOC) (share)

Part 2

Appeal Form Completion (appeal form)

CIF Special Billing Instructions for Long Term Care (cif sp ltc)

Payment Request for Long Term Care (25-1) Completion (pay ltc comp)

TAR Field Office Addresses (tar field)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

Claim Denial Description

Denied claims represent claims that are incomplete, services billed that are not payable or information given by the provider that is inappropriate. Many RAD codes and messages include billing advice to help providers correct denied claims. It is important to verify information on the original claim against the RAD.

10 Most Common Denial Messages

Denial #	RAD Code	Message
1	0010	This service is a duplicate of a previously paid claim.
2	0243	The TAR Control Number submitted on the claim is not found on the TAR master file.
3	0314	Recipient is not eligible for the month of service billed.
4	0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
5	0006	The date(s) of service reported on the claim is not within the TAR (<i>Treatment Authorization Request</i>) authorized period.
6	0036	RTD (<i>Resubmission Turnaround Document</i>) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
7	0171	Aid code 80 recipients are restricted to Medicare coinsurance and deductible payments.
8	0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
9	0044	Accommodation code is not appropriate for patient status code listed.
10	0005	The service billed requires an approved TAR (<i>Treatment Authorization Request</i>).

Denied Claim Follow-Up Options

When providers receive confirmation that a claim has been denied, they can pursue follow-up options to get the claim paid, depending on the reason for the denial. There are three main follow-up procedures available to providers:

- Rebill the claim
- Submit a *Claims Inquiry Form* (CIF)
- Submit an appeal
- Correspondence Specialist Unit (CSU)

Timeliness Policy

Timeliness must be adhered to for proper submission of follow-up claim forms.

Follow-Up Action	Submission Deadline
Rebill a Claim	<u>Six months</u> from the month of service
Submit a CIF	Within <u>six months</u> of the denial date (on RAD)
Submit an Appeal	Within <u>90 days</u> of the denial date (on RAD)

NOTES

CIF Submission Exceptions

Do not submit a CIF for the following Remittance Advice Details (RAD) code messages. Providers should submit an *Appeal Form* instead. A review by the appeals unit is common practice used to resolve denials if the claim has a circumstance needing intervention. Additional information is available in the *Appeal Process Overview* and *Appeal Form Completion* sections of the appropriate provider manual.

RAD Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.
0525	NCCI (National Correct Coding Initiative) void of a column 2 claim previously paid when a column 1 claim has been processed for the same provider and date of service.
9940	NCCI (National Correct Coding Initiative) claim line is billed with multiple NCCI modifiers.
9941	NCCI (National Correct Coding Initiative) column 2 procedure code is not allowed when column 1 procedure has been paid.
9942	NCCI (National Correct Coding Initiative) quantity billed is greater than the allowed MUE (Medically Unlikely Edit) quantity.

Denied Claim Follow-Up Procedures

Denial Code #1

Denied Claim Message

RAD Code: 0010	This service is a duplicate of a previously paid claim.
----------------	---

Follow-up Procedure

The appropriate follow-up procedure for RAD code 0010 is to submit an appeal within 90 days.

Billing Tips

- Check the provider number/National Provider Identifier (NPI).
- Verify the recipient's 14-character ID number.
- Check "from-thru" dates.
- Check records for previous payments. If no payment is found, verify all relevant information.
Example: Procedure code, modifier and rendering provider number/NPI
- Verify the recipient's discharge status when billing for inpatient services.

NOTE

Submitting incorrect recipient admission and discharge dates and/or incorrect patient status codes is a frequent cause of Medi-Cal claim denials. When a provider submits a claim with erroneous from-through dates or patient status, it can result in claim denials for claims billed by another provider. When this happens, the claims are denied even if the other provider billed the claim correctly. This is most often a problem when hospitals and nursing homes transfer a patient. Providers see the result of these billing conflicts on their *Remittance Advice Details* as a claim denied with RAD code 0010.

If the providers of a denied claim choose to dispute the claim and are not able to reach consensus on the dates in question, Medi-Cal could recoup the full reimbursement of the original erroneously billed claim. In this case, Medi-Cal will not make an adjustment without a correction request form from the providers.

Incorrectly paid and denied claims can result in discrepancies in provider reimbursement data and in health service records. This can impact beneficiary Share of Cost (SOC), access to services and estate recovery.

For assistance in resolving billing conflicts, providers may write to the Correspondence Specialist Unit:

Correspondence Specialist Unit
P. O. Box 13029
Sacramento, CA 95813-4029

For more information about how to correctly complete a claim, refer to one of the claim completion sections in the appropriate Part 2 provider manual.

Denial Code #3

Denied Claim Message

RAD Code: 0314	The recipient is not eligible for the month of service billed.
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Follow-up Procedure

The appropriate follow-up procedure for RAD code 0314 is to submit an appeal within 90 days.

Billing Tips

- Verify recipient's eligibility with a valid Medi-Cal Benefits Identification Card (BIC) prior to rendering service, except in an emergency.
- Verify recipient's eligibility.
- Verify if the recipient has a Share of Cost (SOC) and is eligible for the month of service.
- Collect and spend down the SOC.

NOTES

Denial Code #4

Denied Claim Message

RAD Code: 0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
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Follow-up Procedure

The appropriate follow-up procedure for RAD code 0037 is to bill the Managed Care Plan (MCP).

Billing Tips

- Verify the recipient's eligibility.
- Verify the recipient's 14-character ID number on the RAD.
- Check the county code.
- Determine the Health Care Plan (HCP).
- Bill the appropriate HCP.

NOTES

Denial Code #5

Denied Claim Message

RAD Code: 0006	The date(s) of service reported on the claim is not within the TAR (<i>Treatment Authorization Request</i>) authorized period.
----------------	--

Follow-up Procedure

The appropriate follow-up procedure for RAD code 0006 is to rebill the claim or submit a CIF within six months.

Billing Tips

- Verify date(s) of service on the claim. If incorrect, resubmit with correct date(s) of service. Verify recipient's eligibility.
- Verify the approved date(s) of service on the TAR. If incorrect, request correction of the TAR in writing from your local Medi-Cal field office.
- Refer to the *TAR Field Office Addresses* (tar field) section in the appropriate Part 2 provider manual for field office addresses.

NOTES

Denial Code #6

Denied Claim Message

RAD Code: 0036	RTD (<i>Resubmission Turnaround Document</i>) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
----------------	--

Follow-up Procedure

The appropriate follow-up procedure for RAD code 0036 is to rebill the claim.

Billing Tips

- Verify recipient’s eligibility with a valid Medi-Cal BIC prior to rendering service, except in an emergency.
- Check recipient’s name, date of birth (DOB), date of issue (DOI) and all other relevant information.
- Resubmit claim with correct information. If the RTD form is available, find out what error resulted in a denied claim.

NOTES

Denial Code #7

Denied Claim Message

RAD Code: 0171	Aid code 80 recipients are restricted to Medicare coinsurance and deductible payments.
----------------	--

Follow-up Procedure

The appropriate follow-up procedure for RAD code 0171 is to rebill the claim or submit an appeal.

Billing Tips

- If the patient is a Qualified Medicare Beneficiary (QMB) program recipient, verify that the claim is for Medicare deductible and/or coinsurance.
- Medicare non-covered services are not payable for QMB recipients, unless the recipient is eligible for Medi-Cal.
- Some Medi-Cal recipients may have additional eligibility after their Share of Cost (SOC) clears.
- Before denying services to the patient, verify billing eligibility online.

NOTES

Denial Code #8

Denied Claim Message

RAD Code: 0002	Recipient is not eligible for benefits under the Medi-Cal program or other special programs.
----------------	--

Follow-up Procedure

The appropriate follow-up procedure for RAD code 0002 is to submit an appeal within 90 days of the RAD.

Billing Tips

- Verify recipient’s SSN or the number and date of issue on the BIC. Verify the recipient’s 14-character ID number on the RAD.
- Refer to the *Eligibility: Recipient Identification Cards* section of the Part 1 provider manual for billing guidelines.

NOTES

Denial Code #9

Denied Claim Message

RAD Code: 0044	Accommodation code is not appropriate for patient status code listed.
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Follow-up Procedure

The appropriate follow-up procedure for RAD code 0044 is to rebill the claim or submit a CIF within six months.

Billing Tips

- Verify information on the approved TAR.
- Verify the patient status code.
- Verify that the accommodation code is placed in the appropriate field on the 25-1.

NOTES

Denial Code #10

Denied Claim Message

RAD Code: 0005	The service billed requires an approved TAR (<i>Treatment Authorization Request</i>).
----------------	---

Follow-up Procedure

The appropriate follow-up procedure for RAD code 0005 is to rebill the claim or submit a CIF or an appeal.

Billing Tips

- A TAR must be submitted for services that are not part of the Medi-Cal inclusive per-diem rate for nursing facilities.
- Occupational, physical, speech and psychiatric therapy rendered to NF-A or NF-B recipients requires authorization.
- The recipient must reside in an NF-A or NF-B
- The recipient must require therapy services by a trained, licensed therapist.
- The therapy service(s) must be medically necessary and/or necessary to attain or maintain the highest practicable occupational, mental and psychosocial functioning.

NOTES

Common Billing Errors

This section describes the *Payment Request for Long Term Care (25-1)* claim form fields that must be completed accurately and completely to avoid claim suspense or denial. Tips below are designed to supplement instructions in the *Payment Request for Long Term Care (25-1) Completion* section (pay ltc comp) of the Part 2 LTC provider manual.

Field(s)	Description	Error
Explanations	MEDICARE PART B, DUPLICATE CLAIM	<p>Billing two Part B Medicare claim lines for the same recipient with overlapping dates of service.</p> <p>Billing Tip: Enter the reason for the overlapping dates of service in the <i>Explanations</i> field. For example, "Line 1: This is not a duplicate claim. This claim is for speech therapy. Line 2: The physical therapy claim (same recipient for overlapping dates of service was billed on an earlier date [give specific date]). A copy of the claim is attached."</p>
Explanations	SHARE OF COST	<p>Failure to identify the reason for reduction in a recipient's SOC.</p> <p>Billing Tip: Identify the SOC for the patient, minus the non-covered services in the <i>Explanations</i> field. For example, "Share of Cost 300.00 (-) non-covered services 27.70 = Pat Liab/Medicare Deduct 272.30."</p>
11, 30, 49, 68, 87, 106	BILLING LIMIT EXCEPTIONS	<p>Omitting valid delay reason codes for claims submitted more than six months from the date of service.</p> <p>Billing Tip: Enter the delay reason code in the designated field.</p>
14, 33, 52, 71, 90, 109	PATIENT STATUS	<p>Entering the patient status code in the wrong field.</p> <p>Billing Tip: Enter the status code in the <i>Patient Status</i> field.</p>
15, 34, 53, 72, 91, 110	ACCOMMODATION CODE	<p>Entering the accommodation code in the wrong field.</p> <p>Billing Tip: Enter the accommodation code in the <i>Accommodation Code</i> field.</p>
16, 35, 54, 73, 92 and/or 111	PRIM DX CODE	<p>Claims with a diagnosis code in the <i>Prim DX Code</i> field must include the ICD indicator "0". The indicator is placed as the first digit in the field, no spaces or dashes separating it from the diagnosis code.</p>

Common Billing Errors (Continued)

Field(s)	Description	Error
19, 38, 57, 76, 95, 114	OTHER HEALTH COVERAGE	<p>Claim submitted to Medi-Cal with a billing limit exception code or delay reason code or attachment indicating that the claim was submitted to Medicare and/or OHC more than one year from the month of service.</p> <p>Billing Tip: Bill Medicare or the OHC within one year of the month of service to meet Medi-Cal timeliness requirements. Submit claim to the DHCS Fiscal Intermediary within 60 days of Medicare or OHC carrier's resolution. Use the OHC <i>Explanation of Benefits</i> date or Medicare <i>Remittance Advice</i> date to calculate timeliness.</p>
12 and 13, 31 and 32, 50 and 51, 69 and 70, 88 and 89, 107 and 108	DATE OF SERVICE (FROM – THRU)	<p>From – Thru dates of service do not correspond with the authorized from-thru dates of service on the TAR.</p> <p>Billing Tip: Verify that the dates of service on the claim match the approved dates on the TAR or obtain a revised TAR.</p>
14 and 15, 33 and 34, 52 and 53, 71 and 72, 90 and 91, 109 and 110	PATIENT STATUS/ ACCOMMODATION CODE	<p>Entering an accommodation code and status code combination that is inappropriate.</p> <p>Billing Tip: Confirm that the patient status code agrees with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days).</p>

Learning Activities

Learning Activity 1: Word Scramble

Unscramble the following words:

1. ematceRitn _____
2. OCS _____
3. alenDsi _____
4. wol-uplFo _____
5. msleTinise _____
6. ImsiaC _____
7. cRiiptene _____
8. ribesbrcSu _____
9. OHM _____
10. CDI iidtrocan _____

Learning Activity 2: Matching Terms Puzzle

Medi-Cal Knowledge: Match the words in the first column to the best available answer in the second column.

- | | |
|-----------------------------|--|
| _____ BIC | 1. Client Index Number |
| _____ CIN | 2. Resubmission Turnaround Document |
| _____ EOB | 3. Health Care Plan |
| _____ HCP | 4. Share of Cost |
| _____ MCP | 5. ID card |
| _____ POE | 6. Provider Number |
| _____ RAD | 7. Proof of Eligibility |
| _____ RTD | 8. TAR Control Number |
| _____ Spend Down | 9. Remittance Advice Details |
| _____ Authorization Request | 10. Explanation of Benefits |
| _____ TCN | 11. TAR or SAR |
| _____ DHCS | 12. Department of Health Care Services |
| _____ NPI | 13. Managed Care Plan |

Answer Key: 1) Remittance; 2) SOC; 3) Denials; 4) Follow-up; 5) Timeliness; 6) Claims; 7) Recipient; 8) Subscriber 9) HMO 10) ICD indicator
Answer Key: BIC, 5; CIN, 1; EOB, 10; HCP, 3; MCP, 13; POE, 7; RAD, 9; RTD, 2
Spend Down, 4; Authorization Request, 11; TCN, 8; DHCS, 12; NPI, 6

LTC Crossover Claims

Introduction

Purpose

The purpose of this module is to familiarize participants with the Long Term Care (LTC) claim billing process for recipients who are eligible for both Medicare and Medi-Cal.

Module Objectives

- Identify the components of LTC crossover claims through the crossover claim descriptions
- Identify the different types of Medicare health care benefits.
- Discuss Medicare/Medi-Cal information such as eligibility, authorization and Share of Cost (SOC)
- Define coverage for Qualified Medicare Beneficiary (QMB) aid code 80
- Identify specific conditions that prevent claims from automatically crossing over and direct billed claims
- Identify completion requirements for Long Term Care crossover claims
- Discuss claim follow-up and *Claims Inquiry Form* (CIF)

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

Medicare/Medi-Cal Crossover Claims Overview (medicare)

Part 2

CIF Completion (cif co)

Medicare/Medi-Cal Crossover Claims: Long Term Care (medi cr ltc)

*Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples
(medi cr ltc ex)*

Payment Request for Long Term Care (25-1) Completion (pay ltc comp)

Payment Request for Long Term Care (25-1): Tips for Billing (pay ltc tips)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

NOTES

Crossover Claim Description

Some Medi-Cal recipients are eligible for services under the federal Medicare program. For most services rendered, Medicare requires a deductible and/or coinsurance that, in some instances, is paid by Medi-Cal.

Medi-Cal recipients may be Medicare-eligible if they are 65 years or older, blind, disabled, have end-stage renal disease, or if the Medi-Cal eligibility verification system indicates Medicare coverage.

Medicare/Medi-Cal Crossover Claim Terminology

- **Crossover:** A claim billed to Medi-Cal for the Medicare deductible and coinsurance is called a crossover claim. This type of claim has been approved or paid by Medicare.
- **Deductible:** The dollar amount Medicare recipients must pay for Part A or Part B services prior to receiving Medicare benefits.
- **Coinsurance:** The remaining balance of the Medicare Allowed Amount after a Medicare payment.
- **Co-payments:** The amount required by Medicare Part C or D when services are rendered or drugs are purchased. (Providers may choose to waive these co-payments or may deny service if a recipient cannot pay this amount. Medi-Cal does not generally pay for co-payments.)
- **Health Insurance Claim (HIC) number:** The Medicare recipient's identification number.

Medicare Health Care Benefits

Scope of Coverage

Medicare divides its services into specific classifications: Part A, Part B, Part C and Part D. Recipients may be covered for Part A only, Part B only, Part D only or a combination of services.

Service Type	Description
Part A	Inpatient Hospital Services, Skilled Nursing Facility Services, Hospice and Home Health Care
Part B	Outpatient Hospital Services, Physician Services, and Home Health (if recipient is Part B eligible only)
Part C	Medicare Advantage Plans (MSA/PFFS/SNP/HMO/PPO – not crossover claims)
Part D	Prescription drugs not covered by Part A, B or C (not crossover claims)

For a more extensive and current list of Medicare-covered services, refer to the annual *Medicare & You* publication available online at (www.medicare.gov).

Part A – Inpatient Services

Medicare provides coverage for inpatient hospital services, skilled nursing facility services, hospice and home health care services under Part A. These services are reflected on the Medicare *Remittance Advice* (RA) and include the following health care services:

- Blood received in the hospital or Skilled Nursing Facility (NF-B)
- Home health services
- Hospice care
- Inpatient hospital care
- Skilled nursing facility (NF-B) care

NOTE

The services listed above are generally covered by Part A. However, if a recipient does not have Part A coverage, the Medicare Part A contractor will pay for the services otherwise covered by Part B from funds held in trust for this purpose. For NF-B services, providers may bill residual coinsurance and deductible amounts as crossover claims.

Medicare Part A skilled nursing facilities are reimbursed according to the following criteria:

Covered Days	Reimbursement
First 20 days	Medicare pays 100% of the approved amount.
21 st to 100 th day	Medicare pays all but the daily coinsurance. Medi-Cal pays the coinsurance.
Beyond 100 days	Straight Medi-Cal

Medicare Part A recipients receive a maximum benefit period of 100 days in a Nursing Facility Level B (NF-B). There is no limit to the number of benefit periods a recipient may have as long as the Medicare criteria for the break between benefit periods is met. For example, a recipient may require long term care for 30 days in January, be released from a facility for 60 consecutive days, require institutionalization again in April and begin a new benefit period.

Requirements:

- Facility must be Medicare certified.
- Recipient must have been in an acute hospital for at least three days.
- Recipient must be admitted to an NF-B within 30 days after discharge from the acute hospital.
- Recipient must continue to require NF-B level care.

Part B – Outpatient and Professional Services

Medicare provides coverage for medically necessary professional services and some preventive outpatient services under Part B eligibility. Outpatient claims (Part B services billed to Part A contractors) are reflected on the *Medicare National Standard Intermediary Remittance Advice* (MNSIRA). Providers are required to submit hard copy outpatient crossover claims with the Medicare electronic *Remittance Advice* (RA) information formatted in the MNSIRA. PCPrint Software is used to access and print the Medicare ERA in this format. The software is free and available through the Medicare Part A contractors. Part B (outpatient services) billed to Part B (contractors) medical claims are reflected on the *Medicare Remittance Notice* (MRN).

Part B outpatient and professional services include the following:

- Physician and practitioner services
- Outpatient hospital services (emergency, same-day surgery, outpatient imaging and labs)
- Blood received as an outpatient
- Home health services
- Other medical and health services, such as chiropractic services (limited)
 - Clinical trials
 - Diagnostic tests, X-rays, MRIs, CTs and others
 - Durable medical equipment
 - Emergency room and urgent care
 - Kidney dialysis services and supplies
 - Medical transportation
 - Medical supplies, including limited diabetic supplies
 - Mental health care (50 percent reimbursable)
 - Pathology and laboratory services
 - Physical and occupational therapy
 - Prescription drugs (limited)
 - Preventive services (limited)
 - Prosthetics and orthotics
 - Smoking cessation services
 - Speech-language pathology
 - Telemedicine (limited)
 - Transplant services
 - Travel health care (limited)

When recipients are no longer covered by Part A benefits in a facility, Part B claims may be submitted to Medicare for ancillary services. According to Medicare consolidated billing instructions, some Part B services are billed by LTC facilities on a *UB-04* claim to Part A intermediaries, and others are billed by physicians and suppliers on a *CMS-1500* claim directly to Part B carriers. A *Payment Request for Long Term Care (25-1)* may only be used for crossover claims billed hard copy by LTC facilities.

Brain teaser:

1. What types of services does Medicare Part A cover? _____
2. What types of services does Medicare Part B cover? _____ and _____

Answer Key: 1) Inpatient; 2) Outpatient, professional

Part C – Medicare Advantage Plans

A Medicare recipient may choose to join a Medicare Advantage Plan (MSA/PFFS/SNP/HMO/PPO) rather than receive Medicare benefits under Part A or Part B fee-for-service Medicare. These claims do not cross over.

Part D – Prescription Drugs

Medicare Part D provides coverage for prescription drug benefits that would otherwise not be covered by Part A, B or C. Providers supplying drugs to Medicare Part D-eligible recipients should file claims with the Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug (MAPD) plan in which the recipient is enrolled.

Four categories of drugs and supplies will continue to be covered by Medi-Cal:

Category	Description
Coughs and colds	Symptomatic relief
Non-prescription drugs	Part D, not Medi-Cal; covers insulin, syringes and smoking cessation products
Prescription vitamins and minerals	Select single vitamins and minerals pursuant to <i>Treatment Authorization Request</i> (TAR) or utilization restrictions. Combination vitamin and mineral products are not a benefit. Vitamins or minerals used for dietary supplementation are not a benefit.
Weight control	Anorexia, weight loss or weight gain

NOTES

Medicare/Medi-Cal Crossover Claim Policies

Recipient Coverage

Eligibility

The Medi-Cal eligibility verification system indicates a recipient's Medicare coverage. Recipients may be covered for Part A only, Part B only, Part D only or any combination of coverage. One of the following messages will be returned if a recipient has Medicare coverage:

Type of Coverage	Medicare Coverage Message
Part A	Subscriber has Part A Medicare coverage with Health Insurance Claim number (HIC) _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Part B	Subscriber has Part B Medicare coverage with HIC Number _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Parts A and B	Subscriber has Parts A and Part B Medicare coverage with HIC Number _____. Medicare-covered services must be billed to Medicare before Medi-Cal.
Parts A and D	Subscriber has Parts A and D Medicare coverage with HIC Number _____. Medicare Part A-covered services must be billed to Medicare before billing Medi-Cal.
Parts B and D	Subscriber has Parts B and D Medicare coverage with HIC Number _____. Medicare Part B-covered services must be billed to Medicare before billing Medi-Cal.
Parts A, B and D	Subscriber has Parts A, B and D Medicare coverage with HIC Number _____. Medicare Part A and Part B-covered services must be billed to Medicare before billing Medi-Cal.
Part D	Subscriber has Part D Medicare coverage with HIC number _____. Medicare Part D covered drugs need to be billed to Medicare carrier before billing Medi-Cal. Carrier name: _____, Cov: R.

Limited Income Recipient – QMB

A Qualified Medicare Beneficiary (QMB), identified with Medi-Cal aid code 80 only, is a Medicare recipient who has limited income and resources. Under this program, Medi-Cal will only pay for Medicare premiums, deductibles and coinsurance within Medi-Cal guidelines.

The following message is returned from the Medi-Cal eligibility verification system when inquiring about eligibility for a QMB with aid code 80 only:

MEDI-CAL ELIGIBILITY LIMITED TO MEDICARE COINSURANCE, DEDUCTIBLES.
PART A, B MEDICARE COVERAGE WITH HIC #_____. BILL MEDICARE
BEFORE MEDI-CAL.

As with other crossover claims, Medi-Cal pays coinsurance and/or deductibles for both Medicare Part A and Part B services on crossover claims for aid code 80 only QMBs. Medi-Cal payment, combined with the Medicare payment, will not exceed the lower of either the Medicare or Medi-Cal allowed amount. Straight Medi-Cal claims submitted for Medicare denied and non-covered services for aid code 80 only QMBs will be denied.

Medicare Payment Protection

California has a buy-in agreement with the federal government whereby the Department of Health Care Services (DHCS) pays the Medicare premiums on behalf of most individuals eligible for Medi-Cal. These individuals are therefore protected by federal Medicaid rules that preclude providers from charging recipients any sums in addition to payment made to the provider.

Claim Terms and Conditions

Authorization

A *Treatment Authorization Request* (TAR) is not required for Medicare Part A covered days, including crossover days, or Part B covered services that would not otherwise require a TAR.

However, a TAR is required for the straight Medi-Cal portion (beyond day 100) and for Medicare denied days or non-covered services.

Medi-Cal Crossover Claim Reimbursement

Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare Administrative Contractor (MAC) for processing of Medicare benefits. If Medicare approves the claim, it must then be billed to Medi-Cal as a crossover claim. California law limits Medi-Cal's reimbursement of coinsurance and deductibles billed on a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum-allowed amount for similar services. Part A and Part B Long Term Care (LTC) crossover claims are not subject to this limitation but are paid the full coinsurance and deductible billed.

Share of Cost

Providers should bill recipients for Medi-Cal Share of Cost (SOC) when applicable. Providers are strongly advised to wait until they receive the Medicare payment before collecting SOC to avoid collecting amounts greater than the Medicare deductible and/or coinsurance. Automatic crossover claims for Medi-Cal recipients with an unmet Share of Cost will deny on the Medi-Cal *Remittance Advice Details* (RAD) with RAD code **0314: Recipient is not eligible for the month of service billed**. Providers should re-bill these claims on a *Payment Request for Long Term Care* (25-1) to Medi-Cal showing the amount of the SOC collected. This amount may not be more than the coinsurance and/or deductible billed on the claim.

LTC SOC applies only to LTC providers. They cannot be cleared online.

Brainteaser

Recipients with aid code 80 have coverage that is _____ to

_____.

Answer Key: restricted; Medicare services only

Medicare/Medi-Cal Crossover Claim Billing

Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare Administrative Contractor (MAC). If Medicare approves the claim, it must then be billed to Medi-Cal as a crossover claim. However, providers must bill a straight Medi-Cal claim if the services are not covered by Medicare, Medicare benefits have been exhausted or the claim has been denied.

Crossover Claim Procedures

Automatically Billed Crossover Claims

Medicare providers bill Medicare for crossover claims in one of the following ways:

- Part A services billed to Part A contractors
- Part B services billed to Part A contractors
- Part B services billed to Part B contractors

Most Medicare-approved Part A and Part B services billed to Medicare contractors can cross over to Medi-Cal automatically. Medicare uses a consolidated Coordination of Benefits Contractor (COBC) to automatically cross over Medi-Cal claims billed to Part A and Part B contractors for Medicare/Medi-Cal-eligible recipients.

Make sure the National Provider Identifier (NPI) used on your Medicare claims is registered with Medi-Cal.

Direct Billed Claims

Most Medicare-approved Part A and Part B services billed to the Medicare Administrative Contractor cross over to Medi-Cal automatically. Claims that do not automatically cross over to Medi-Cal must be submitted as hard copy crossover claims.

The following claims may not cross over electronically and must be billed directly to Medi-Cal:

- Claims for recipients with Other Health Coverage (OHC), particular Health Care Plans or Managed Care coverage (may be submitted as straight Medi-Cal claims only)
- Unassigned claims
- Medicare 100 percent paid or 100 percent denied claims (denied claims may be submitted as straight Medi-Cal claims only)
- Claims for which Medi-Cal does not have a provider record for the NPI used on the original Medicare claim (This can happen if the NPI used for Medicare claims is not the same as the NPI registered with Medi-Cal).
- Claims that Medicare indicates were automatically crossed over to Medi-Cal, but do not appear on a Medi-Cal *Remittance Advice Details* (RAD) within four to six weeks from the MNSIRA or MRN date, or that cannot be located in the system (Part B “zero pay” claims)
 - Claims that price to pay zero, or “zero pay” claims, appear on Medi-Cal RADs for institutional providers only. For all other providers, a hard copy Medicare crossover claim must be billed to Medi-Cal for “zero pay” claims to appear on a Medi-Cal RAD.

Brainteaser

List two reasons why a crossover claim may not automatically cross over to Medi-Cal:

1. _____
2. _____

Answer Key: 1) Claim is unassigned; 2) Medicare denied 100% of the claim

Non-Crossover Claim Procedures

Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare Administrative Contractor for processing of Medicare benefits.

The following situations are not crossovers and must be billed as straight Medi-Cal:

- Medicare non-covered service
- Medicare denied services
- Medicare exhausted services
- Medicare non-eligible recipient
- Medicare Health Maintenance Organization (HMO) recipient
- Inpatient claims for recipients not covered by Part A (type of bill 12X – inpatient services for recipients with Part B-only eligibility)

Medicare Non-Covered Service

DHCS maintains a list of Medicare non-covered services that may be billed directly to the DHCS Fiscal Intermediary (FI) 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 to Medi-Cal without any Medicare payment or denial documentation. If a service or supply is not included in the chart, but was not covered by Medicare, submit the claim with the corresponding MNSIRA or MRN showing the non-covered services or supplies.

Medicare Denied Service

Medicare-denied services may only be billed as straight Medi-Cal claims with the MNSIRA/MRN attached showing the denial. When billed on a crossover claim, Medicare denied services will not be paid by Medi-Cal and may be reflected on the Medi-Cal RAD with a RAD code **0395: 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.**

Medicare Exhausted Service

If a service or supply exceeds Medicare's limitations, supporting documentation must be included with the straight Medi-Cal claim. Physical therapy and occupational therapy for Medi-Cal patients with Medicare coverage must be billed to Medicare first. After Medicare benefits for physical and occupational therapy have been exhausted, providers may bill Medi-Cal directly (claim must include a copy of the MNSIRA or MRN that shows the benefits are exhausted).

Brainteaser

What are the four types of claims that should not be billed as crossovers?

1. _____
2. _____
3. _____
4. _____

Answer Key: 1) Medicare non-covered services; 2) Medicare denied services; 3) Medicare exhausted services; 4) Medicare non-eligible recipients

Medicare Non-Eligible Recipients

Providers must submit formal documentation that indicates a recipient is not eligible for Medicare when billing straight Medi-Cal for the following recipients:

- Recipients who are 65 years or older
- Recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage

Claims submitted without documentation, or with insufficient Medicare documentation for recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage, will be denied.

Acceptable documentation for Medicare non-eligible recipients includes the following:

Document Type	Conditions
Medicare card	Showing eligibility start date after DOS (date of service)
Document <u>signed</u> , <u>dated</u> and <u>stamped</u> by Social Security Administration (SSA) or any documentation on SSA or Department of Health and Human Services (HHS) letterhead	The document is valid only for dates of service up to the end of the month of the date on the document, or the date of entitlement. Handwritten statements are acceptable if they bear an SSA stamp and contain the specific date criteria mentioned above.
Common Working File (CWF) print out or 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.

Other Health Coverage – HMO

Medi-Cal recipients who receive benefits from a Medicare-contracted Health Maintenance Organization (HMO) are identified with Other Health Coverage (OHC) code "F." Medi-Cal recipients who also have Medicare HMO coverage must seek medical treatment through the HMO. Neither the HMO nor Medi-Cal pays for services rendered by non-HMO providers.

Exception

HMO plans often cover required emergency care until the patient's condition permits transfer to the HMO's facilities. Providers should contact the HMO for emergency treatment authorization and billing instructions.

Straight Medi-Cal claims may be submitted for services not covered by the Medicare HMO plan. Claims must be accompanied by an HMO denial letter or *Explanation of Benefits* (EOB) documenting that the Medicare HMO does not cover the service.

Brain teaser:

Which OHC code is used to identify a Medicare HMO? _____.

Answer Key: F

Billing Tips – Medicare Non-Covered, Denied and Exhausted Services

Follow these billing tips to help prevent rejections, delays, misapplied payments and/or denials of claims for Medicare non-covered, denied or exhausted services:

- Bill as straight Medi-Cal claims. Use the *Payment Request for Long Term Care (25-1)* claim form.
- Attach a copy of the MNSIRA or MRN.
- Obtain a TAR if the service normally requires authorization.
- For a Medicare recipient who also has OHC, bill the OHC before billing Medi-Cal.
- Ensure that the MNSIRA/MRN shows the reason for denial. If a Medicare denial description is not printed on the front of an MNSIRA/MRN that shows a Medicare-denied service, copy the Medicare denial description from the back of the original MNSIRA/MRN, or from the Medicare manual, and submit it to Medi-Cal with the claim. This applies to any service denied by Medicare for any reason.
- For MNSIRAs and MRNs showing both Medicare approved and non-approved services, only include non-approved services on the straight Medi-Cal claim.

NOTES

Crossover Claim Submission

Timeliness

Original Medi-Cal claims must be received by the FI within six months following the month in which services were rendered.

NOTE

If the crossover claim has a date of service beyond six months from the month of service, the crossover claim may be submitted within 60 days from the Medicare *Remittance Advice* (RA) date.

Claims received beyond the timeliness guidelines require a delay reason code, justification in the remarks section of the claim and the necessary attachments in order to receive full reimbursement.

Mailing Instructions

Medicare/Medi-Cal crossover claims for Medicare paid services that do not automatically cross over, or that cross over but cannot be processed and are rejected, may be billed by hard copy directly to Medi-Cal. Providers must submit hard copy crossover claims to:

Attn: Crossover Unit
Xerox State Healthcare, LLC
P.O. Box 15400
Sacramento, CA 95851-1400

Hard Copy Submission Requirements

For detailed hard copy billing instructions, refer to the Part 2 provider manual sections *Payment Request for Long Term Care (25-1) Completion* (pay ltc comp) and *Medicare/Medi-Cal Crossover Claims: Long Term Care* (medi cr ltc).

Follow these instructions to bill for services rendered using the 25-1 claim form:

Box #	Form Fields	Instructions
1	CLAIM CONTROL NUMBER	For Fiscal Intermediary (FI) use only. Do not mark in this area. A unique 13-digit number, assigned by the FI to track each claim, will be entered here when the FI receives the claim.
1A and Box 128	PROVIDER'S NAME, ADDRESS ZIP CODE	Enter your name and address (of the facility) if this information is not pre-imprinted. Please confirm that this information is correct before submitting claims. Enter the nine-digit ZIP code of the facility. NOTE The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.
2	PROVIDER NUMBER	Enter the NPI if not pre-imprinted. Be sure to include all <u>10</u> characters of the NPI. Do not submit claims using a provider number if different from the NPI registered with Medi-Cal. Claims from providers and/or billing services that bill with other than the NPI/provider number may be denied.
3	DELETE	If an error has been made for a particular patient, enter an "X" in this space to delete both the upper and lower lines. Enter the correct billing information on another line. When the <i>Delete</i> box is marked "X," the information on both lines will be ignored by the system and will not be entered as a claim line.
4	PATIENT NAME	Patient name must match the Medicare RA. All <i>Patient Name</i> fields (Boxes 4, 23, 42, 61, 80, 99) require commas between each segment of the patient's name: last, first, middle initial (without a period). For example, for a patient named James T. Smith Jr., enter: SMITH, JAMES, T, JR
5	MEDI-CAL IDENTIFICATION NUMBER	Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC).
6	YEAR OF BIRTH	Enter the patient's year of birth in a two-digit format (YY) from the BIC. If the recipient is 100 years of age or older, enter the recipient's age and the full four-digit year of birth (CCYY) in the <i>Explanations</i> area (Box 126A).

Box #	Form Fields	Instructions
7	SEX	Use the capital letter "M" for male or "F" for female. Obtain the sex indicator from the BIC.
8	TAR CONTROL NUMBER	Leave blank unless the claim is for a Medicare non-covered, denied, or exhausted service that normally requires a TAR. If a TAR is required, enter the nine-digit TAR Control Number (TCN). It is not necessary to attach a copy of the TAR to the claim. Recipient information on the TAR must match the claim. Be sure the billed dates fall within the TAR-authorized dates.
9	MEDICAL RECORD NUMBER	This is an optional field that will help providers easily identify a recipient on <i>Resubmission Turnaround Documents</i> (RTD) and <i>Remittance Advice Details</i> (RAD). Enter the patient's medical record number, account number or other identifier in this field (maximum of five characters – either numbers or letters may be used). Whatever you enter here will appear on the RTD and RAD.
10	ATTENDING M.D. PROVIDER NUMBER	Enter the physician's NPI. Be sure the attending physician's NPI number is entered on: <ul style="list-style-type: none"> • An admit claim • An initial Medi-Cal claim for a Medicare/Medi-Cal crossover patient • A claim when there is a change in the attending physician's NPI
11	BILLING LIMIT EXCEPTIONS (DELAY REASON CODE)	Enter delay reason code 7 in this box if the Medi-Cal claim is submitted more than six months from the month of service. Attach a copy of the Medicare <i>Explanation of Medicare Benefits</i> (EOMB)/ <i>Remittance Advice</i> (RA).
12/13	DATE OF SERVICE	Enter the period billed using a six-digit MMDDYY [Month, Day, Year] format for the FROM and THRU dates. Bill only one calendar month of service at a time. Be sure the authorization dates on the TAR cover the period billed. For example, "April 5, 2007" is written "040507." NOTE When a patient is discharged, the thru date of service must be the discharge date. If a patient expires, the thru date of service must be the date of death. Part A Coinsurance: Dates of service reflect only those dates covered by coinsurance. No TAR required. Part B Crossover: Only a one-month period may be billed on any one billing line. If the Part B Medi-Cal Crossover service involves only one day, enter the <u>same</u> date in both the FROM and THRU boxes. If the services were performed over a range of dates in the same month, the FROM date is the first service date and the last service date is as it appears on the Medicare form.

Box #	Form Fields	Instructions
14	PATIENT STATUS	<p>Enter the appropriate patient status code.</p> <p>The patient status code must agree with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days).</p> <p>NOTE The DHCS Fiscal Intermediary (FI) does not require a copy of Form MC-171 (<i>Notification of Patient Admission, Discharge, or Death</i>) to be attached to the <i>Payment Request for Long Term Care</i> form.</p>
15	ACCOMMODATION CODE	<p>Enter the appropriate accommodation code for the type of care billed, as listed in the <i>Accommodation Codes for Long Term Care</i> section of the manual.</p> <p>Part B Crossover: Leave blank.</p> <p>NOTE The FI does not require that a copy of Form HS 231 (<i>Certification for Special Program Services</i>) be attached to the <i>Payment Request for Long Term Care (25-1)</i>. Form HS 231 should be attached to the LTC TAR sent to the Medi-Cal field office.</p>
16	PRIMARY DX (DIAGNOSIS) CODE	<p>Enter the Primary ICD-10-CM diagnosis code for the following:</p> <ul style="list-style-type: none"> • ICD Indicator “0” must precede primary diagnosis code in all <i>Primary Diagnosis Code</i> fields (Boxes 16, 35, 54, 73, 92 or 111). • Admit claims • Initial Medi-Cal claim for Medicare/Medi-Cal crossover patient • Change in diagnosis <p>NOTE ICD-10-CM coding must be three, four, five, six or seven digits with the fourth through seventh digits included, if present. The vertical line serves as the decimal point. Do not enter the decimal point when entering this code.</p> <p>Part B Crossover: Leave blank.</p>
17	GROSS AMOUNT	<p>Part A Coinsurance: Multiply the per diem rate allowed by Medicare, by the total coinsurance days being billed and enter the total.</p> <p>Part B Crossover: Enter the amount <u>allowed</u> by Medicare for these services directly from the Medicare EOMB/RA.</p> <p>When entering the gross amount, do not use symbols (\$) or (.). Use this method in entering all dollar amounts on the <i>Payment Request for Long Term Care (25-1)</i> form.</p>

Box #	Form Fields	Instructions
18	PATIENT LIABILITY/MEDICARE DEDUCT	<p>If the Share of Cost (SOC) is zero, leave blank.</p> <p>If there is a SOC, enter the recipient's net Share of Cost (SOC) liability. The recipient's net SOC liability is the amount billed to the recipient. The recipient's net SOC liability is determined by subtracting from the recipient's original SOC (listed on the Medi-Cal eligibility verification system) the amount expended by the recipient that qualifies under Medi-Cal rules to reduce the patient's SOC liability.</p> <p>For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items not covered by Medi-Cal. A description of non-covered services is included in the <i>Share of Cost (SOC): 25-1 for Long Term Care</i> section of the Part 2 provider manual.</p> <p>The PATIENT LIABILITY (SOC) entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the <i>Record of Non-Covered Services (DHS 6114)</i> form, item 15. (See the <i>Share of Cost [SOC]: 25-1 for Long Term Care</i> section in the provider manual for an example.)</p> <p>When billing the recipient for less than the SOC amount indicated by the Medi-Cal eligibility verification system, show why in the <i>Explanations</i> field.</p> <p>The PATIENT LIABILITY (SOC) amount is deducted from the amount billed to Medi-Cal.</p> <p>Medicare Deductible for Part B Crossover: This field is for Medicare deductible information only. Enter the deductible found on the Medicare EOMB/RA. If the Medicare deductible has already been met, leave this area blank.</p> <p>SOC for Part B Crossover: Do not show SOC (patient liability) information in this box. When the Medi-Cal eligibility verification system shows the recipient has an SOC, enter that information in the <i>Explanations</i> area of the claim. Refer to the <i>Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples</i> section of the provider manual.</p>
18A	MEDICARE TYPE	<p>Part A Coinsurance: Enter the capital letter "A."</p> <p>NOTE A copy of the Medicare EOMB/RA must be attached to the Payment Request form.</p> <p>Part B Crossover: Enter the capital letter "B."</p> <p>NOTE A copy of the Medicare EOMB/RA must be attached to the Payment Request form.</p>

Box #	Form Fields	Instructions
19	OTHER COVERAGE	<p>Enter the amount paid by other insurance carrier(s) for the period billed, if applicable. Other Health Coverage (OHC) includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs.</p> <p>NOTE If the Medi-Cal eligibility verification system indicates a scope of coverage code "L" for the recipient, providers must bill other insurance carriers prior to billing Medi-Cal. For more information about OHC, refer to the <i>Other Health Coverage (OHC)</i> section in the provider manual.</p> <p>Part A Coinsurance: Enter the amount actually paid by the Medicare intermediary for the coinsurance days being billed. Attach a copy of the EOMB/RA to the payment request form.</p> <p>Part B Crossover: Enter the amount Medicare paid for service(s) as shown on the Medicare EOMB/RA. Attach a copy of the EOMB/RA to the Payment Request form. Do not attach a copy of the <i>UB-04</i> claim form. If there is a "contract adjusted amount" on the EOMB/RA, add this figure to the Medicare paid amount and enter the total in the <i>Other Coverage</i> field.</p>
20	NET BILLED AMOUNT	<p>Enter the amount requested for this billing. To compute the net amount, subtract patient liability and OHC (if any) from the gross amount billed. If the net amount billed computes to \$0.00, enter the amount as "0000." Do not leave blank. (Gross Amount – Patient Liability = Net Amount.)</p> <p>Part A Coinsurance: Enter the amount billed to Medi-Cal (coinsurance) as shown on the EOMB/RA from the Medicare intermediary, less any patient liability applied to this billing line.</p> <p>Part B Crossover: Enter the portions to be billed to Medi-Cal (coinsurance plus any Medicare deductible as shown on EOMB/RA from the Medicare intermediary, minus any patient liability as shown in the <i>Explanations</i> field).</p>

Box #	Form Fields	Instructions
21	M.D. CERTIFICATION	Not required.
22 - 116	ADDITIONAL CLAIM LINES	May be used to bill services for as many as six patients. Bill only one month's services on each line.
117	ATTACHMENTS	Enter an "X" if attachments are included with the claim. Leave blank if not applicable. NOTE If this box is not marked, attachments may not be seen by the examiner, which may cause the claim to be denied.
118	PROVIDER REFERENCE NUMBER	Enter any number up to seven digits to identify this claim form in your filing system. Any combination of alpha or numeric characters may be used. This number will be referenced by the FI on any forms sent to you that pertain to the billing data on the form. It will <u>not</u> be included on the RAD.
119	DATE BILLED	In six-digit format, enter the date the claim is submitted for Medi-Cal payment.
120 - 126	FI USE ONLY	Leave blank.
126A	EXPLANATIONS	Use this area for procedures that require additional information or justification. It is essential to clearly indicate the billing line number in this area. Part A Coinsurance: Use for explanations of SOC adjustments. Part B Crossover: Enter Medi-Cal SOC amount.
127	SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER (REPRESENTATIVE)	The claim must be signed and dated by the provider or a representative assigned by the provider. Use <u>black</u> ballpoint pen only. An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file at the FI.

Hard Copy Claims

Part A Services Billed to Part A Contractor

For detailed straight Medi-Cal hard copy billing instructions, refer to the Part 2 provider manual *Medicare/Medi-Cal Crossover Claims: Long Term Care* section (medi cr ltc).

NOTE

Refer to billing instructions regarding implementation of the NPI and 25-1 claim form.

Submit an original *Payment Request for Long Term Care (25-1)* according to the instructions under the Part A Coinsurance Claim Description column of “Explanation of Form Items” in the *Payment Request for Long Term Care (25-1) Completion* section of the Part 2 manual. Refer to *Figure 1* in the *Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples* section.

Attach a copy of the *Medicare National Standard Intermediary Remittance Advice* showing the Part A payment. Providers who receive electronic RAs may submit a printout.

Please adapt the example in Figure 1 to your billing situation.

On line 1, the gross amount of \$3789.68 (Box 17) is the Medicare-covered charges less the contract adjustment amount from the Medicare RA. There is a \$50.00 Medi-Cal Share of Cost (SOC) (patient liability) (Box 18). The Medicare paid amount of \$2977.68 is entered in the *Other Coverage* field (Box 19). The Medicare payment and SOC amounts are subtracted from the gross amount (\$3789.68 minus \$50.00 minus \$2977.68), leaving the *Net Amount Billed* field (Box 20) as \$762.00.

NOTE

This claim is for a bill type 214 where the last date of service is the discharge date and therefore not included when calculating the coinsurance days. Due to Medicare consolidated billing and contract adjustments, Medicare allowed amounts may appear excessive, but are not uncommon for crossover claims.

Line 2 illustrates a recipient whose Part A benefits have been exhausted (Box 38, *Other Coverage*, is blank). After 100 days, the recipient’s claim becomes a straight Medi-Cal claim. Therefore, the net amount of \$3456.30 (Box 39) billed to Medi-Cal equals the gross amount (Box 36), which is calculated for straight Medi-Cal by multiplying the appropriate Medi-Cal daily rate for the accommodation code by the total number of days.

The Medi-Cal payment on Part A LTC crossover claims is the full coinsurance less any SOC.

Formula for Calculating Part A Crossover Amounts	
Gross Amounts (Box 17)	Medicare covered charges minus the contract adjustment amount, if any (from EOMB/RA).
Patient Liability (Box 18)	On a Part A LTC claim, patient liability only applies to the Medi-Cal SOC. There is no Medicare deductible. If the patient has a "0" SOC (patient liability), leave blank. If a patient has an SOC, enter the amount being applied to this claim.
Other Coverage (Box 19)	Medicare paid amount (from EOMB/RA).
Net Amount Billed (Box 20)	Gross Amount minus Patient Liability (SOC) minus Other Coverage.

NOTE

LTC SOC is cleared solely by the facility in which the recipient resides. Claims (for LTC recipients) from other than the LTC facility should contain no SOC information. Refer to the *Share of Cost (SOC)* section in the Part 1 provider manual for detailed instructions on clearing a recipient's SOC.

Use the Medicare *Remittance Advice* when completing the *Payment Request for Long Term Care (25-1)* for a Part A crossover claim.

MEDICARE CONTRACTOR									
1234 B STREET									
ANYTOWN, CA 95555-555									
555-555-5555									
05000	GARDEN GROVE CARE CENTER	SKILLED NURSING		PAID DATE: 10/15/2015		REMIT#: 01061		PAGE 1	
PATIENT NAME	PATIENT CNTRL#	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ	
HIC#	ICNUMBER	RC	REM	OUT CD CAPCD		COVD CHGS	ESRD NET ADJ	PER DIEM RATE	
FROM DT THRU DT	NACHG HICG TOB	RC	REM	PROF COMP	MSP PAYMT	NCOVD CHGS	INTEREST	PROC CD AMT	
CLAIM STATUS IDE#	COST COMDY NOOBY RC	RC	REM	DRG AMT	DEDUCTIBLE	DENIED CHGS		NET REIMBURS	
DOE, JANE	648648					992.00		415.03	
123456789X	2091882184	.00		.00		4204.71	.00	405.00	
10/01/2015 10/09/2015		.00		.00		.00	.00	.00	
	214								
1	8 8			.00		.00	.00	2977.68	

Sample: Medicare Remittance Advice (RA) for Part A

Part B Services Billed to Part A Contractor

Hard copy submission requirements for Part B services billed to Part A contractors are as follows:

- Submit a *Payment Request for Long Term Care (25-1)*
 - Refer to the instructions under the Part B Crossover Claim Description column of “Explanation of Form Items” in the *Payment Request for Long Term Care (25-1) Completion* section found in Part 2 of the manual. A specific example may be found in the *Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples* section, *Figure 2*.
- When a Part B payment appears on a Medicare RA, enter the payment amount in the *Other Coverage* field (Box 19).
- Attach a copy of the Medicare RA showing the Part B payment.
 - Providers who receive electronic RAs may submit a printout.

Please adapt the example in Figure 2 to your billing situation.

On line 1, the gross amount of \$2939.17 (Box 17) is the amount allowed by Medicare. The recipient has a Medicare deductible of \$100.00 (Box 18). The sum of the Medicare paid amount of \$2227.39 and the contract adjustment amount of \$77.56 (\$2304.95) is entered in the *Other Coverage* field (Box 19). The coinsurance of \$534.22 from the Medicare RA plus the Medicare deductible of \$100.00 equals the net amount of \$634.22 billed to Medi-Cal (Box 20).

On line 2, the gross amount of \$959.25 (Box 36) is the amount allowed by Medicare. There is a Medicare deductible of \$100.00 (Box 37). The sum of the Medicare paid amount of \$643.43 and the contract adjustment amount of \$77.56 (\$720.99) is entered in the *Other Coverage* field (Box 38). The SOC of \$200.00 is identified in the *Explanations* area of the claim: “Line 2: Patient has a \$200.00 Share of Cost applied to this Part B claim.” The coinsurance from the Medicare RA plus the Medicare deductible minus the SOC equals the net amount of \$38.26 billed to Medi-Cal (Box 39).

The Medi-Cal payment on Part B crossover claims is calculated as the full coinsurance plus the deductible less any Medi-Cal SOC.

Formula for Calculating Part B Crossover Amounts	
Gross Amounts	Medicare allowed amount (from EOMB/RA)
Patient Liability/Medicare to the Medicare Deductible	On a Part B claim, recipient liability only applies to the Medicare deductible. If a recipient has an SOC, it must be documented in the <i>Explanations</i> area of the claim. If a portion of the Medicare claim is applied to the recipient's annual deductible, enter the deductible applied in this field (from EOMB/RA); if no deductible is applied to this claim, leave blank.
Other Coverage	Medicare paid amount plus any "contract adjusted amount" (from EOMB/RA).
Net Amount Billed	The coinsurance plus Medicare deductible minus any SOC being applied to this claim.

Use the Medicare RA to assist in completing the *Payment Request for Long Term Care (25-1)* for a Part B crossover claim.

MEDICARE CONTRACTOR									
1234 B STREET									
ANYTOWN, CA 95555-5555									
555-555-5555									
05999 GARDEN GROVE CARE CENTER		PART B	PAID DATE:	REMIT#:	PAGE 1				
			11/01/2015	500					
PATIENT NAME	PATIENT CNTRL#	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ	
HIC#	ICNNUMBER	RC	REM	OUT CD CAPCD		COVD CHGS	ESRD NET ADJ	PER DIEM RATE	
FROM DT	THRU DT	NACHG	HICG	TOB	RC	MSP PAYMT	INTEREST	PROC CD AMT	
CLAIM STATUS	IDE#	CCST	COMDY	NCOMDY	RC	DEDUCTIBLE	DENIED CHGS	NET REIMBURS	
DOE, JOHN	1234JS							77.56	
123456789A	202071029402					534.22		.85	
10/01/2015	10/28/2015	QC	N221			2939.17		2861.61	
					100.00			2227.39	
DOE, JANE	654811							77.56	
9469673257A	20207102890602					138.26		.85	
10/01/2015	10/28/2015	QC	N221			959.25		881.69	
					100.00			643.43	

Sample: Medicare Remittance Advice (RA) for Part B

Billing Tips Part B Services Billed to Part B Contractor

Follow these billing tips to help prevent rejections, delays, mispayments and/or denials of crossover claims for Part B services billed to Part B contractors:

- Do not highlight information on the claim or attachments.
- Do not write in undesignated white space or the top one-inch of the claim form.
- MRNs must be complete, legible and unaltered. For example, make sure the date in the upper right-hand corner is legible. For providers who receive an electronic remittance, the single claim detail level MRN printed with the free Medicare Remit Easy Print (MREP) software is preferred and may be required in the future.
- Crossover claims must not be combined. Examples of common errors include:
 - Multiple recipients on one claim form
 - One MRN for multiple claim forms
 - Multiple claims (one or more MRNs) for the same recipient on one 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, or on the MRN with Medicare-allowed claim lines, cannot be paid with the crossover claim.

NOTE

When billing Part B services to a Medicare Part A contractor, follow the billing instructions in the *Medicare/Medi-Cal Crossover Claims: Long Term Care* section (medi cr ltc) of the appropriate Part 2 provider manual.

Crossover Claim Follow-Up

Tracing Claims

A *Claims Inquiry Form* (CIF) must be submitted to trace a crossover claim. Do not submit a crossover claim (*Payment Request for Long Term Care* [25-1]) to trace crossover claims.

Claims Inquiry Form (CIF)

A CIF is used to initiate an adjustment or correction on a claim. The four ways to use a CIF for a crossover claim are:

- Reconsideration of a denied claim
- Trace a claim
- Adjustment for an overpayment or underpayment
- Adjustment related to a Medicare adjustment

Crossover CIF Billing Tips

Follow these billing tips to help prevent rejections, delays, misapplied payments and/or denials of crossover CIFs:

- Submit only one crossover claim (that is, only one Claim Control Number [CCN] for each CIF).
- Enter the 13-digit CCN of the most recently denied crossover claim from the RAD in Box 9. This number must end with a "91," "92," "93," "94," "95" or "96."
- Mark *Attachment* field (Box 10) and include appropriate documentation that is clear, concise and complete.
- Mark *Underpayment* field (Box 11) or *Overpayment* field (Box 12), if applicable.
- Do not mark *Underpayment* field (Box 11) or *Overpayment* field (Box 12) if submitting a CIF for reconsideration of a denial.
- If requesting an adjustment, use the approved CCN that is being requested for adjustment.
- In the *Remarks* field, indicate the reason for the adjustment or the denial, the type of action desired, and corrected information.
- Failure to complete the *Remarks* field of the CIF may cause claim denial or delayed processing.
- Make sure timeliness requirements are met.

NOTE

It is acceptable to make corrections on the claim copy being submitted with the CIF if the *Remarks* field (Box 19) is completed.

Acronyms

ACF	Attachment Control Form
AR	Accounts Receivable
BIC	Benefits Identification Card
CA-MMIS	California Medicaid Management Information System
CIF	Claims Inquiry Form
CIN	Client Index Number
CMC	Computer Media Claims
COBC	Coordination of Benefits Contractor
DHCS	Department of Health Care Services
DOB	Date of Birth
DOI	Date of Issue
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
HCP	Health Care Plan
HIC	Health Insurance Claim
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
LTC	Long Term Care
MAC	Medicare Administrative Contractor
MNSIRA	Medicare National Standard Intermediary Remittance Advice
MRN	Medicare Remittance Notice
NCPDP	National Council for Prescription Drug Programs
NF-A	Nursing Facility Level A
NF-B	Nursing Facility Level B
NPI	National Provider Identifier
OHC	Other Health Coverage
PHP	Prepaid Health Plan
POE	Proof of Eligibility
POS	Point of Service

QMB	Qualified Medicare Beneficiary
RAD	Remittance Advice Details
RTD	Resubmission Turnaround Document
SAR	Service Authorization Request
SOC	Share of Cost
TAR	Treatment Authorization Request
TCN	TAR Control Number