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)

Acronyms

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

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.
21st to 100th 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. PC-Print 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.

Knowledge Review

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

NOTES

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 *Treatment Authorization Request* (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 Medi-Cal rules that preclude providers from charging recipients any sums in addition to payment made to the provider.

NOTES

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.

Knowledge Review

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.

Knowledge Review

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

1. _____
2. _____

NOTES

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 California MMIS 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).

Knowledge Review

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

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

NOTES

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 signed, dated and stamped 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.

Knowledge Review

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:

California MMIS Fiscal Intermediary
Attn: Crossover Unit
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 10 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 *Delete* 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 *Patient Name* 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 *Explanations* 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 the *Remittance Advice Details* (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 RAD.
10	ATTENDING M.D. PROVIDER NUMBER	Enter the physician’s NPI. Be sure the attending physician’s NPI number is entered on: • 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 *Explanation of Medicare Benefits* (EOMB)/*Remittance Advice* (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 same 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	Enter the appropriate patient status code. 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). **NOTE** The California MMIS Fiscal Intermediary (FI) does not require a copy of Form MC-171 (*Notification of Patient Admission, Discharge, or Death*) to be attached to the *Payment Request for Long Term Care* form.
15	ACCOMMODATION CODE	Enter the appropriate accommodation code for the type of care billed, as listed in the *Accommodation Codes for Long Term Care* section of the manual. **Part B Crossover:** Leave blank. **NOTE** The FI does not require that a copy of Form HS 231 (*Certification for Special Program Services*) be attached to the *Payment Request for Long Term Care* (25-1). Form HS 231 should be attached to the LTC TAR sent to the Medi-Cal field office.
16	PRIMARY DX (DIAGNOSIS) CODE	Enter the Primary ICD-10-CM diagnosis code for the following: • ICD Indicator “0” must precede primary diagnosis code in all *Primary Diagnosis Code* fields (Boxes 16, 35, 54, 73, 92 or 111). • Admit claims • Initial Medi-Cal claim for Medicare/Medi-Cal crossover patient • Change in diagnosis **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. Part B Crossover: Leave blank.
17	GROSS AMOUNT	**Part A Coinsurance:** Multiply the per diem rate allowed by Medicare, by the total coinsurance days being billed and enter the total. **Part B Crossover:** Enter the amount allowed by Medicare for these services directly from the Medicare EOMB/RA. When entering the gross amount, do not use symbols ($) or (.). Use this method in entering all dollar amounts on the *Payment Request for Long Term Care* (25-1) form.

Box #	Form Fields	Instructions
18	PATIENT LIABILITY/MEDICARE DEDUCT	If the Share of Cost (SOC) is zero, leave blank. 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. 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 *Share of Cost (SOC): 25-1 for Long Term Care* section of the Part 2 provider manual. The PATIENT LIABILITY (SOC) entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the *Record of Non-Covered Services* (DHS 6114) form, item 15. (See the *Share of Cost [SOC]: 25-1 for Long Term Care* section in the provider manual for an example.) When billing the recipient for less than the SOC amount indicated by the Medi-Cal eligibility verification system, show why in the *Explanations* field. The PATIENT LIABILITY (SOC) amount is deducted from the amount billed to Medi-Cal. **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. **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 *Explanations* area of the claim. Refer to the *Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples* section of the provider manual.
18A	MEDICARE TYPE	**Part A Coinsurance:** Enter the capital letter "A." **NOTE** A copy of the Medicare EOMB/RA must be attached to the Payment Request form. **Part B Crossover:** Enter the capital letter "B." **NOTE** A copy of the Medicare EOMB/RA must be attached to the Payment Request form.

Box #	Form Fields	Instructions
19	OTHER COVERAGE	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. **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 *Other Health Coverage (OHC)* section in the provider manual. **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. **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 *UB-04* 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 *Other Coverage* field.
20	NET BILLED AMOUNT	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.) **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. **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 *Explanations* field).

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 not 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 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 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.

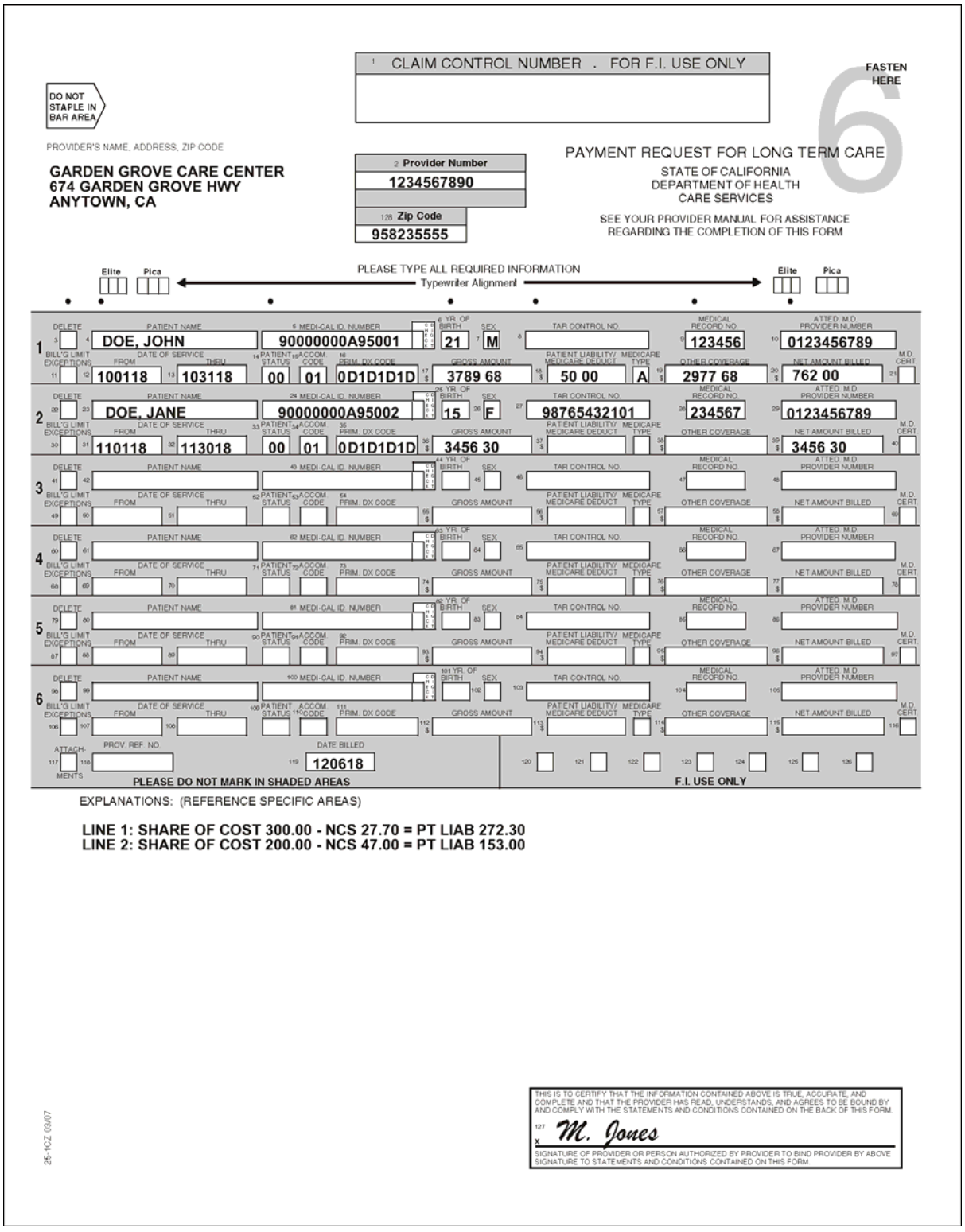
Attach a copy of the *Medicare National Standard Intermediary Remittance Advice* showing the Part A payment. Providers who receive electronic RAs may submit a printout.

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.



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

FASTEN HERE

DO NOT STAPLE IN BAR AREA

PROVIDER'S NAME, ADDRESS, ZIP CODE

GARDEN GROVE CARE CENTER
674 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

Elite Pica — PLEASE TYPE ALL REQUIRED INFORMATION — Typewriter Alignment — Elite Pica

	PATIENT NAME	5 MEDI-CAL ID. NUMBER	6 YR. OF BIRTH	SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER
1	DOE, JOHN	90000000A95001	21	M		123456	0123456789
2	DOE, JANE	90000000A95002	15	F	98765432101	234567	0123456789
3							
4							
5							
6							

	DATE OF SERVICE FROM	DATE OF SERVICE THRU	PATIENT STATUS	ACCOM. CODE	PRIM. DX CODE	GROSS AMOUNT	PATIENT LIABILITY/ MEDICARE DEDUCT	MEDICARE TYPE	OTHER COVERAGE	NET AMOUNT BILLED	M.D. CERT
1	100118	103118	00	01	0D1D1D1D	3789 68	50 00	A	2977 68	762 00	
2	110118	113018	00	01	0D1D1D1D	3456 30				3456 30	
3											
4											
5											
6											

ATTACHMENTS — PROV. REF. NO. — DATE BILLED: 120618

PLEASE DO NOT MARK IN SHADED AREAS

F.I. USE ONLY

EXPLANATIONS: (REFERENCE SPECIFIC AREAS)

LINE 1: SHARE OF COST 300.00 - NCS 27.70 = PT LIAB 272.30
LINE 2: SHARE OF COST 200.00 - NCS 47.00 = PT LIAB 153.00

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 M. Jones

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

MC 6090 (12-92)

Figure 1. **Billing Medi-Cal Hard Copy 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	
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: 10/15/2018 | REMIT#: 01061 | PAGE 1

PATIENT NAME / HIC# / FROM DT THRU DT / CLAIM STATUS IDE#	PATIENT CNTRL# / ICN NUMBER / NACHG HICHG TOB / COST COMDY NCOMDY	RC / REM / RC / REM / RC / REM	DRG# / OUT CD CAPCD / PROF COMP / DRG AMT	DRG OUT AMT / MSP PAYMT / DEDUCTIBLE	COINSURANCE / COVD CHGS / NCOVD CHGS / DENIED CHGS	PAT REFUND / ESRD NET ADJ / INTEREST	CONTRACT ADJ / PER DIEM RATE / PROC CD AMT / NET REIMBURS
DOE, JANE	648648				992.00		415.03
123456789X	2091882184	.00	.00		4204.71	.00	405.00
10/01/2018 10/09/2018		.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).

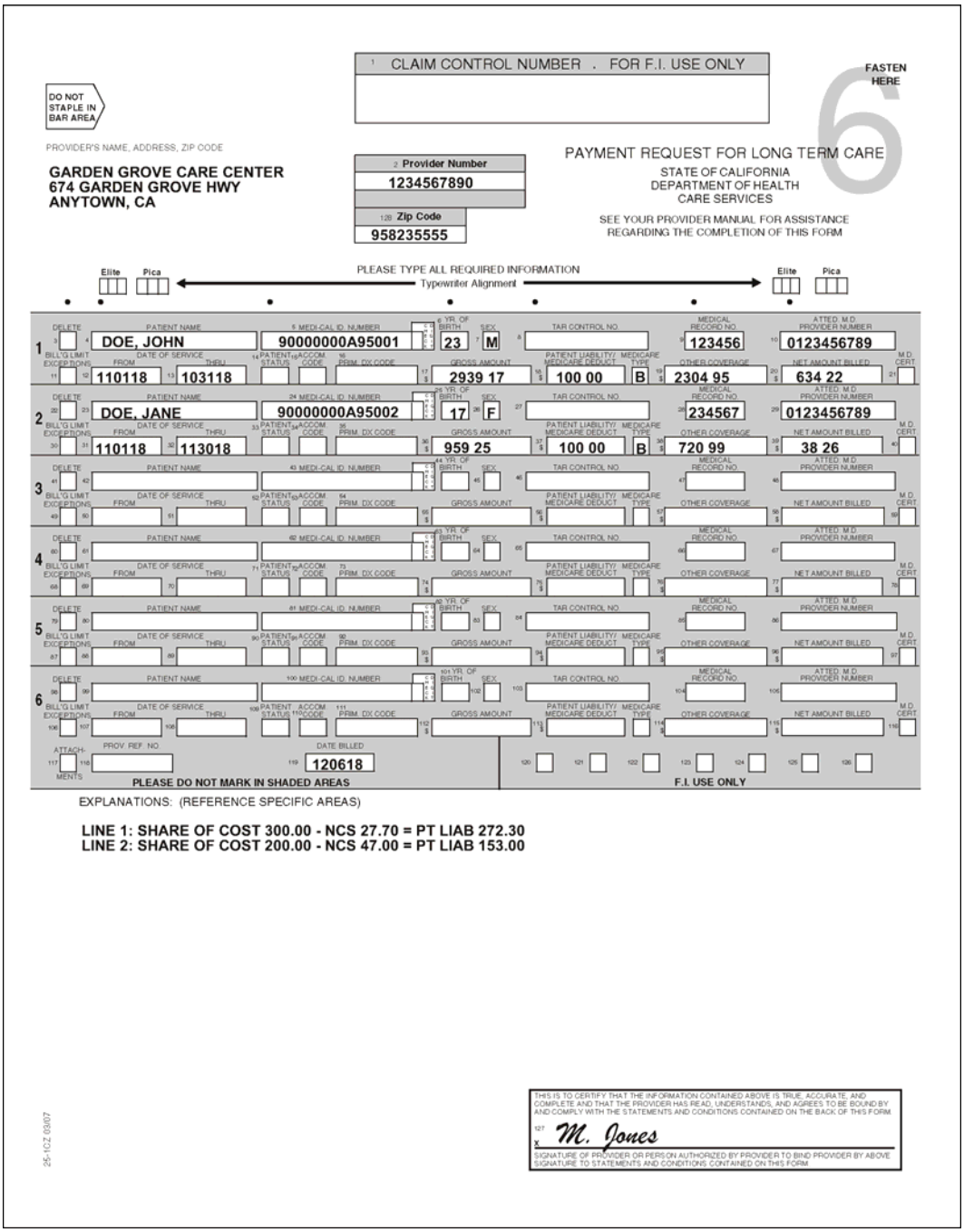


Figure 2. **Billing Medi-Cal Hard Copy for Part B Services Billed to a Part A Contractor.**

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	
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 *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 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: 11/01/2018 REMIT#: 500 PAGE 1

PATIENT NAME / HIC# / FROM DT THRU DT / CLAIM STATUS IDE#	PATIENT CNTRL# / ICN NUMBER / NACHG HICHG TOB / COST COMDY NCOMDY	RC / REM / DRG# / OUT CD CAPCD / PROF COMP / DRG AMT	DRG OUT AMT / MSP PAYMT / DEDUCTIBLE	COINSURANCE / COVD CHGS / NCOVD CHGS / DENIED CHGS	PAT REFUND / ESRD NET ADJ / INTEREST	CONTRACT ADJ / PER DIEM RATE / PROC CD AMT / NET REIMBURS
DOE, JOHN	1234JS					
123456789A	202071029402			534.22		77.56
10/01/2018 10/28/2018	QC N221			2939.17		.85
			100.00			2861.61
						2227.39
DOE, JANE	654811					
9469673257A	202071028906O2			138.26		77.56
10/01/2018 10/28/2018	QC N221			959.25		.85
			100.00			881.69
						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.

Resource Information

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)