LTC Code and Claim Conversion: Forthcoming Crossover Changes

Effective for dates of service on or after February 1, 2024, the fee-for-service Long Term Care (LTC) local service codes and the local *Payment Request for Long Term Care* (25-1) claim form are replaced with HIPAA-compliant national code sets and the *UB-04* claim form.

With the fee-for-service LTC code and claim form conversion, LTC providers can expect to prepare and submit crossover claims according to the instructions below.

Medicare/Medi-Cal LTC Crossover Claim Changes

Effective for dates of service on or after February 1, 2024, crossover claims billed hard copy by LTC facilities are submitted on the *UB-04* claim form.

Refer to the *Medicare/Medi-Cal Crossover Claims Overview* section of the provider manual for general eligibility information and guidelines about Medicare/Medi-Cal crossover claims.

Billing for Part A Services

Hard copy submission requirements for Part A services billed to Part A intermediaries, and associated claim form examples, are as follows:

Part A Services Billed to Part A Intermediaries UB-04 Requirements

UB-04 Field Number(s)	UB-04 Field Name	Claim Completion Instructions
4	Type of Bill	Enter Type of Bill 18, 21, or 28 as applicable
31 thru 34	Occurrence Codes and Dates	Enter code 50 and the date (MMDDYY) of the Medicare RA
39 thru 41 a-d	Value Codes and Amounts	Patient's Share of Cost: Enter code 23 and the patient's Share of Cost for the claim. Leave blank if not applicable. Medicare Deductible: Enter code A1 if Medicare is the primary payer, or B1 if Medicare is a secondary payer. Enter the deductible amount. Leave blank if not applicable. Medicare Coinsurance: Enter code A2 if Medicare is the primary payer, or B2 if Medicare is a secondary payer. Enter the coinsurance amount. Leave blank if not applicable. Medicaid Rate Code: Enter code 24 (Medicaid Rate Code) and the corresponding Designated State Level Medicaid Rate Code. Refer to the *LTC Accommodation Code to Revenue Code, Value Code and Value Code Amount Crosswalk* for the appropriate combination of Value Code 24 (Medicaid Rate Code), Value Code 24 Amounts (Designated State Level Medicaid Rate Code), and Revenue Code. Leave blank if not applicable.

Part A Services Billed to Part A Intermediaries UB-04 Requirements

UB-04 Field Number(s)	UB-04 Field Name	Claim Completion Instructions
42	Revenue Codes	Enter the appropriate Revenue Code. Refer to the *LTC Accommodation Code to Revenue Code, Value Code and Value Code Amount Crosswalk* for the appropriate combination of Value Code 24 (Medicaid Rate Code), Value Code 24 Amounts (Designated State Level Medicaid Rate Code), and Revenue Code. For Box 42, Line 23, enter "001" to indicate that this is the total charge line. Leave blank if not applicable.
47	Total Charges	Multiply the per diem rate allowed by Medicare times the total coinsurance days being billed and enter the total. Thus, enter the total charge amount in Box 47, Line 23, as the Medicare covered charges minus the contract adjustment amount, if any (from EOMB/RA).
50	Payer Name	The payers must be listed in the following order of payment: 1. Other Health Coverage (OHC) (if applicable), except Medicare Supplemental Insurance 2. Medicare 3. Medicare Supplemental Insurance (if applicable) 4. Medi-Cal **Note:** **Medicare/Medi-Cal Payers.** If only Medicare and Medi-Cal are involved, enter "Medicare A" on line A and "LTC Medi-Cal" on line B. **OHC Payers.** If OHC is involved and is primary, enter the name of the OHC on line A, enter "Medicare A" on line B, and enter "LTC Medi-Cal" on line C. **Medicare Supplemental Insurance Payers.** If Medicare supplemental insurance is involved, it is secondary to Medicare. Enter "Medicare A" on line A, enter the name of the Medicare supplemental insurance on line B, and enter "LTC Medi-Cal" on line C.

Part A Services Billed to Part A Intermediaries UB-04 Requirements

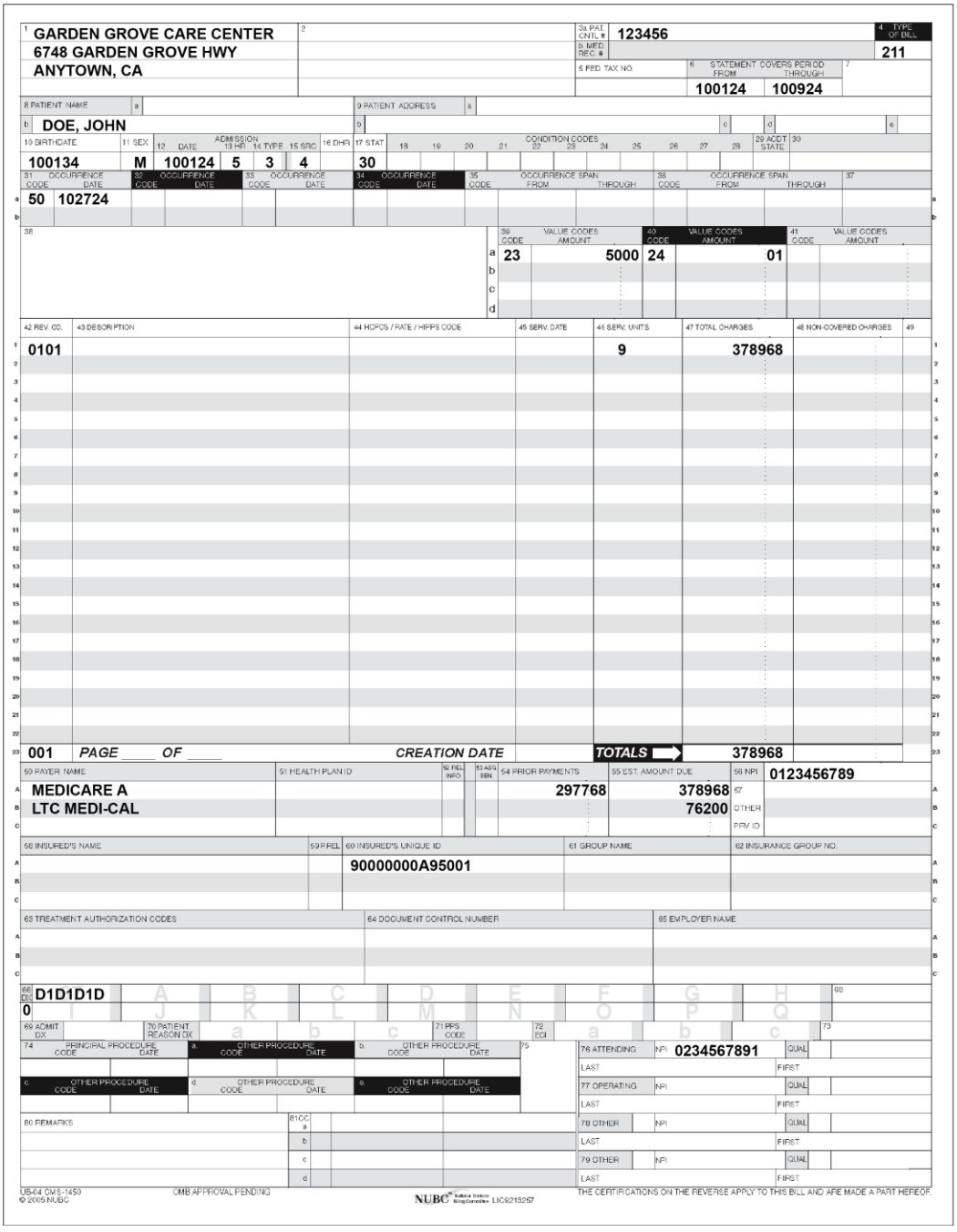
UB-04 Field Number(s)	UB-04 Field Name	Claim Completion Instructions
54	Prior Payments	On the corresponding Payer Name (Box 50) Medicare line, enter the Medicare paid amount.
55	Estimated Amount Due	On the corresponding Payer Name (Box 50) **Medicare line**, enter the total charges from Box 47, line 23. On the corresponding Payer Name (Box 50) **Medi-Cal line**, follow the instructions below: Add the Share of Cost (SOC) amount (Boxes 39-41, Value Code 23) and the Medicare Paid Amount (Box 54). Then subtract that amount from the Total Charges (Box 47, Line 23). The difference equals the Estimated Amount Due (Box 55).

Figure 1a: Billing Medi-Cal for Part A Services Billed to a Part A Contractor Claim Example

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

The total charges of $3789.68 (Box 47, Line 23) are the Medicare covered charges less the contract adjustment amount from the Medicare RA. There is a $50 Medi-Cal SOC (Box 39a [Value Code 23 and Value Code Amount]). The Medicare paid amount of $2977.68 is entered in the *Prior Payments* field (Box 54a). The Medicare payment and SOC amounts are subtracted from the total charges ($3789.68 minus $50 minus $2977.68), leaving the *Estimated Amount Due* field (Box 55b) as $762.00.

Note: This claim is for bill type 211 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.



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

3a PAT. CNTL # 123456
4 TYPE OF BILL 211
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 100124 THROUGH 100924

8 PATIENT NAME: DOE, JOHN
9 PATIENT ADDRESS

10 BIRTHDATE 100134 | 11 SEX M | 12 ADMISSION DATE 100124 | 13 HR 5 | 14 TYPE 3 | 15 SRC 4 | 16 DHR | 17 STAT 30
29 ACDT STATE | 30

31 OCCURRENCE CODE 50 DATE 102724

39 VALUE CODES a 23 5000 | 40 VALUE CODES 24 01 | 41 VALUE CODES

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0101				9	378968	
001	PAGE ____ OF ____		CREATION DATE	TOTALS	378968	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789
A MEDICARE A				297768	378968	57
B LTC MEDI-CAL				76200		OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		90000000A95001		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX D1D1D1D
0

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 0234567891 QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d

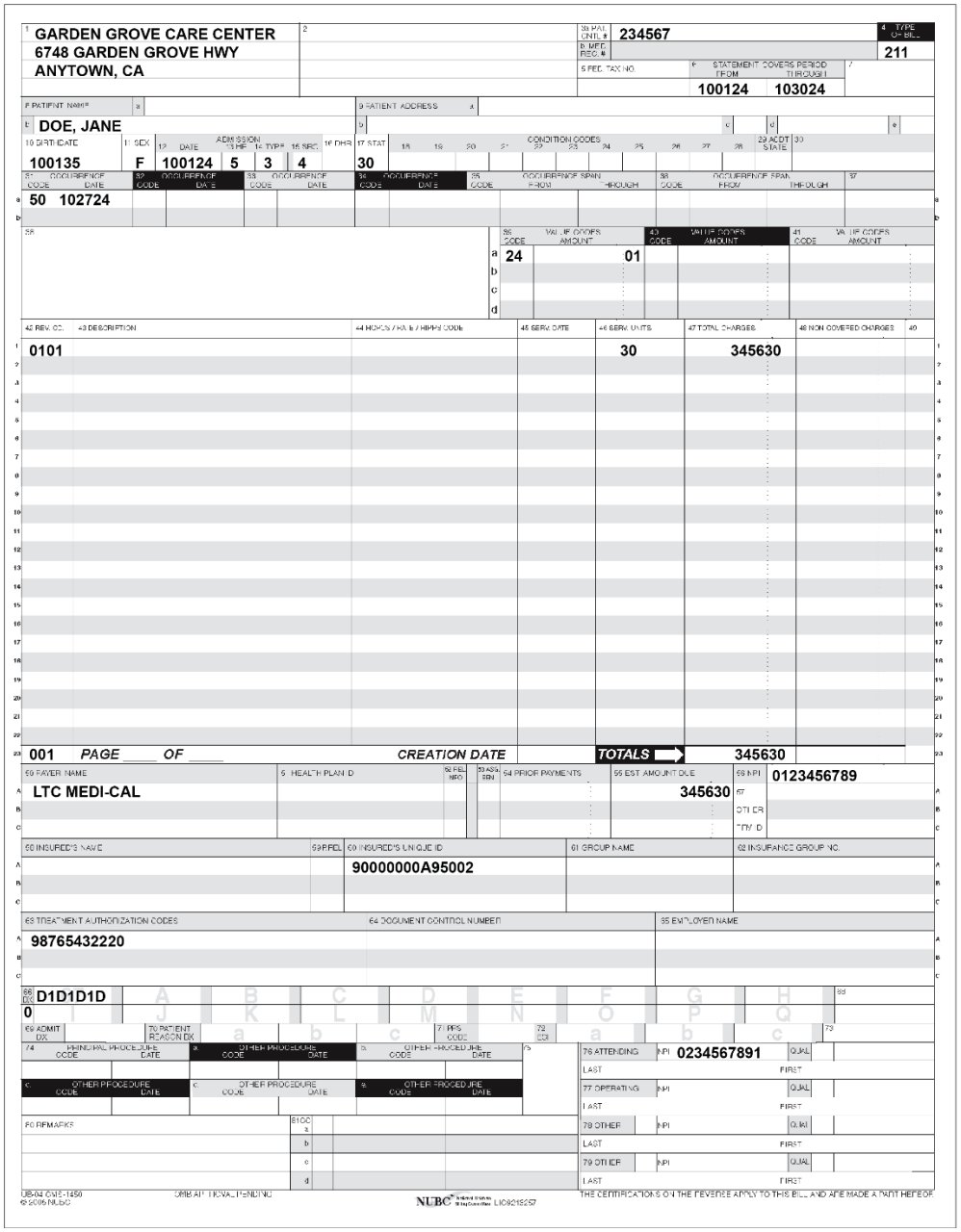
UB-04 CMS-1450 © 2005 NUBC | OMB APPROVAL PENDING | NUBC National Uniform Billing Committee LIC9213257 | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

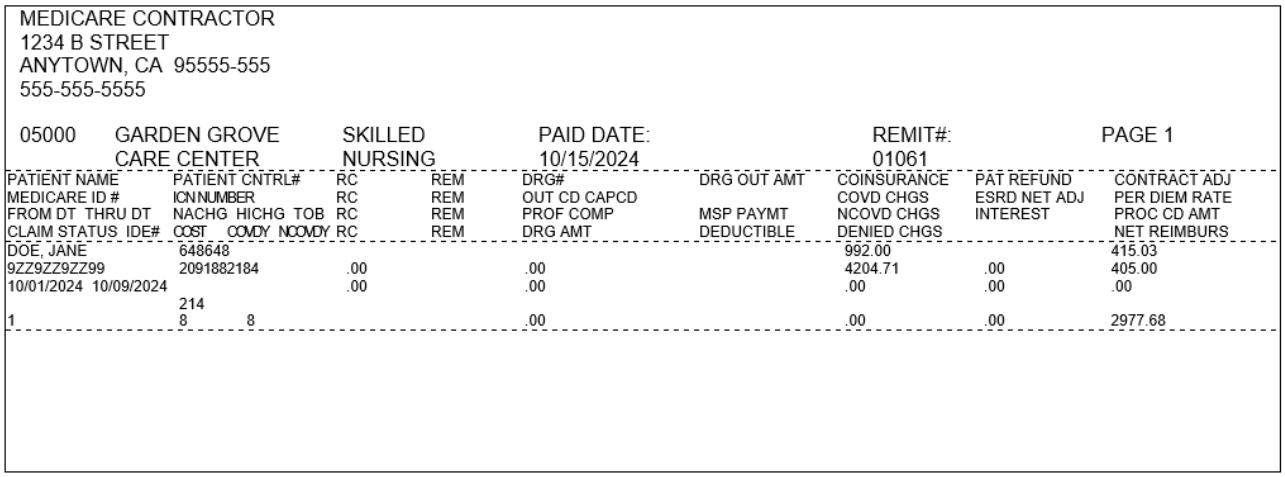
Figure 1b: Billing Medi-Cal for a Recipient whose Part A Services Have Been Exhausted

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

A recipient whose Part A benefits have been exhausted is illustrated by the absence of "Medicare A" in the *Payer Name* field (Box 50a) and the absence of a Medicare Paid amount in the *Prior Payments* field (Box 54a). Only "LTC Medi-Cal" is listed in the *Payer Name* field (Box 50a).

After 100 days, the recipient's claim becomes a straight Medi-Cal claim. Therefore, the net amount of $3456.30 is entered in the *Estimated Amount Due* field (Box 55a), equals the total charges (Box 47, Line 23) and is billed to Medi-Cal. The total charges are calculated for straight Medi-Cal claims by multiplying the appropriate Medi-Cal daily rate for the Revenue Code (Box 42, Line 1) and the Designated State Level Medicaid Rate Code (Boxes 39a [Value Code 24 and Value Code Amount]) combination by the total number of days. Enter the total number of days in the *Service Units* field (Box 46, Line 1).





MEDICARE CONTRACTOR
1234 B STREET
ANYTOWN, CA 95555-555
555-555-5555

05000 GARDEN GROVE CARE CENTER | SKILLED NURSING | PAID DATE: 10/15/2024 | REMIT#: 01061 | PAGE 1

PATIENT NAME	PATIENT CNTRL#	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ
MEDICARE ID #	ICN NUMBER	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	NCOVD CHGS	INTEREST	PROC CD AMT
CLAIM STATUS IDE#	COST COVDY NCOVDY	RC	REM	DRG AMT	DEDUCTIBLE	DENIED CHGS		NET REIMBURS
DOE, JANE	648648					992.00		415.03
9ZZ9ZZ9ZZ99	2091882184	.00		.00		4204.71	.00	405.00
10/01/2024 10/09/2024		.00		.00		.00	.00	.00
	214							
1	8 8			.00		.00	.00	2977.68

Figure 1c: Medicare Remittance (RA) for Part A Figure 1a Example

Billing for Part B Services

Hard copy submission requirements for Part B services billed to Part A intermediaries, and associated claim form examples, are as follows:

Part B Services Billed to Part A Intermediaries UB-04 Requirements

UB-04 Field Number(s)	UB-04 Field Name	Claim Completion Instructions
4	Type of Bill	Enter Type of Bill 22 or 23 as applicable
31 thru 34	Occurrence Codes and Dates	Enter code 50 and the date (MMDDYY) of the Medicare RA
39 thru 41 a-d	Value Codes and Amounts	Patient's Share of Cost: Enter code 23 and the patient's Share of Cost for the claim. Leave blank if not applicable. Medicare Deductible: Enter code A1 if Medicare is the primary payer, or B1 if Medicare is a secondary payer. Enter the deductible amount. Leave blank if not applicable. Medicare Coinsurance: Enter code A2 if Medicare is the primary payer, or B2 if Medicare is a secondary payer. Enter the coinsurance amount. Leave blank if not applicable.
42	Revenue Code	Box 42, Line 23: Enter "001" to indicate that this the total charge line
47	Total Charges	Box 47, Line 23: Enter the Medicare allowed amount (from EOMB/RA).

Part B Services Billed to Part A Intermediaries UB-04 Requirements

UB-04 Field Number(s)	UB-04 Field Name	Claim Completion Instructions
50	Payer Name	The payers must be listed in the following order of payment: 1. Other Health Coverage (OHC) (if applicable), except Medicare Supplemental Insurance 2. Medicare 3. Medicare Supplemental Insurance (if applicable) 4. Medi-Cal **Note:** **Medicare/Medi-Cal Payers.** If only Medicare and Medi-Cal are involved, enter “Medicare B” on line A and “LTC Medi-Cal” on line B. **OHC Payers.** If OHC is involved and is primary, enter the name of the OHC on line A, enter “Medicare B” on line B, and enter “LTC Medi-Cal” on line C. **Medicare Supplemental Insurance Payers.** If Medicare supplemental insurance is involved, it is secondary to Medicare. Enter “Medicare B” on line A, enter the name of the Medicare supplemental insurance on line B, and enter “LTC Medi-Cal” on line C.
54	Prior Payments	On the corresponding Payer Name (Box 50) Medicare line, enter the Medicare paid amount plus any contract adjustment amount (from EOMB/RA).
55	Estimated Amount Due	On the corresponding Payer Name (Box 50) **Medicare line**, enter the total charges from Box 47, line 23. On the corresponding Payer Name (Box 50) **Medi-Cal line**, follow the instructions below: Add the Medicare Coinsurance Amount (Value Code A2 or B2) and the Medicare Deductible (Value Code A1 or B1). Then, subtract any SOC (Value Code 23) being applied to the claim. (See Boxes 39-41). The difference equals the Estimated Amount Due (Box 55).

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.

The total charges of $2939.17 (Box 47, Line 23) is the amount allowed by Medicare. The recipient has a Medicare deductible of $100.00 (Box 39a [Value Code A1 and Value Code Amount]). The sum of the Medicare paid amount of $2227.39 and the contract adjustment amount of $77.56 ($2304.95) is entered in the *Prior Payments* field (Box 54a). The coinsurance of $534.22 from the Medicare RA, which is entered in the *Value Codes and Amount* field (Box 40a [Value Code A2 and Value Code Amount]), plus the Medicare deductible of $100.00 equals the net amount of $634.22 billed to Medi-Cal in the *Estimated Amount Due* field (Box 55b).

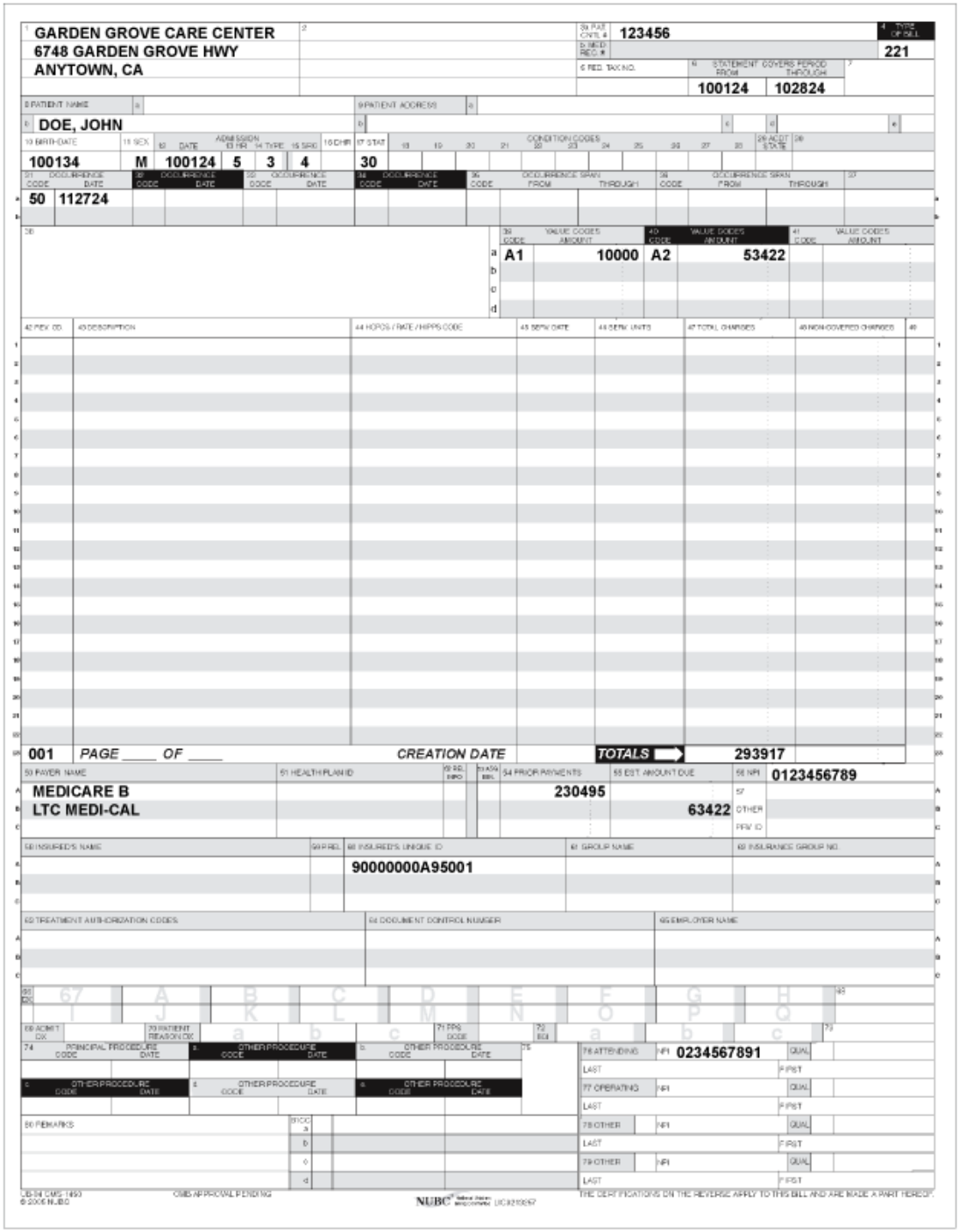
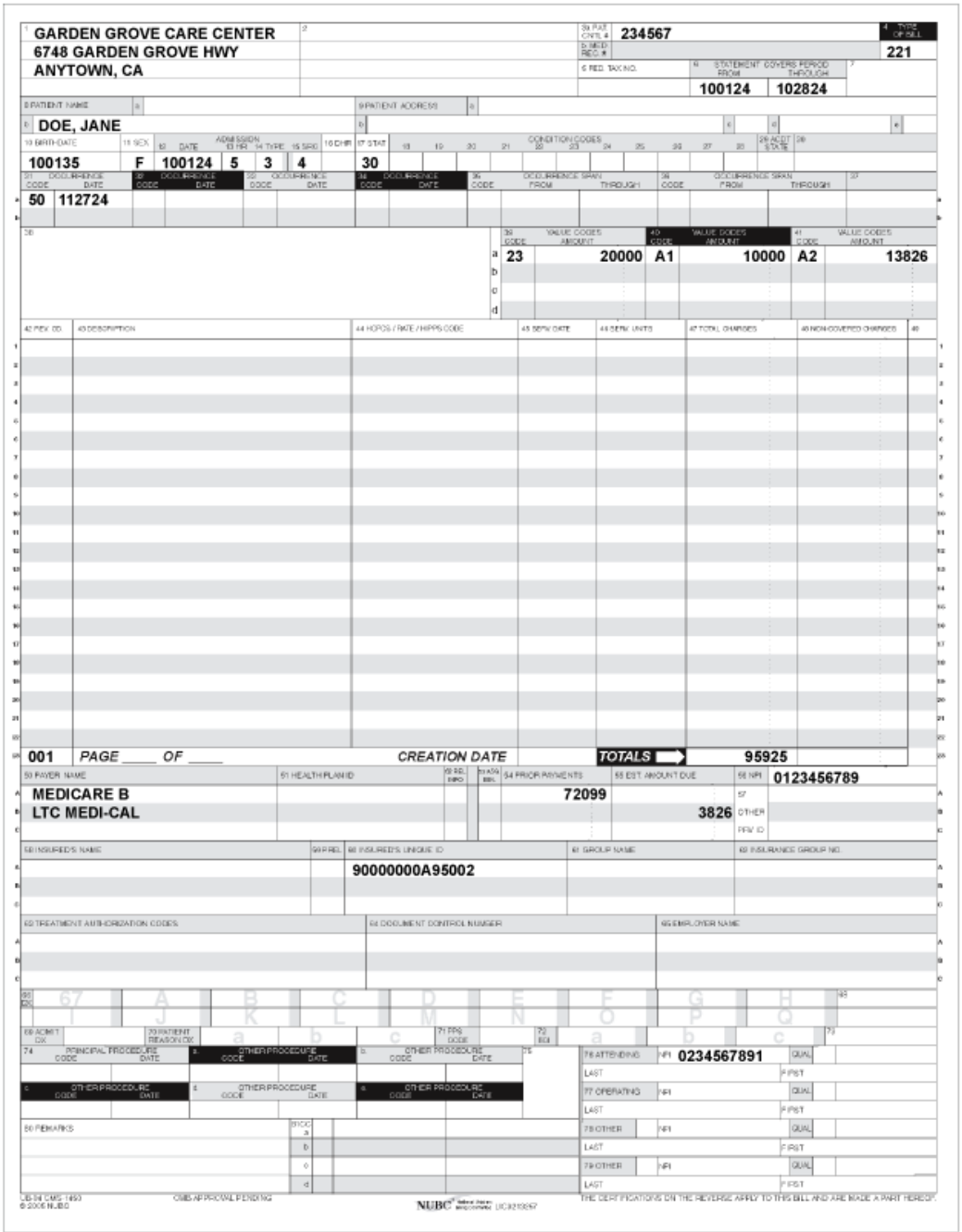


Figure 2b. Billing Medi-Cal for Part B Services Billed to a Part A Contractor with SOC

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

The total charges of $959.25 (Box 47, Line 23) is the amount allowed by Medicare. There is a Medicare deductible of $100.00 (Box 40a [Value Code A1 and Value Code Amount]). The sum of the Medicare paid amount of $643.43 and the contract adjustment amount of $77.56 ($720.99) is entered in the *Prior Payments* field (Box 54a). The SOC of $200.00 is entered in the *Value Codes and Amount* field (Box 39a [Value Code 23 and Value Code Amount]). The coinsurance from the Medicare RA, which is entered in the *Value Codes and Amount* field (Box 41a [Value Code A2 and Value Code Amount]) plus the Medicare deductible minus the SOC equals the net amount of $38.26 billed to Medi-Cal in the *Estimated Amount Due* field (Box 55b).



GARDEN GROVE CARE CENTER
6748 GARDEN GROVE HWY
ANYTOWN, CA

234567 | 221

100124 | 102824

DOE, JANE

100135 | F | 100124 | 5 | 3 | 4 | 30

50 | 112724

39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a 23	20000	A1	10000	A2	13826

001 | PAGE ____ OF ____ | CREATION DATE | TOTALS | 95925

50 PAYER NAME	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MEDICARE B	72099		0123456789
LTC MEDI-CAL		3826	

90000000A95002

76 ATTENDING NPI 0234567891

MEDICARE CONTRACTOR
1234 B STREET
ANYTOWN, CA 95555-5555
555-555-5555

05999 GARDEN GROVE CARE CENTER | PART B | PAID DATE: 11/01/2024 | REMIT#: 500 | PAGE 1

PATIENT NAME / **MEDICARE ID** # / FROM DT THRU DT / CLAIM STATUS IDE#	PATIENT CNTRL# / ICN NUMBER / NACHG HICHG TOB / COST COVDY NCOVDY	RC / RC / RC / RC	REM / REM / REM / 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							
9ZZ9ZZ9ZZ99	202071029402					534.22		77.56
10/01/2024 10/28/2024	QC	N221				2939.17		.85
					100.00			2861.61
								2227.39
DOE, JANE	654811							
9ZZ99Z9ZZ99	20207102890602					138.26		77.56
10/01/2024 10/28/2024	QC	N221				959.25		.85
					100.00			881.69
								643.43

Figure 2c: *Medicare Remittance Advice (RA) for Part B Figure 2a and 2b Examples*

Billing Medi-Cal for Part B Overlapping Dates of Service

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

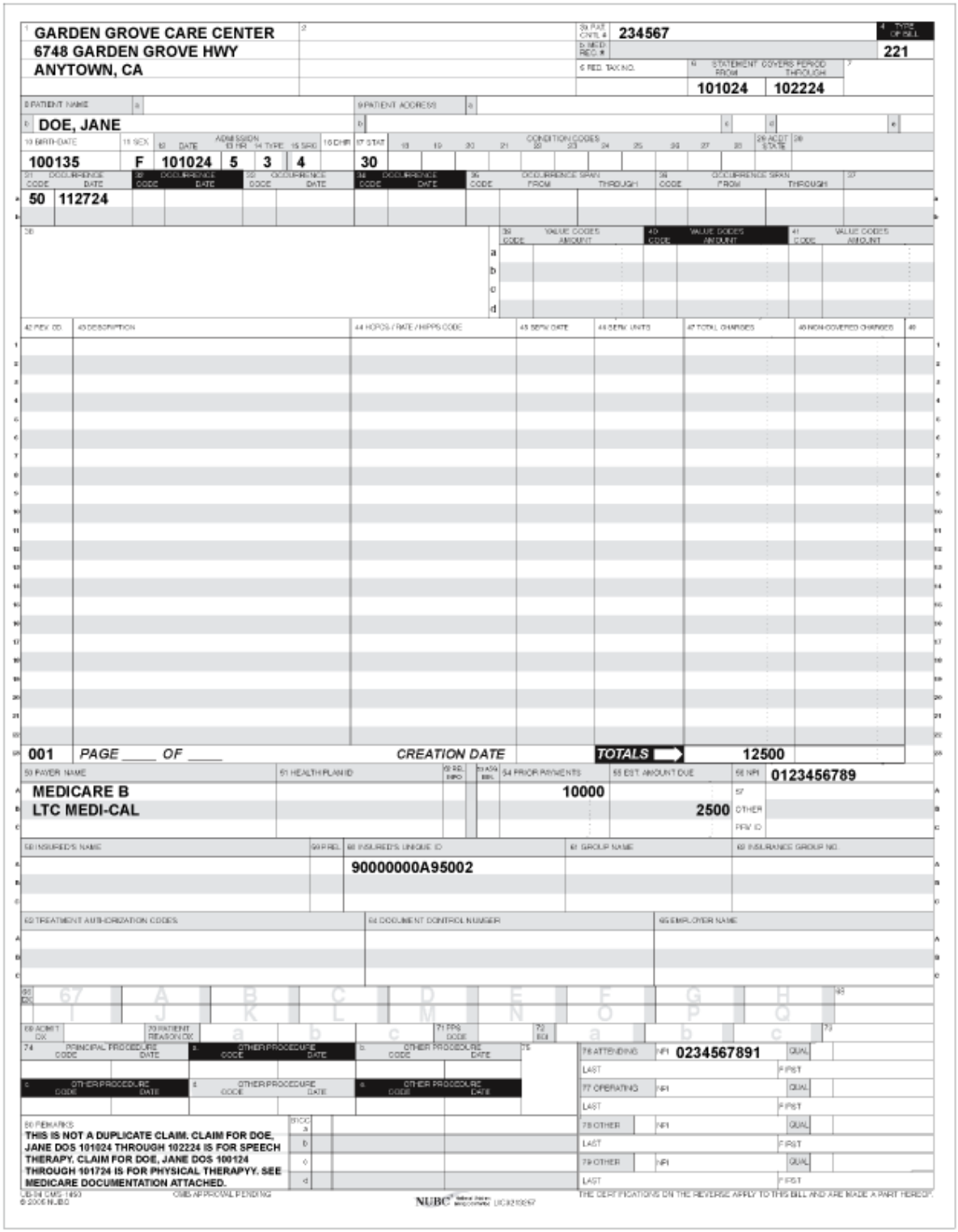
Occasionally, two Part B claim lines are billed for the same recipient with overlapping dates of service (for example, physical therapy and speech therapy). To avoid denial of the claim as a duplicate in these situations, use the *Remarks* area to identify the reason for the overlapping dates of service.

In the examples below, the provider is billing for speech therapy on Claim #1 (Figure 3a) and physical therapy on Claim #2 (Figure 3b). The recipient is the same and the dates of service overlap.

In the *Remarks* area, the biller writes: “This is not a duplicate claim.
Claim for Doe, Jane DOS 10/10/2024 through 10/22/2024 is for speech therapy.
Claim for Doe, Jane, DOS 10/01/2024 through 10/17/2024 is for physical therapy. See Medicare documentation attached.”

Similarly, if the provider is billing the speech therapy and physical therapy claims at different times and one claim has already been processed by Medi-Cal, instead of attaching the Medicare documentation, the provider can attach a copy of the previously submitted/processed claim.

Figure 3a: Billing Medi-Cal for Part B Overlapping Dates of Service, Claim 1



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

3a PAT CNTL # 234567
4 TYPE OF BILL 221
6 STATEMENT COVERS PERIOD FROM 101024 THROUGH 102224

5 PATIENT NAME: DOE, JANE

10 BIRTH DATE 100135 | 11 SEX F | 12 ADMISSION DATE 101024 | 13 HR 5 | 14 TYPE 3 | 15 SRC 4 | 17 STAT 30

31 OCCURRENCE CODE 50 DATE 112724

42 REV CD | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV DATE | 46 SERV UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES

001 PAGE ____ OF ____ CREATION DATE TOTALS 12500

50 PAYER NAME | 54 PRIOR PAYMENTS | 55 EST AMOUNT DUE | 56 NPI 0123456789
MEDICARE B | 10000
LTC MEDI-CAL | 2500

60 INSURED'S NAME | 61 INSURED'S UNIQUE ID | 62 GROUP NAME | 63 INSURANCE GROUP NO.
90000000A95002

67 A T | B J | C K | D L | E M | F N | G O | H P | Q

74 PRINCIPAL PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 0234567891 | LAST | FIRST | QUAL
77 OPERATING NPI | LAST | FIRST | QUAL
78 OTHER NPI | LAST | FIRST | QUAL
79 OTHER NPI | LAST | FIRST | QUAL

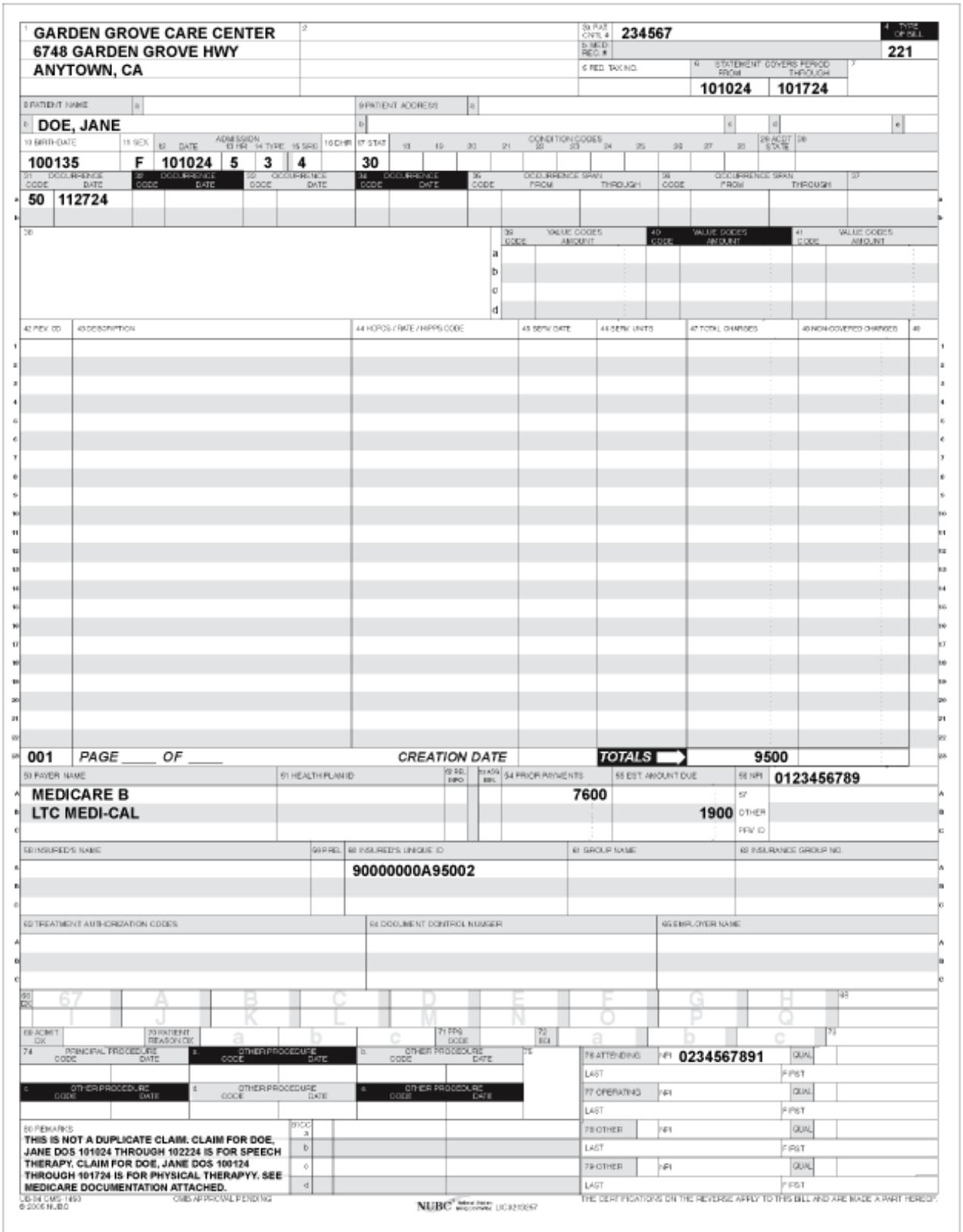
80 REMARKS
THIS IS NOT A DUPLICATE CLAIM. CLAIM FOR DOE, JANE DOS 101024 THROUGH 102224 IS FOR SPEECH THERAPY. CLAIM FOR DOE, JANE DOS 100124 THROUGH 101724 IS FOR PHYSICAL THERAPYY. SEE MEDICARE DOCUMENTATION ATTACHED.

81CC

CMS-1450 OMB APPROVAL PENDING NUBC

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

Figure 3b: Billing Medi-Cal for Part B Overlapping Dates of Service, Claim 2



GARDEN GROVE CARE CENTER
6748 GARDEN GROVE HWY
ANYTOWN, CA

234567

221

101024 101724

DOE, JANE

100135 F 101024 5 3 4 30

50 112724

001 PAGE ____ OF ____ CREATION DATE TOTALS 9500

MEDICARE B 7600
LTC MEDI-CAL 1900

0123456789

90000000A95002

0234567891

THIS IS NOT A DUPLICATE CLAIM. CLAIM FOR DOE, JANE DOS 101024 THROUGH 102224 IS FOR SPEECH THERAPY. CLAIM FOR DOE, JANE DOS 100124 THROUGH 101724 IS FOR PHYSICAL THERAPYY. SEE MEDICARE DOCUMENTATION ATTACHED.