

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

## Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples

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This section illustrates billing examples of Medicare/Medi-Cal crossover claims for long term care (LTC) services on the *Payment Request for Long Term Care (25-1)* and correlating *Remittance Advice (RA)* examples. Refer to the *Medicare/Medi-Cal Crossover Claims: Long Term Care* section in this manual for detailed policy information. Refer to the *Payment Request for Long Term Care (25-1) Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

**Note:** A crossover claim reflects what was billed to Medicare, but only Medi-Cal-required fields are used for claims processing.

**Billing Tips:** When completing claims, do not enter the decimal points in ICD-9 codes or dollar amounts. If requested information does not fit neatly in the *Explanations* area of the 25-1, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

### Hard Copy Billing Examples

The following examples show how to bill hard copy Medicare/Medi-Cal crossover claims:

- *Figures 1a and 1b.* Billing Medi-Cal for Part A Services Billed to a Part A Contractor.
- *Figures 2a and 2b.* Billing Medi-Cal for Part B Services Billed to a Part A Contractor.
- *Figure 3.* Billing Medi-Cal for Part B Overlapping Dates of Service.

### Medicare RA Examples

Sample Medicare RAs on the following pages are partial examples of applicable fields only.

**Billing Medi-Cal for Part A Services Billed to a Part A Contractor**

*Figure 1a. Billing Medi-Cal for Part A Services Billed to a Part A Contractor.*

This is a sample only. Please adapt 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 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 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.

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

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PROVIDER'S NAME, ADDRESS, ZIP CODE

**GARDEN GROVE CARE CENTER**  
**6748 GARDEN GROVE HWY**  
**ANYTOWN, CA**

2 Provider Number

**1234567890**

128 Zip Code

**958235555**

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	5 MEDICAL ID NUMBER	6 YR OF BIRTH	7 SEX	TAR CONTROL NO	MEDICAL RECORD NO	ATTED. M.D. PROVIDER NUMBER				
1	DOE JOHN	90000000A95001	21	M		123456	0123456789				
BILL'G LIMIT EXCEPTIONS	DATE OF SERVICE FROM THRU	14 PATIENT ACCOM STATUS 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		
	060107 060907	00 01	436	3789 68	50 00	A	2977 68	762 00			
DELETE	PATIENT NAME	24 MEDICAL ID NUMBER	25 YR OF BIRTH	26 SEX	TAR CONTROL NO	MEDICAL RECORD NO	ATTED. M.D. PROVIDER NUMBER				
2	DOE JANE	90000000A95002	15	F	98765432101	234567	0123456789				
BILL'G LIMIT EXCEPTIONS	DATE OF SERVICE FROM THRU	33 PATIENT ACCOM STATUS CODE	36 PRIM. DX CODE	37 GROSS AMOUNT	38 PATIENT LIABILITY/ MEDICARE DEDUCT	39 MEDICARE TYPE	40 OTHER COVERAGE	41 NET AMOUNT BILLED	M.D. CERT		
	060107 063007	00 01	436	3456 30			3456 30	3456 30			
DELETE	PATIENT NAME	43 MEDICAL ID NUMBER	44 YR OF BIRTH	45 SEX	TAR CONTROL NO	MEDICAL RECORD NO	ATTED. M.D. PROVIDER NUMBER				
3											
BILL'G LIMIT EXCEPTIONS	DATE OF SERVICE FROM THRU	53 PATIENT ACCOM STATUS CODE	56 PRIM. DX CODE	57 GROSS AMOUNT	58 PATIENT LIABILITY/ MEDICARE DEDUCT	59 MEDICARE TYPE	60 OTHER COVERAGE	61 NET AMOUNT BILLED	M.D. CERT		
DELETE	PATIENT NAME	62 MEDICAL ID NUMBER	63 YR OF BIRTH	64 SEX	TAR CONTROL NO	MEDICAL RECORD NO	ATTED. M.D. PROVIDER NUMBER				
4											
BILL'G LIMIT EXCEPTIONS	DATE OF SERVICE FROM THRU	71 PATIENT ACCOM STATUS CODE	74 PRIM. DX CODE	75 GROSS AMOUNT	76 PATIENT LIABILITY/ MEDICARE DEDUCT	77 MEDICARE TYPE	78 OTHER COVERAGE	79 NET AMOUNT BILLED	M.D. CERT		
DELETE	PATIENT NAME	81 MEDICAL ID NUMBER	82 YR OF BIRTH	83 SEX	TAR CONTROL NO	MEDICAL RECORD NO	ATTED. M.D. PROVIDER NUMBER				
5											
BILL'G LIMIT EXCEPTIONS	DATE OF SERVICE FROM THRU	90 PATIENT ACCOM STATUS CODE	93 PRIM. DX CODE	94 GROSS AMOUNT	95 PATIENT LIABILITY/ MEDICARE DEDUCT	96 MEDICARE TYPE	97 OTHER COVERAGE	98 NET AMOUNT BILLED	M.D. CERT		
DELETE	PATIENT NAME	100 MEDICAL ID NUMBER	101 YR OF BIRTH	102 SEX	TAR CONTROL NO	MEDICAL RECORD NO	ATTED. M.D. PROVIDER NUMBER				
6											
BILL'G LIMIT EXCEPTIONS	DATE OF SERVICE FROM THRU	109 PATIENT ACCOM STATUS CODE	112 PRIM. DX CODE	113 GROSS AMOUNT	114 PATIENT LIABILITY/ MEDICARE DEDUCT	115 MEDICARE TYPE	116 OTHER COVERAGE	117 NET AMOUNT BILLED	M.D. CERT		
ATTACHMENTS	PROV. REF. NO	DATE BILLED									
117	X	113007									
PLEASE DO NOT MARK IN SHADED AREAS											
F.I. USE ONLY											

EXPLANATIONS: (REFERENCE SPECIFIC AREAS)

**LINE 1: MEDICARE RA 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.

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 x *Sue Smith*

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Figure 1a. Billing Medi-Cal for Part A Services Billed to a Part A Contractor.

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

Formula for Calculating Part A Crossover Amounts

The formulas for calculating Part A crossover amounts are as follows:

Gross Amounts: Medicare covered charges minus the contract adjustment amount, if any (from EOMB/RA).

Patient Liability: 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: Medicare paid amount (from EOMB/RA).

Net Amount Billed: 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 manual for detailed instructions on clearing a recipient's SOC.

<b>MEDICARE CONTRACTOR</b>									
<b>1234 B STREET</b>									
<b>ANYTOWN, CA 95555-555</b>									
<b>555-555-5555</b>									
05000	GARDEN GROVE	SKILLED		PAID DATE:		REMIT#:			PAGE 1
	CARE CENTER	NURSING		05/15/2007		01061			
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	HICHG	TOB	RC	REMI	INTEREST	PROC CD AMT	
CLAIM STATUS	IDE#	COST	COVDY	NOVDY	RC	REMI		NET REIMBURS	
DOE, JANE	648648					992.00		415.03	
123456789X	2091882184	.00		.00		4204.71	.00	405.00	
05/01/2007	05/09/2007	.00		.00		.00	.00	.00	
	214								
1	8	8		.00		.00	.00	2977.68	

Figure 1b. Medicare Remittance Advice (RA) for Part A Example.

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

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**Billing Medi-Cal for Part B  
Services Billed to a  
Part A Contractor**

*Figure 2a. Billing Medi-Cal for Part B services billed to a Part A Contractor.*

This is a sample only. Please adapt 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).

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PROVIDER'S NAME, ADDRESS, ZIP CODE

**GARDEN GROVE CARE CENTER**  
**6748 GARDEN GROVE HWY**  
**ANYTOWN, CA**

2 Provider Number

**1234567890**

128 Zip Code

**958235555**

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	5 MEDICAL ID NUMBER	6 YR OF BIRTH	7 SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER			
1	DOE JOHN	90000000A95001	23	M		123456	0123456789			
3	DATE OF SERVICE FROM	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
11	060107	062807			2939 17	100 00	B	2304 95	634 22	
22	DELETE	PATIENT NAME	24 MEDICAL ID NUMBER	25 YR OF BIRTH	26 SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER		
2		DOE JANE	90000000A95002	17	F		234567	0123456789		
30	DATE OF SERVICE FROM	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	M.D. CERT
30	060107	062807			959 25	100 00	B	720 99	38 26	
41	DELETE	PATIENT NAME	43 MEDICAL ID NUMBER	44 YR OF BIRTH	45 SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER		
3										
49	DATE OF SERVICE FROM	53 PATIENT STATUS	54 ACCOM CODE	55 PRIM DX CODE	56 GROSS AMOUNT	57 PATIENT LIABILITY/ MEDICARE DEDUCT	58 MEDICARE TYPE	59 OTHER COVERAGE	60 NET AMOUNT BILLED	M.D. CERT
49										
60	DELETE	PATIENT NAME	62 MEDICAL ID NUMBER	63 YR OF BIRTH	64 SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER		
4										
68	DATE OF SERVICE FROM	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	M.D. CERT
68										
79	DELETE	PATIENT NAME	81 MEDICAL ID NUMBER	82 YR OF BIRTH	83 SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER		
5										
87	DATE OF SERVICE FROM	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	M.D. CERT
87										
98	DELETE	PATIENT NAME	100 MEDICAL ID NUMBER	101 YR OF BIRTH	102 SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER		
6										
106	DATE OF SERVICE FROM	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	M.D. CERT
106										
117	ATTACHMENTS	PROV. REF. NO.	DATE BILLED							
117	X		113007							

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EXPLANATIONS: (REFERENCE SPECIFIC AREAS)

**LINE 1 & 2: MEDICARE RA ATTACHED**

**LINE 2: PATIENT HAS A 200.00 SHARE OF COST APPLIED TO THIS PART B CLAIM**

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.

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Figure 2a. Billing Medi-Cal for Part B Services Billed to a Part A Contractor.

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

The formula for calculating Part B crossover amounts is as follows:

- Gross Amount: Medicare allowed amount (from EOMB/RA).
- Patient Liability/Medicare Deductible: On a Part B claim, recipient liability only applies to the Medicare deductible. If a recipient has a SOC, it must be documented in the *Explanations* 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: The coinsurance plus Medicare deductible minus any SOC being applied to this claim.

<b>MEDICARE CONTRACTOR</b>									
<b>1234 B STREET</b>									
<b>ANYTOWN, CA 95555-5555</b>									
<b>555-555-5555</b>									
05999	GARDEN GROVE CARE CENTER		PART B	PAID DATE: 07/01/2007	REMIT#: 500	PAGE 1			
PATIENT NAME	PATIENT CNTRL#	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ	
HC#	ICNNUMBER	RC	REM	OUT CD CAPCD		COVD CHGS	ESRD NET ADJ	PER DIEM RATE	
FROM DT	THRU DT	NACHG	HICHG	TOB	RC	REM	PROF COMP	MSP PAYMT	NET REIMBURS
CLAIM STATUS	IDE#	COST	COVDY	NOVDY	RC	REM	DRG AMT	DEDUCTIBLE	DENIED CHGS
DOE, JOHN	1234JS								
123456789A	202071029402					534.22			77.56
06/01/2007	06/28/2007	QC	N221			2939.17			.85
					100.00				2861.61
									2227.39
DOE, JANE	654811								
9469673257A	20207102890602					138.26			77.56
06/01/2007	06/28/2007	QC	N221			959.25			.85
					100.00				881.69
									643.43

Figure 2b. Medicare Remittance Advice (RA) for Part B Example.

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

**Billing Medi-Cal for Part B  
Overlapping Dates of Service**

*Figure 3. Billing Medi-Cal for Part B overlapping dates of service.*

This is a sample only. Please adapt to your billing situation.

Occasionally, two Part B claim lines are billed for the same recipient with overlapping dates of service (for example, physical therapy and speech therapy). To avoid denial of the claim as a duplicate in these situations, use the *Explanations* area to identify the reason for the overlapping dates of service.

In this example, the provider is billing for speech therapy on line 1 and physical therapy on line 2 for the same claim. The recipient is the same and the dates of service overlap.

In the *Explanations* area, the biller writes: "Lines 1 and 2: This is not a duplicate claim. Line 1 is for speech therapy and line 2 is for physical therapy. See Medicare documentation attached."

Similarly, the provider is billing for speech therapy on line 3 of this claim, but billed for physical therapy on line 2 of a claim submitted 10 days earlier.

In the *Explanations* area, the biller writes: "Line 3: This is not a duplicate claim. This claim is for speech therapy. The physical therapy claim was billed on 6/15/07 on line 2. A copy of the claim is attached."

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

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PROVIDER'S NAME, ADDRESS, ZIP CODE

**GARDEN GROVE CARE CENTER**  
6748 GARDEN GROVE HWY  
ANYTOWN, CA

2 Provider Number

**1234567890**

128 Zip Code

**958235555**

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	5 MEDICAL ID NUMBER	6 YR OF BIRTH	7 SEX	TAR CONTROL NO	MEDICAL RECORD NO	ATTED. M.D. PROVIDER NUMBER			
1	DOE JANE	90000000A95001	22	F			0123456789			
11	DATE OF SERVICE FROM	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
	061007	062207			125 00		B	100 00	25 00	
2	DOE JANE	90000000A95001	22	F			0123456789			
	060107	061707			95 00		B	76 00	19 00	
3	DOE JOHN	90000000A95002	25	M			0123456789			
	062107	062807			115 00		B	92 00	23 00	
4										
5										
6										
117	ATTACHMENTS	118	PROV. REF. NO	119	DATE BILLED					
X					113007					
PLEASE DO NOT MARK IN SHADED AREAS						F.I. USE ONLY				

EXPLANATIONS: (REFERENCE SPECIFIC AREAS)

**LINE 1 & 2: THIS IS NOT A DUPLICATE CLAIM. LINE 1 IS FOR SPEECH THERAPY AND LINE 2 IS FOR PHYSICAL THERAPY. SEE MEDICARE DOCUMENTATION ATTACHED.**  
**LINE 3: THIS IS NOT A DUPLICATE CLAIM. THIS CLAIM IS FOR SPEECH THERAPY. THE PHYSICAL THERAPY CLAIM WAS BILLED ON 041506 ON LINE 2. A COPY OF THE CLAIM IS 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.

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Figure 3. Billing Medi-Cal for Part B Overlapping Dates of Service.