

Medicare/Medi-Cal Crossover Claims: Long Term Care

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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 contains billing information, billing tips and Medicare documentation requirements for Medicare/Medi-Cal crossover claims submitted on a *Payment Request for Long Term Care (25-1)*. 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 *Payment Request for Long Term Care (25-1)* 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 25-1 form, following the hard copy billing instructions on a previous page 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, or 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:

- Submit an original *Payment Request for Long Term Care (25-1)* according to 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 this manual. Refer to Figure 1 in the *Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples* section of this manual.
- 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 *Payment Request for Long Term Care (25-1)* according to 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 of this manual. Refer to Figure 2 in the *Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples* section of this manual.
- When 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. 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 *Payment Request for Long Term Care (25-1) Completion* and *Payment Request for Long Term Care (25-1) 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.