

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

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CIF Special Billing Instructions

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

Claim Attached to CIF Requires ICD Indicator

CIFs received by the DHCS Fiscal Intermediary (FI) on or after September 22, 2014, require an ICD indicator of "9" in the diagnosis area of the attached claim only if the initial claim contained an ICD-9-CM diagnosis code. CIFs accompanied by claims (as supporting documentation) without an ICD indicator will not be processed.

SHARE OF COST (SOC) CLAIMS

Submitting SOC CIFs

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

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

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

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

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

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

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

DO NOT
STAPLE
IN BAR
AREA

(1) CORRESPONDENCE REFERENCE NUMBER • FOR F.I. USE ONLY

8

CLAIMS INQUIRY

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

(3) PROVIDER NAME/ADDRESS

(4) PROVIDER NUMBER

0123456789

ABC PROVIDER
123 ANY STREET
ANYTOWN CA 999995555

(2) DOCUMENT NUMBER

(5) CLAIM TYPE CHECK ONE BOX ONLY

<input type="checkbox"/> 01 PHARMACY	<input type="checkbox"/> 03 HOSPITAL INPATIENT	<input type="checkbox"/> 05 PHYSICIAN/ ALLIED
<input type="checkbox"/> 02 LTC	<input type="checkbox"/> 04 HOSPITAL OUTPATIENT CLINIC	<input type="checkbox"/> 07 VISION

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK) LINE	(10) ATTACHMENT
<input type="checkbox"/>	01 TANNER	90000000A95001	72591234567 01	(11) UNDERPAYMENT
	(13) DATE OF SERVICE	(14) NDC/JPN OR PROCEDURE CODE	(15) AMOUNT BILLED	(12) OVERPAYMENT
	071507			<input checked="" type="checkbox"/> (10) <input type="checkbox"/> (11) <input type="checkbox"/> (12)

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK) LINE	(10) ATTACHMENT
<input type="checkbox"/>	02			(11) UNDERPAYMENT
	(13) DATE OF SERVICE	(14) NDC/JPN OR PROCEDURE CODE	(15) AMOUNT BILLED	(12) OVERPAYMENT
				<input type="checkbox"/> (10) <input type="checkbox"/> (11) <input type="checkbox"/> (12)

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK) LINE	(10) ATTACHMENT
<input type="checkbox"/>	03			(11) UNDERPAYMENT
	(13) DATE OF SERVICE	(14) NDC/JPN OR PROCEDURE CODE	(15) AMOUNT BILLED	(12) OVERPAYMENT
				<input type="checkbox"/> (10) <input type="checkbox"/> (11) <input type="checkbox"/> (12)

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK) LINE	(10) ATTACHMENT
<input type="checkbox"/>	04			(11) UNDERPAYMENT
	(13) DATE OF SERVICE	(14) NDC/JPN OR PROCEDURE CODE	(15) AMOUNT BILLED	(12) OVERPAYMENT
				<input type="checkbox"/> (10) <input type="checkbox"/> (11) <input type="checkbox"/> (12)

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT.)

SOC REIMBURSEMENT; MC 1054 ATTACHED.

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.

JANE DOE

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

9/15/07

DATE

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

MEDICARE/MEDI-CAL CROSSOVER CLAIMS

Submitting Crossover CIFs

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

Note: Charpentier claims must not be submitted on a CIF. Refer to “Charpentier Rebilling” in the Medicare/Medi-Cal Crossover Claims section in the appropriate Part 2 manual for specific instructions.

Reconsideration of Denied Crossover Claims

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

- Submit only one crossover claim (that is, only one Claim Control Number [CCN]) for each CIF.
- Enter in Box 9 the 13-digit CCN of the most recently denied crossover claim from the *Remittance Advice Details* (RAD). This number must end with a “99” or “00”.
- Mark *Attachment* in Box 10.

-
- Attach the following documentation:
 - If Part B services are billed to a Part A intermediary, submit a clear copy of the original crossover claim form billed to Medi-Cal.
 - If Part B services are billed to a Part B carrier, submit a clear copy of one of the following:
 - ❖ Original crossover claim form billed to Medi-Cal
 - ❖ Claim form billed to Medicare
 - ❖ Facsimile of the claim form submitted to Medicare (same format as *CMS-1500, Pharmacy Claim Form (30-1)* or *Compound Drug Pharmacy Claim Form (30-4)* with visible background)
 - All claims for Part B services must include a clear copy of both of the following:
 - ❖ *Medicare Remittance Notice (MRN)/Medicare National Standard Intermediary Remittance Advice (RA)*
 - ❖ Medi-Cal RAD showing the Medi-Cal crossover denial
 - In the *Remarks* section, indicate the denial code and include any additional information needed to correct the claim.

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

**Adjustments to Medi-Cal
Crossover Payments**

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

- Submit only one crossover claim (that is, only one Claim Control Number [CCN]) for each CIF.
- Enter in Box 9 the 13-digit CCN of the most recent crossover payment from the *Remittance Advice Details* (RAD). This number must end with a “99” or “00”.
- Mark *Attachment* in Box 10.
- Mark *Underpayment* in Box 11 or *Overpayment* in Box 12.
- Attach the following documentation* for an adjustment not related to a Medicare adjustment:
 - If Part B services are billed to a Part B carrier, submit a clear copy of one of the following:
 - ❖ Original crossover claim form billed to Medi-Cal
 - ❖ Claim form billed to Medicare
 - ❖ Facsimile of the claim form submitted to Medicare (same format as *CMS-1500*, if not billed via NCPDP, *Pharmacy Claim Form (30-1)* or *Compound Drug Pharmacy Claim Form (30-4)* if billed via NCPDP with visible background)
 - If Part B services are billed to a Part A intermediary, submit a clear copy of the original crossover claim form billed to Medi-Cal.
 - All claims for Part B services must include a clear copy of both of the following:
 - ❖ Medicare MRN/RA
 - ❖ Medi-Cal RAD showing the Medi-Cal crossover payment
- In the *Remarks* section, indicate the specific reason for the adjustment and the type of action desired.

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

Reimbursement for Beds
and Mattresses: DME
Providers

Claims for rentals of low air-loss/air-fluidized bed, nonpowered advanced pressure-reducing overlays or mattresses, or powered air overlays are paid by Medicare on a monthly basis. When claims for these cross over automatically to Medi-Cal, the crossover claim and *Medicare Remittance Notice* (MRN) reflect only one date of service and a quantity of one. Because Medi-Cal reimburses rental of these items on a daily basis, the crossover claims are processed for only one date of service, instead of one month. To request full reimbursement for these claims, providers must submit a CIF stating the actual from-through dates of service and the actual quantity in the *Remarks* area of the CIF.

<u>Durable Medical Equipment</u>	<u>HCPCS Code</u>
Low air-loss/air-fluidized bed	E0193, E0194
Powered air overlay	E0372
Nonpowered advanced pressure-reducing overlay or mattress	E0371, E0373

**Adjustments Related
to Medicare Adjustments**

When Medicare automatically crosses over a Medicare adjustment, it is not processed by Medi-Cal, since Medi-Cal does not process Medicare adjustments. As a result, the Medicare adjustment claim must be submitted in hard copy form.

Providers need to properly adjust the claim and submit the adjusted Medicare claim to Medi-Cal. They must also void the original Medicare payment, or the claim will be denied with RAD code 010: This service is a duplicate of a previously paid claim.

To receive correct reimbursement from Medi-Cal for a previously reimbursed Medicare crossover claim, providers may either file a *Claims Inquiry Form* (CIF) or an appeal.

When completing a CIF due to a Medicare adjustment, follow these additional instructions:

- Include only one crossover claim (that is, only one Claim Control Number [CCN]) per CIF.
- Enter in Box 9 the 13-digit CCN of the most recent crossover payment from the *Remittance Advice Details* (RAD). This number must end with a “99” or “00”.
- Mark *Attachment* (Box 10).
- Mark *Underpayment* (Box 11) or *Overpayment* (Box 12).
- Attach the following documentation for an adjustment related to a Medicare adjustment:
 - If Part B services are billed to a Part B carrier, submit a clear copy of the Medicare adjusted claim form and one of the following:
 - ❖ Original crossover claim form billed to Medi-Cal
 - ❖ Original claim form billed to Medicare
 - ❖ Facsimile of the original claim form submitted to Medicare (same format as *CMS-1500*, if not billed via NCPDP, *Pharmacy Claim Form* (30-1) or *Compound Drug Pharmacy Claim Form* (30-4) if billed via NCPDP, with visible background)

- If Part B services are billed to a Part A intermediary, submit a clear copy of the original crossover claim form billed to Medi-Cal.
- All claims for Part B services must include a clear copy of both of the following:
 - ❖ Original and adjusted Medicare MRN/RA
 - ❖ Medi-Cal RAD showing the Medi-Cal crossover payment or denial
- In the *Remarks* section, indicate the specific reason for the adjustment and the type of action desired.

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

Tracing Crossover Claims

A CIF must be submitted to trace a crossover claim. Do not submit a crossover claim (*CMS-1500, Pharmacy Claim Form [30-1], Compound Drug Pharmacy Claim Form [30-4]* or Medicare EOMB/MRN) to trace crossover claims.

Billing Tips for Crossover CIFs

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

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

Note: For information about claims that are attached to CIFs submitted on or after September 22, 2014, refer to “Claim Attached to CIF Requires ICD Indicator” in this section.

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

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(1) CORRESPONDENCE REFERENCE NUMBER • FOR F.I. USE ONLY

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FASTEN
HERE

CLAIMS INQUIRY

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

(3) PROVIDER NAME/ADDRESS

ABC PROVIDER
123 ANY STREET
ANYTOWN CA 999995555

(4) PROVIDER NUMBER

7891236540

(2) DOCUMENT NUMBER

(5) CLAIM TYPE CHECK ONE BOX ONLY

<input type="checkbox"/> 01 PHARMACY	<input type="checkbox"/> 03 HOSPITAL INPATIENT	<input type="checkbox"/> 05 PHYSICIAN/ ALLIED
<input type="checkbox"/> 02 LTC	<input type="checkbox"/> 04 HOSPITAL OUTPATIENT CLINIC	<input type="checkbox"/> 07 VISION

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK)	LINE	(10) ATTACHMENT
<input type="checkbox"/>	BRIGHT	90000000A95001	12345678901	01	(11) UNDERPAYMENT (12) OVERPAYMENT
	(13) DATE OF SERVICE	(14) NDCA/PN OR PROCEDURE CODE	(15) AMOUNT BILLED		(16) <input checked="" type="checkbox"/> (17) <input type="checkbox"/> (18) <input type="checkbox"/>
	081507		25.00		

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK)	LINE	(10) ATTACHMENT
<input type="checkbox"/>					(11) UNDERPAYMENT (12) OVERPAYMENT
	(13) DATE OF SERVICE	(14) NDCA/PN OR PROCEDURE CODE	(15) AMOUNT BILLED		(16) <input type="checkbox"/> (17) <input type="checkbox"/> (18) <input type="checkbox"/>

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK)	LINE	(10) ATTACHMENT
<input type="checkbox"/>					(11) UNDERPAYMENT (12) OVERPAYMENT
	(13) DATE OF SERVICE	(14) NDCA/PN OR PROCEDURE CODE	(15) AMOUNT BILLED		(16) <input type="checkbox"/> (17) <input type="checkbox"/> (18) <input type="checkbox"/>

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK)	LINE	(10) ATTACHMENT
<input type="checkbox"/>					(11) UNDERPAYMENT (12) OVERPAYMENT
	(13) DATE OF SERVICE	(14) NDCA/PN OR PROCEDURE CODE	(15) AMOUNT BILLED		(16) <input type="checkbox"/> (17) <input type="checkbox"/> (18) <input type="checkbox"/>

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT.)

CROSSOVER CLAIM DENIED BY MEDI-CAL WITH RAD CODE 001. THE DATE OF SERVICE HAS BEEN CORRECTED. PLEASE RECONSIDER.

ATTACHED ARE:

CMS-1500
MEDICARE EOMB
MEDI-CAL RAD

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.

JANE DOE

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

12/21/07

DATE

PROVIDER COPY - RETAIN FOR YOUR FILE 60-1 03/07

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