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

Page updated: December 2023

‹‹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 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-10-CM 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.

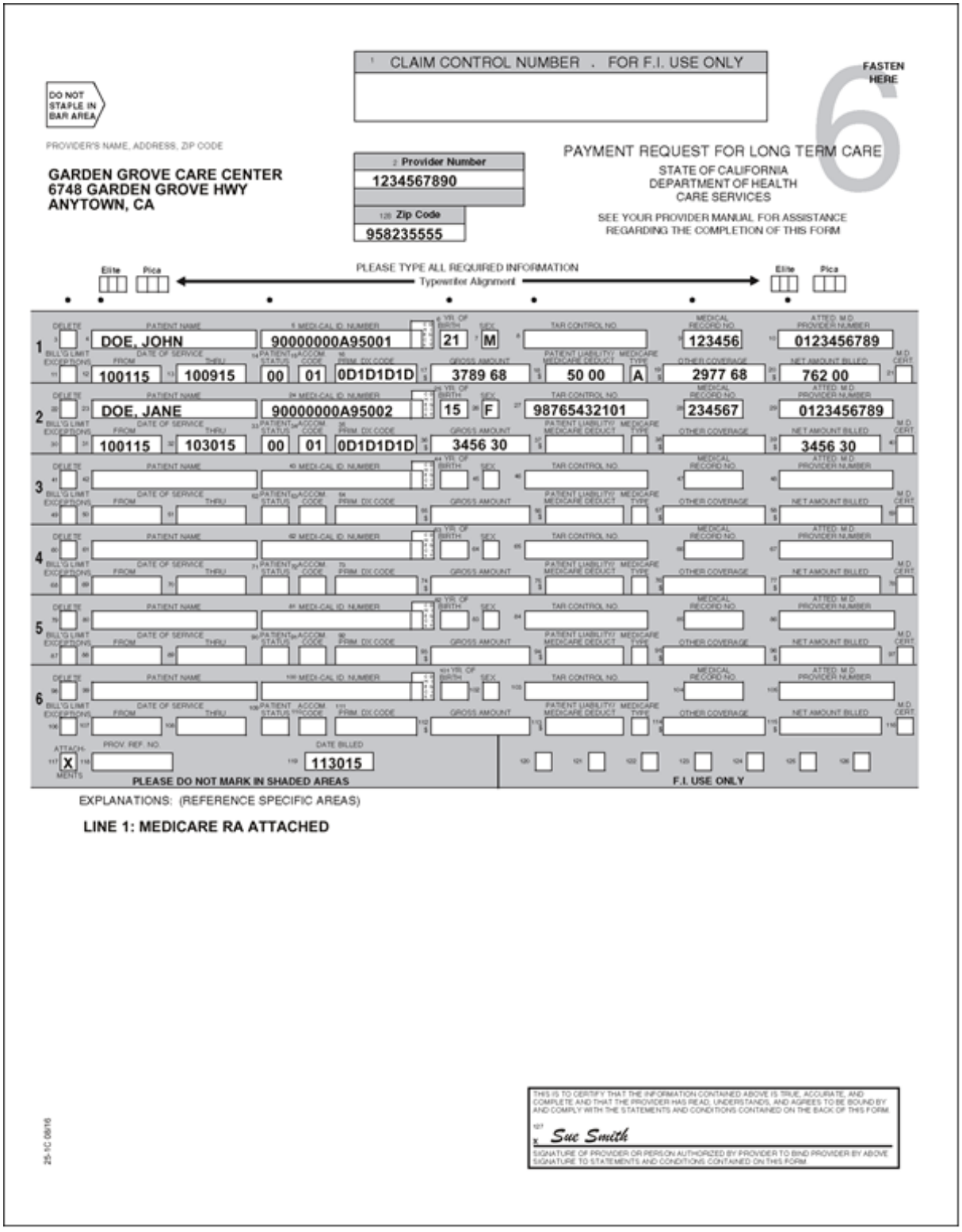
Figure 1a. Billing Medi-Cal for Part A Services Billed to a Part A Contractor

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.



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
6748 GARDEN GROVE HWY
ANYTOWN, CA

2 Provider Number: 1234567890

12B 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.	ATTEND 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	100115	100915	00	01	0D1D1D1D	3789 68	50 00	A	2977 68	762 00	
2	100115	103015	00	01	0D1D1D1D	3456 30				3456 30	
3											
4											
5											
6											

ATTACHMENTS: X — PROV. REF. NO. — DATE BILLED: 113015

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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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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.

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

05000 GARDEN GROVE CARE CENTER | SKILLED NURSING | PAID DATE: 10/15/2015 | 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
10/01/2015 10/09/2015		.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.

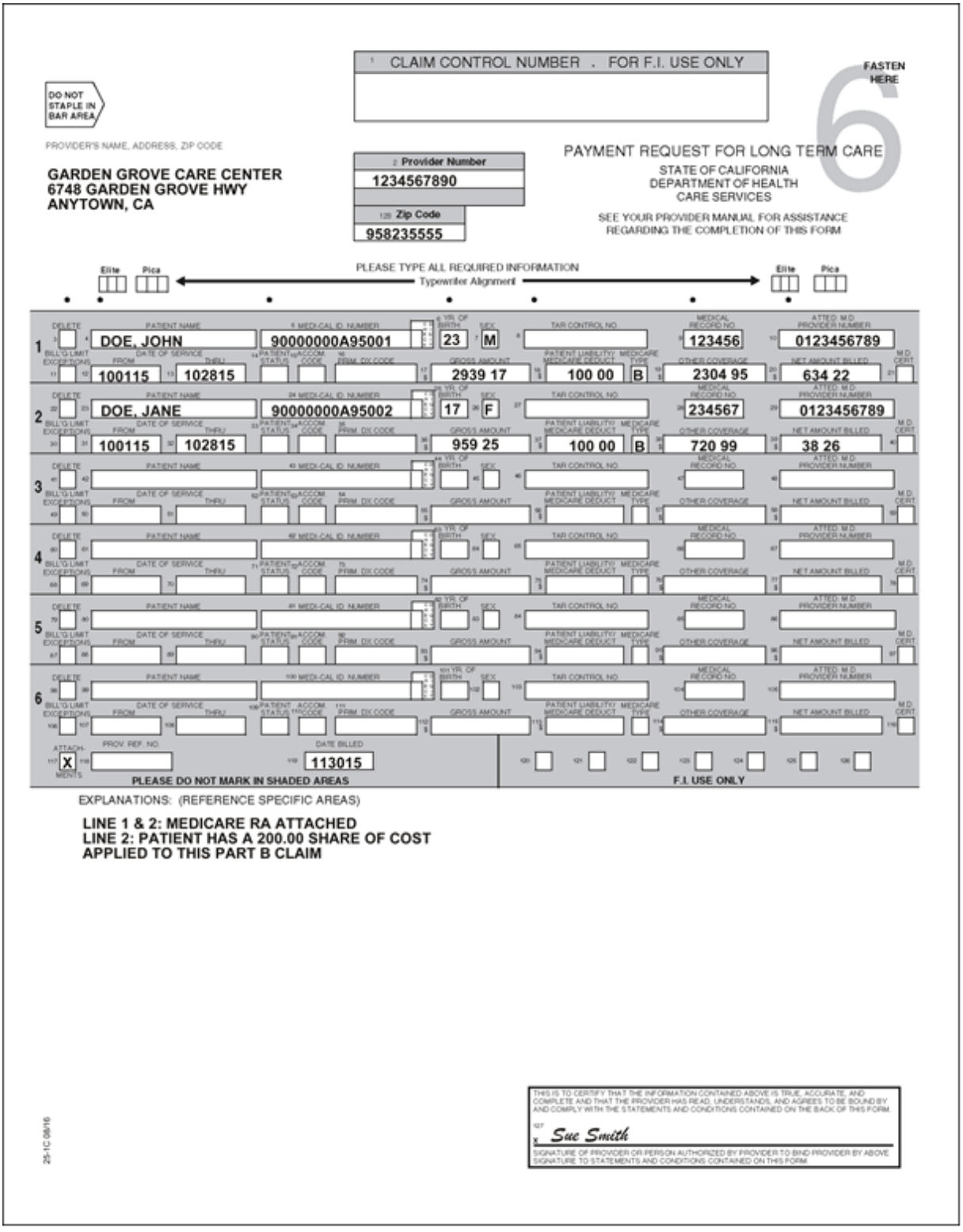
Billing Medi-Cal for Part B Services Billed to a Part A Contractor

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).



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

12b 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.	ATTEND. M.D. PROVIDER NUMBER
1	DOE, JOHN	90000000A95001	23	M		123456	0123456789

BILL'G LIMIT EXCEPTIONS	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
	100115	102815				2939 17	100 00	B	2304 95	634 22	

	PATIENT NAME	24 MEDI-CAL ID. NUMBER	25 YR. OF BIRTH	SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTEND. M.D. PROVIDER NUMBER
2	DOE, JANE	90000000A95002	17	F		234567	0123456789

BILL'G LIMIT EXCEPTIONS	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
	100115	102815				959 25	100 00	B	720 99	38 26	

	PATIENT NAME	43 MEDI-CAL ID. NUMBER	44 YR. OF BIRTH	SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTEND. M.D. PROVIDER NUMBER
3							

BILL'G LIMIT EXCEPTIONS	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

	PATIENT NAME	62 MEDI-CAL ID. NUMBER	63 YR. OF BIRTH	SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTEND. M.D. PROVIDER NUMBER
4							

BILL'G LIMIT EXCEPTIONS	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

	PATIENT NAME	81 MEDI-CAL ID. NUMBER	82 YR. OF BIRTH	SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTEND. M.D. PROVIDER NUMBER
5							

BILL'G LIMIT EXCEPTIONS	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

	PATIENT NAME	100 MEDI-CAL ID. NUMBER	101 YR. OF BIRTH	SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTEND. M.D. PROVIDER NUMBER
6							

BILL'G LIMIT EXCEPTIONS	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

ATTACH-MENTS: X — PROV. REF. NO. — DATE BILLED: 113015

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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

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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.

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

05999 GARDEN GROVE CARE CENTER PART B PAID DATE: 11/01/2015 REMIT#: 500 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, JOHN	1234JS							
9ZZ9ZZ9ZZ99	202071029402					534.22		77.56
10/01/2015 10/28/2015	QC N221					2939.17		.85
					100.00			2861.61
								2227.39
DOE, JANE	654811							
9ZZ99Z9ZZ99	20207102890602					138.26		77.56
10/01/2015 10/28/2015	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.

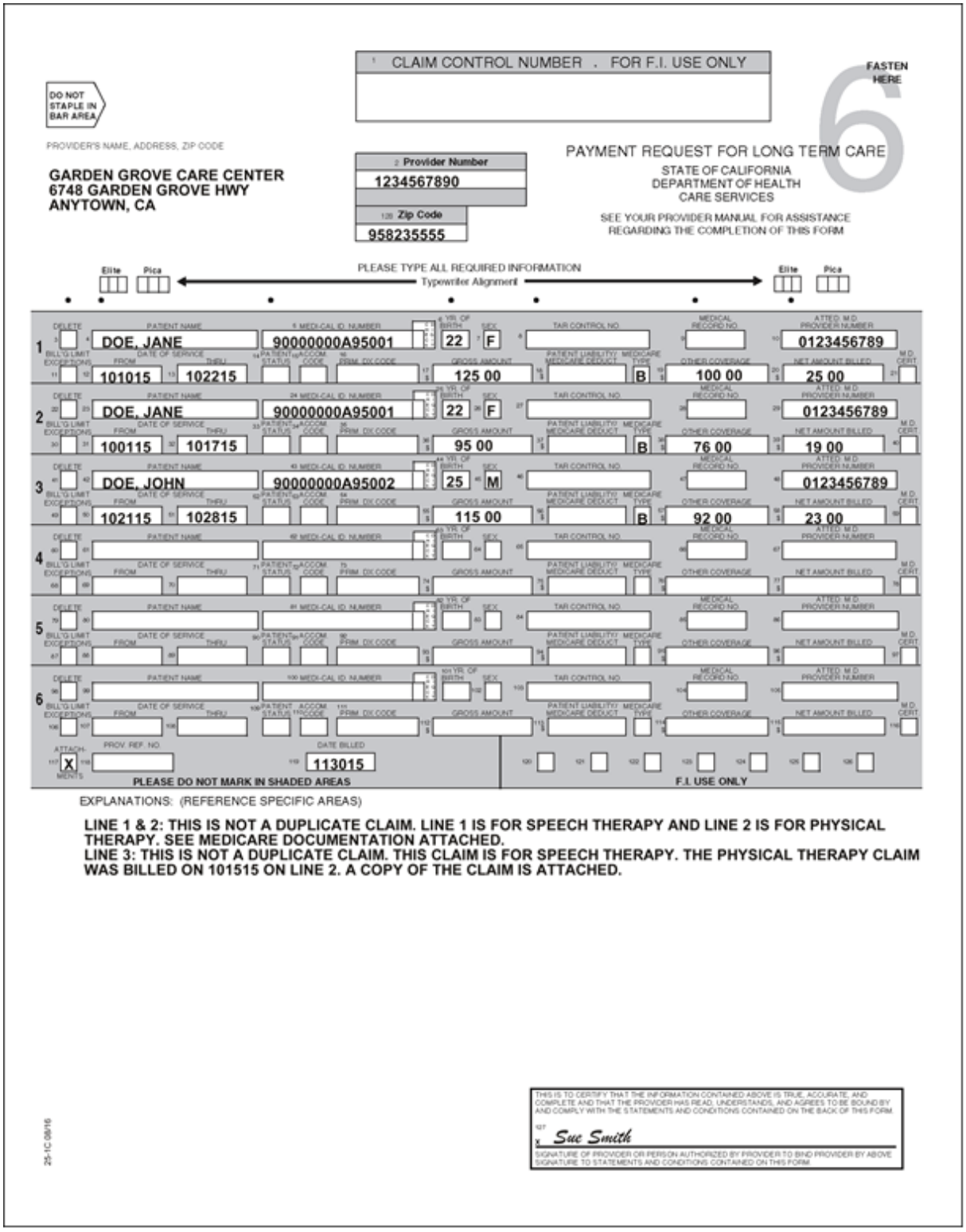
Occasionally, two Part B claim lines are billed for the same recipient with overlapping dates of service (for example, physical therapy and speech therapy). To avoid denial of the claim as a duplicate in these situations, use the *Explanations* area to identify the reason for the overlapping dates of 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 10/15/15 on line 2. A copy of the claim is attached."



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PROVIDER'S NAME, ADDRESS, ZIP CODE

GARDEN GROVE CARE CENTER
6748 GARDEN GROVE HWY
ANYTOWN, CA

2 Provider Number: 1234567890

12B 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

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	PATIENT NAME	5 MEDI-CAL ID. NUMBER	6 YR. OF BIRTH	SEX	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTEND. M.D. PROVIDER NUMBER
1	DOE, JANE	90000000A95001	22	F			0123456789
2	DOE, JANE	90000000A95001	22	F			0123456789
3	DOE, JOHN	90000000A95002	25	M			0123456789
4							
5							
6							

	DATE OF SERVICE FROM	DATE OF SERVICE THRU	PATIENT STATUS	ACCOM. CODE	PRIM. DIX CODE	GROSS AMOUNT	PATIENT LIABILITY/ MEDICARE DEDUCT	MEDICARE TYPE	OTHER COVERAGE	NET AMOUNT BILLED	M.D. CERT
1	101015	102215				125 00		B	100 00	25 00	
2	100115	101715				95 00		B	76 00	19 00	
3	102115	102815				115 00		B	92 00	23 00	
4											
5											
6											

ATTACHMENTS: X

PROV. REF. NO.

DATE BILLED: 113015

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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 101515 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

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.