

Medicare/Medi-Cal Crossover Claims: Long Term Care

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«This section contains billing information, billing tips and Medicare documentation requirements for Medicare/Medi-Cal crossover claims submitted on a *UB-04* claim form for Long Term Care (LTC) services.» Refer to the *Medicare/Medi-Cal Crossover Claims Overview* section in the Part 1 manual for eligibility information and general guidelines. Refer also to the *Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples* section in this manual for claim form billing examples. Information in this section is organized as follows:

- Medicare Eligibility
- Automatic Claim Submissions: Additional Information
- Hard Copy Submission Requirements for Medicare Approved Services
- *Crossover Claims Inquiry Forms (CIFs)*
- Billing for Medicare Non-Covered, Exhausted or Denied Services, or Medicare Non-Eligible Recipients

Medicare Eligibility

Part A

Medicare Part A benefits are reimbursed according to the following criteria:

Table of Covered Days and Reimbursement for Part A Benefits

Days	Reimbursement
First 20 days	Medicare pays 100% of the approved amount.
21 st to 100 th 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 an acute hospital.
 - Recipient must continue to require skilled nursing level care.

Part B

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 *UB-04* claim form for LTC services may only be used for crossover claims billed hard copy by LTC facilities.»

Prior Authorization

A *Treatment Authorization Request* (TAR) is not required for Medicare Part A covered days, including crossover days, or Part B covered services, which 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.

Automatic Claim Submissions: Additional Information

Deductible/Coinsurance Reconciliation

When deductible/coinsurance claims automatically cross over from Medicare to Medi-Cal, carefully reconcile the Medi-Cal *Remittance Advice Details* (RAD) to ensure that expected deductible/coinsurance amounts are paid correctly.

- «If deductible/coinsurance amounts do not appear on the RAD within 45 days after receipt of the Medicare RA, manually bill the deductible/coinsurance on the *UB-04* form, following the hard copy billing instructions in this section.»
- If the deductible/coinsurance amounts were incorrectly paid on the RAD, submit a *Claims Inquiry Form* (CIF) requesting the appropriate adjustment. (Refer to the *CIF Completion* section in this manual.)

Share of Cost (Patient Liability)

Follow the instructions in the Medicare manual when completing Medicare claims, except as noted below for Medi-Cal Share of Cost (SOC).

Indicate the Medi-Cal SOC (patient liability) to be deducted from a Part A or Part B deductible and/or coinsurance payment by entering value code 23 and the corresponding dollar amount of a recipient's SOC on the Medicare claim (*UB-04* claim or Medicare electronic submission).

Example: The Medicare Part A claim totals \$1240 for the coinsurance on a 10-day stay, at \$124 per day. The patient's Medi-Cal SOC liability is \$500.

Enter value code 23 and the SOC amount of \$500 on the Medicare claim. In this instance, Medi-Cal pays \$740.

NPI Used to Bill Medicare

The National Provider Identifiers (NPIs) used to bill Medicare must be on the Medi-Cal Provider Master File for Medicare coinsurance and deductibles to be paid through the automated process. Providers must register their NPIs with Medi-Cal.

Hard Copy Submission Requirements for Medicare Approved Services

Where to Submit Hard Copy Crossover Claims

Medicare/Medi-Cal crossover claims for Medicare approved or covered services that do not automatically cross over or that cross over but cannot be processed must be hard copy billed directly to Medi-Cal. Providers must submit crossover claims to the California MMIS Fiscal Intermediary.

Attn: Crossover Unit
California MMIS Fiscal Intermediary
P.O. Box 15400
Sacramento, CA 95851-1400

Medicare billing questions should be directed to the Medicare intermediary, not the California MMIS Fiscal Intermediary.

Part A Services Billed to Part A Intermediaries

Hard copy submission requirements for Part A services billed to Part A intermediaries are as follows:

«With Part A Payment

- Submit an original *UB-04* claim form according to instructions listed below and in the *UB-04 Completion: Long Term Care Services* section of this manual. Refer to the *Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples* section of this manual for Part A billing examples.
- When billing LTC claims with Part A payments, the following items must be completed as applicable:
 - Type of Bill (Box 4)
 - ❖ Enter Type of Bill 18, 21, or 28 as applicable.
 - Occurrence Codes and Dates (Boxes 31 thru 34)
 - ❖ Date of Remittance Advice (RA): Enter code 50 and the date (MMDDYY) of the Medicare RA.»

- <<Value Codes and Amounts (Boxes 39 thru 41 a-d)
 - ❖ 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 value code 24 (Medicaid Rate Code) and the corresponding value code amount (Designated State Level Medicaid Rate Code). Refer to the *Revenue and Value Codes for Long Term Care* manual section for the appropriate combination of value code 24, value code 24 amounts and revenue code.
 - Leave blank if not applicable.
- Revenue Codes (Box 42)
 - ❖ Enter the appropriate revenue code. Refer to the *Revenue Codes and Value Codes for Long Term Care Services* manual section for the appropriate combination of value code 24, value code 24 amounts and revenue code.
 - ❖ For Box 42, Line 23, enter "001" to indicate that this is the total charge line.
 - ❖ Leave blank if not applicable.
- Total Charges (Box 47)
 - ❖ 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).>>

- «Payer Name (Box 50)
 - ❖ 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
 - ❖ 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.»

- «Prior Payments (Box 54)
 - ❖ On the corresponding Payer Name (Box 50) Medicare line, enter the Medicare paid amount.
- Estimated Amount Due (Box 55)
 - ❖ 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 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).

Total Charge (Box 47, Line 23)
- Medicare Paid Amount (Box 54)
- SOC Amount (Boxes 39-41, Value Code 23)
= Estimated Amount Due (Box 55)

Figure 1: Estimated Amount Due (Box 55) Calculation for Part A Payment»

- Attach a copy of the *Medicare National Standard Intermediary Remittance Advice* (Medicare RA) showing the Part A payment.
 - Providers who receive electronic RAs may submit a printout. This printout must include the following fields:
 - ❖ Date of Medicare RA
 - ❖ Intermediary name
 - ❖ Provider name
 - ❖ Patient last name or Medicare ID number
 - ❖ “From-through” dates
 - ❖ Billed or total charges
 - ❖ Medicare paid amount
 - ❖ Deductible and/or coinsurance amount and/or blood deductible
 - ❖ Non-covered charges (if applicable)
 - ❖ Denial reason (Medicare denied claims only; not crossovers)
 - ❖ Non-covered days (applies to Part A and B crossovers and straight Medi-Cal claims)
 - ❖ Claim type, bill type or Type of Bill (TOB) (that is, inpatient, outpatient or Nursing Facility Level B [NF-B])
 - ❖ Contract adjustment amount

Do not obtain a *Treatment Authorization Request* (TAR). A TAR is not required for this type of billing.

Note: If an RA indicates a Medicare denial and the description is not printed on the front of the RA, providers must include a copy of the Medicare denial description from the back of the original RA or from the Medicare manual when billing for a Medicare denied claim.

Part B Services Billed to Part A Intermediaries

Hard copy submission requirements for Part B services billed to Part A intermediaries are as follows:

- «Submit a *UB-04* claim form according to instructions listed below and in the *UB-04 Completion: Long Term Care Services* section of this manual. Refer to the *Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples* section of this manual for Part B billing examples.
- When Part B payment appears on a Medicare RA, enter the payment amount in the *Prior Payments* field (Box 54).
- Do not complete claim detail lines.
- When billing LTC claims with Part B payments for Part B services billed to Part A intermediaries, the following items must be completed as applicable:
 - Type of Bill (Box 4)
 - ❖ Enter Type of Bill 22 or 23 as applicable
 - Occurrence Codes and Dates (Boxes 31 thru 34)
 - ❖ Date of RA: Enter code 50 and the date (MMDDYY) of the Medicare RA.
 - Value Codes and Amounts (Boxes 39 thru 41 a-d)
 - ❖ 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 A2 if Medicare is the primary payer, or B2 if Medicare is a secondary payer
 - Enter coinsurance amount
 - Leave blank if not applicable»»

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- «Revenue Code (Box 42), Description (Box 43), and Total Charges (Box 47)
 - ❖ Box 42, Line 23: Enter “001” to indicate that this the total charge line.
 - ❖ Box 47, Line 23: Enter the Medicare allowed amount (from EOMB/RA).
 - Payer Name (Box 50)
 - ❖ 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
 - ❖ 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.
 - Prior Payments (Box 54)
 - ❖ On the corresponding Payer Name (Box 50) Medicare line, enter the Medicare paid amount plus any contract adjustment amount (from EOMB/RA).»

- «Estimated Amount Due (Box 55)
 - ❖ 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).

Medicare Coinsurance Amount (Boxes 39-41, Value Code A2 or B2)
+ Medicare Deductible (Boxes 39-41, Value Code A1 or B1)
- SOC Amount (Boxes 39-41, Value Code 23)
= Estimated Amount Due (Box 55)

Figure 2: Estimated Amount Due (Box 55) Calculation for Part B Payment»

- Attach a copy of the Medicare RA showing the Part B payment.
 - Providers who receive electronic RAs may submit a printout. This printout must include the following fields:
 - ❖ Date of RA
 - ❖ Intermediary name and code
 - ❖ Provider name
 - ❖ Patient last name or Medicare ID number
 - ❖ “From-through” dates
 - ❖ Billed or total charges
 - ❖ Medicare paid amount
 - ❖ Deductible and/or coinsurance amount and/or blood deductible
 - ❖ Non-covered charges (if applicable)
 - ❖ Denial reason (Medicare denied claims only; not crossovers)
 - ❖ Non-covered days (applies to Part A and B crossovers and straight Medi-Cal claims)
 - ❖ Claim type, bill type or Type of Bill (TOB) (that is, inpatient, outpatient or Nursing Facility Level B [NF-B])
 - ❖ Contract adjustment amount

Note: If an RA indicates a Medicare denial and the description is not printed on the front of the RA, providers must include a copy of the Medicare denial description from the back of the original RA or from the Medicare manual when billing for a Medicare denied claim.

Crossover Claims Inquiry Forms (CIFs)

CIF for All Crossover Claims

Refer to the *CIF Special Billing Instructions for Long Term Care* section in this manual to complete a CIF for a Medicare/Medi-Cal crossover claim.

CIF for Medicare Adjustments

Medicare adjustments will not be included in the automated submission of Part A or B Medicare crossover claims. Submit a CIF for adjustment of these claims.

Billing for Medicare Non-Covered, Exhausted or Denied Services, or Medicare Non-Eligible Recipients

Medicare Reimbursement

Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare carrier or intermediary for processing of Medicare benefits. Medi-Cal recipients are considered Medicare-eligible if they are aged 65 years or older, blind or disabled, or if the Medi-Cal eligibility verification system indicates Medicare coverage. If Medicare approves the claim, it must then be billed to Medi-Cal as a crossover claim.

Straight Medi-Cal Claims

Providers should bill as a straight Medi-Cal claim if any of the following apply: the services are not covered by Medicare, Medicare benefits have been exhausted, Medicare has denied the claim or the recipient is not eligible for Medicare. These are not crossover claims. «For billing and timeliness instructions, refer to the *UB-04 Completion: Long Term Care Services* and *UB-04 Submission and Timeliness Instructions* sections in this manual.»

Medicare Non-Covered Services

Medicare non-covered services must be included with the covered services billed to Medi-Cal on Part A crossover claims. See “Part A Services Billed to Part A Intermediaries” on a previous page in this section. Do not bill the non-covered services separately.

Medicare Non-Eligible Recipients

The Department of Health Care Services (DHCS) requires providers to submit formal documentation indicating a recipient is not eligible for Medicare when billing Medi-Cal for the following recipients:

- Recipients who are 65 years or older (for example, those with non-citizen status)
- Recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage

To bill such claims, attach the appropriate documentation.

Note: Refer to “Types of Medicare Eligibility” in the *Medicare/Medi-Cal Crossover Claims Overview* section of the Part 1 manual for information about recipient Medicare coverage retrieved from the eligibility verification system.

Medicare Documentation Requirements

Providers must submit Medicare payment or denial documentation with their claims for all Medi-Cal recipients for whom the Medi-Cal eligibility verification system indicates Medicare coverage.

Claims with no documentation or with insufficient or unacceptable Medicare documentation will be denied.

Note: If the Medicare denial description is not printed on the front of the EOMB/RA, include a copy of the description from the back of the EOMB/RA or from the Medicare manual when billing for a Medicare denied claim.

Acceptable Medicare Documentation

Examples of acceptable Medicare eligibility documentation are:

- Any document signed, dated and stamped by an SSA district office, or any documentation on SSA or Department of Health and Human Services letterhead:
 - Valid for dates of service up to the end of the month of the date on the document or date of entitlement

Note: Handwritten statements are acceptable if they bear an SSA stamp and contain the specific date criteria mentioned above.

- Medicare *Common Working File* (CWF), which must include the following fields:
 - Recipient name
 - Recipient Medicare ID number
 - Online access date
 - Part A/Part B current entitlement/termination date; for example:

A:CURR-ENT DT TERM DT

B:CURR-ENT DT TERM DT

The absence of a date in either of the fields “A:CURR-ENT DT” or “B:CURR-ENT DT” establishes that the recipient is not eligible for Part A or Part B Medicare coverage, respectively.

- Form LBDO-111, *Request for Medicare Verification*, when signed by patient and signed and dated by SSA:
 - Valid for dates of service up to the end of the month of the date on the document or date of entitlement
- SSA Form 2458, *Report of Confidential Social Security Benefit Information*, indicating no Medicare coverage
- Medicare ID number indicating Part A or Part B benefits after the date of service billed
- Any document bearing an SSA district office stamp, which indicates that eligibility cannot be determined and there is a valid nine-digit Social Security Number (SSN) present
- Forms containing pseudo SSN (nine-digit SSN ending in “P,” for example 111-22-333P):
 - MEDS Full Status Inquiry Screen showing a MEDS ID ending in “P”
- The HCFA-18 F5, *Application for Social Security Hospital Insurance*, page 5, “Receipt for Your Claim,” as proof of ineligibility for dates of service until the form is processed as written in by SSA
- HCFA 1600 form, *Request for Claim Number Verification*
- HCFA Form 921, *Report of Eligibility (ROE)*:
 - “Reject – Disposition Code 42” means the recipient is not eligible for Part A benefits, but is eligible for Part B benefits; it is acceptable up to entitlement date or date on the form for Part A ineligibility only
 - If the “Hospital Days Remaining” figures show a certain number of days remaining, and the claim admission date matches the ROE admission date, and it can be determined by counting forward from the admit date that the period of service being billed falls outside of the remaining days (including lifetime) covered period, then the ROE is acceptable to verify exhausted Part A-only benefits

- 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
- Printout of electronic *Medicare National Standard Intermediary Remittance Advice* (Medicare RA):
 - Date of Medicare RA
 - Intermediary name (this field may be handwritten or typed) and code
 - Provider name
 - Patient last name or Medicare ID number
 - “From-through” dates
 - Billed/total/submitted charges
 - Medicare paid amount
 - Deductible and/or coinsurance amount and/or Blood Deductible
 - Non-covered/non-allowed charges (if applicable)
 - Denial reason/reason code (Medicare denied claims only, not crossovers. For older RAs, there is no date element field in the header; however, there will be a code on the line prior to the patient name.)
 - Non-covered days (applies to Part A and B crossovers and straight Medi-Cal claims)
 - Claim type, bill type or Type of Bill (TOB) (that is, inpatient, outpatient and Nursing Facilities Level B [NF-Bs])
 - Contract adjustment amount

Note: If an RA indicates a Medicare denial and the Medicare denial description is not printed on the front of the RA, providers must include a copy of the Medicare denial description from the back of the original RA or from the Medicare manual when billing for a Medicare denied claim.

Non-Acceptable Medicare Documentation

Examples of non-acceptable Medicare documentation are any:

- Medicare Eligibility Certification Forms completed by the recipient or any statement from the recipient
- Forms indicating that the recipient's name and SSN do not match or are incorrect
- Permanent Resident or "Green" Cards
- Statements from the provider regarding the recipient's Medicare eligibility
- Documents not dated
- Medicare claim denials due to incomplete, unacceptable or inappropriate information from the provider or recipient or denials stating that the claim should be resubmitted to Medicare

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.