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

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‹‹This manual section has been retained to provide reference to LTC-related billing instructions for dates of service prior to February 1, 2024. This manual section is not live and does not reflect current billing policy and should not be referenced when billing for dates of service on or after February 1, 2024. For current billing instructions as of February 1, 2024, refer to the appropriate manual section in the Long Term Care Provider Manual.››

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

Common Billing Errors Table

Field	Description	Error
Explanations	Medicare Part B, duplicate claim	Billing two Part B Medicare claim lines for the same recipient with overlapping dates of service. **Billing Tip:** Enter the reason for the overlapping dates of service in the *Explanations* field. For example, "Line 1: This is not a duplicate claim. This claim is for speech therapy. Line 2: The physical therapy claim (same recipient for overlapping dates of service) was billed on an earlier date [give specific date]. A copy of the claim is attached."
Explanations	Share of Cost (SOC)	Failure to identify the reason for reduction in a recipient's Share of Cost (SOC). **Billing Tip:** Identify the SOC for the patient minus the non-covered services in the *Explanations* field. For example, "Share of Cost 300.00 (–) non-covered services 27.70 = Pat Liab/Medicare Deduct 272.30."
11, 30, 49, 68, 87, 106	Billing Limit Exceptions	Omitting valid delay reason codes for claims submitted more than six months from the date of service. **Billing Tip:** Enter the delay reason code in the designated field.

Common Billing Errors Table (continued)

Field	Description	Error
14, 33, 52, 71, 90, 109	Patient Status	Entering the patient status code in the wrong field. **Billing Tip:** Enter the status code in the *Patient Status* field.
15, 34, 53, 72, 91, 110	Accommodation Code	Entering the accommodation code in the wrong field. **Billing Tip:** Enter the accommodation code in the *Accommodation Code* box.
19, 38, 57, 76, 95, 114	Other Health Coverage (OHC)	Claim submitted to Medi-Cal with a billing limit exception code or delay reason code or attachment indicating that the claim was submitted to Medicare and/or Other Health Coverage (OHC) more than one year from the month of service. **Billing Tip:** Bill Medicare or the OHC within one year of the month of service to meet Medi-Cal timeliness requirements. Submit claim to the California MMIS Fiscal Intermediary within 60 days of Medicare or OHC carrier's resolution. Use the OHC *Explanation of Benefits* date or Medicare Remittance Advice date to calculate timeliness.
12 and 13, 31 and 32, 50 and 51, 69 and 70 88 and 89 107 and 108	Date of Service (From – Thru)	From – thru dates of service do not correspond with the authorized from – thru dates of service on the *Treatment Authorization Request* (TAR). **Billing Tip:** Verify that the dates of service on the claim match the approved dates on the TAR, or obtain a revised TAR.

Common Billing Errors Table (continued)

Field	Description	Error
14 and 15, 33 and 34, 52 and 53, 71 and 72, 90 and 91, 109 and 110	Patient Status/ Accommodation Code	Entering an accommodation code and status code combination that is inappropriate. **Billing Tip:** Confirm that the patient status code agrees with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days).

Field Completion Reminders

Providers should remember the following when completing the claim form.

- The "white" space to the right of the bar code is reserved for FI use only. Type only in areas of the claim form designated as fields. Do not type in undesignated white space.
- If an error has been made for a particular recipient, enter an "X" in the *Delete* field (Box 3, 22, 41, 60, 79, or 98) to delete both the upper and lower lines. The information on both lines will be "ignored" by the system and will not be entered as a claim line. Enter the correct billing information on any other line.
- Enter the 9-digit TAR Control Number in the *TAR Control Number* field (Box 8).
- Enter dates of service in a six-digit format for Month, Day, Year (MMDDYY). For example, if the date of service is July 12, 2002, enter as 071202 in the *Date of Service* field (Boxes 12 and 13, 31 and 32, 50 and 51, 69 and 70, 88 and 89, 107 and 108).

Bed Hold Reminders

To prevent claim denials because the service(s) on the claim is a duplicate of a previously paid claim, providers should remember the following:

- Check regularly for recipients on leave at home, at an acute hospital or transferred to another LTC facility.

  Note: If the patient has changed to another facility, be sure to bill with the appropriate patient status code. For additional patient status code information, refer to the *Payment Request for Long Term Care (25-1) Completion* section of this manual.
- Verify that dates of service on the claim reflects only the dates for services rendered.
- Verify that the facility to which the recipient was transferred is billed correctly.

If another facility erroneously submitted a claim and received payment for the same recipient and same date of service but has not resubmitted a corrected claim, providers are advised to submit an inquiry to the Correspondence Specialist Unit for research. Refer to the *Provider Relations Directory* in the Part 1 manual for the mailing address.

Paper Claim Form Requirements

The following paper claim form requirements and standard billing procedures can speed claim processing and prevent delays. Before submitting claims, check to see that:

- The original claim is submitted. Carbon copies or photocopies, computer-generated claim form facsimiles or claim forms created on laser printers are not acceptable.

  Individual claim forms are separated. Each claim is processed separately. Do not staple original claims together. Stapling original claims together indicates the second claim is an "attachment," not an original claim to be processed separately.

- All perforated sides are removed. For accurate scanning, be sure to leave a ¼-inch border on the left and right side of the form after removing the perforated sides.

- Information is typed within the designated area of the field. Be sure the type falls completely within the text space and is properly aligned with corresponding information. If using a DOT matrix printer, do not use "draft mode." The characters do not have enough distinction and clarity for the optical character reader to accurately determine the contents.

- All dates are entered without slashes. Do not use punctuation, such as decimal point (.), dollar sign ($), positive (+) or negative (-) symbol when entering amounts.

- Attachments are taped to an 8½ x 11-inch sheet of paper with non-glare tape. Do not use original claims as attachments.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.