LTC (UB-04) Crossover Claims

Introduction

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.

Purpose

The purpose of this module is to familiarize participants with the LTC billing information, billing tips and Medicare documentation requirements for Medicare/Medi-Cal crossover claims submitted on a UB-04 claim form for recipients who are eligible for both Medicare and Medi-Cal.

Module Objectives

- Define crossovers.
- Identify the components of LTC crossovers.
- Discuss Medicare/Medi-Cal including eligibility, authorization, and Share of Cost (SOC).
- Review LTC *UB-04* claim completion requirements for crossover claims.
- Provide billing tips for completion of Crossover CIFs.
- Review claim examples.

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Crossover Claim Description

Some Medi-Cal recipients are eligible for services under the federal Medicare program. For most services rendered, Medicare requires a deductible and/or coinsurance that, in some instances, is paid by Medi-Cal.

Medi-Cal recipients may be Medicare-eligible if they are 65 years or older, blind, disabled, have end-stage renal disease, or if the Medi-Cal eligibility verification system indicates Medicare coverage.

Medicare/Medi-Cal Crossover Claim Terminology

1. **Crossover:** A claim billed to Medi-Cal for the Medicare deductible and coinsurance is called a crossover claim. This type of claim has been approved or paid by Medicare.
2. **Deductible:** The dollar amount Medicare recipients must pay for Part A or Part B services prior to receiving Medicare benefits.
3. **Coinsurance:** The remaining balance of the Medicare Allowed Amount after a Medicare payment.
4. **Co-payments:** The amount required by Medicare Part C or D when services are rendered, or drugs are purchased. (Providers may choose to waive these co-payments or may deny service if a recipient cannot pay this amount. Medi-Cal does not generally pay for co-payments.)
5. **Medicare Beneficiary Identifier (MBI) number:** The Medicare beneficiary identification number.

Medicare Health Care Benefits

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.

Scope of Coverage

Medicare divides its services into specific classifications: Part A, Part B, Part C and Part D. Recipients may be covered for Part A only, Part B only, Part D only or a combination of services.

Scope of Coverage Table

Service Type	Description
Part A	Inpatient Hospital Services, Skilled Nursing Facility Services, Hospice and Home Health Care
Part B	Outpatient Hospital Services, Physician Services, and Home Health (if recipient is Part B eligible only)
Part C	Medicare Advantage Plans (MSA/PFFS/SNP/HMO/PPO – not crossover claims)
Part D	Prescription drugs not covered by Part A, B or C (not crossover claims)

For a more extensive and current list of Medicare-covered services, refer to the annual *Medicare & You* publication available online on the Medicare website.

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.
21st to 100th 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

1. Facility must be Medicare-certified.
2. Recipient must have been in an acute hospital for at least three days.
3. Recipient must be admitted to an NF-B within 30 days after discharge from an acute hospital.
4. 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.

Medical Supplies

Most medical supplies are not covered by Medicare and can be billed directly to Medi-Cal. However, the medical supplies listed in the Medical Supplies: *Medicare-Covered Services* section of the appropriate Part 2 manual are covered by Medicare and must be billed to Medicare prior to billing Medi-Cal.

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.

1. 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.
2. 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.

When billing Part A services to Part A Intermediaries, submit an original *UB-04* claim form according to the instructions listed below as applicable.

Electronic Billing

Crossover claims cannot be submitted to Medi-Cal through the Point of Service (POS) network but can be submitted through the Computer Media Claims (CMC) process. Refer to *the CMC Submissions and Billing Instructions* section of the *Medi-Cal Computer Media Claims* (CMC*) Billing and Technical Manual* for additional information.

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 (continued)

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 (continued)

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).

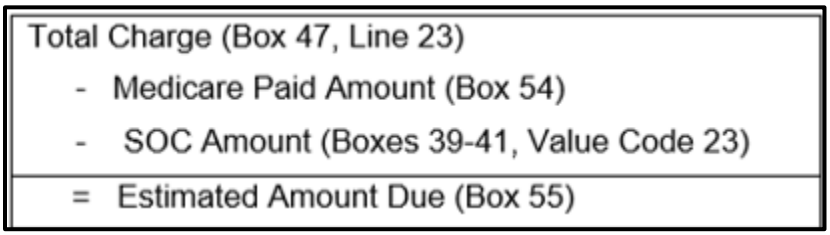


Figure 1.1: Estimated Amount Due (Box 55) Calculation for Part A Payment.

Claim Example: Billing Medi-Cal for Part A Services to Part A Contractor

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 a 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.

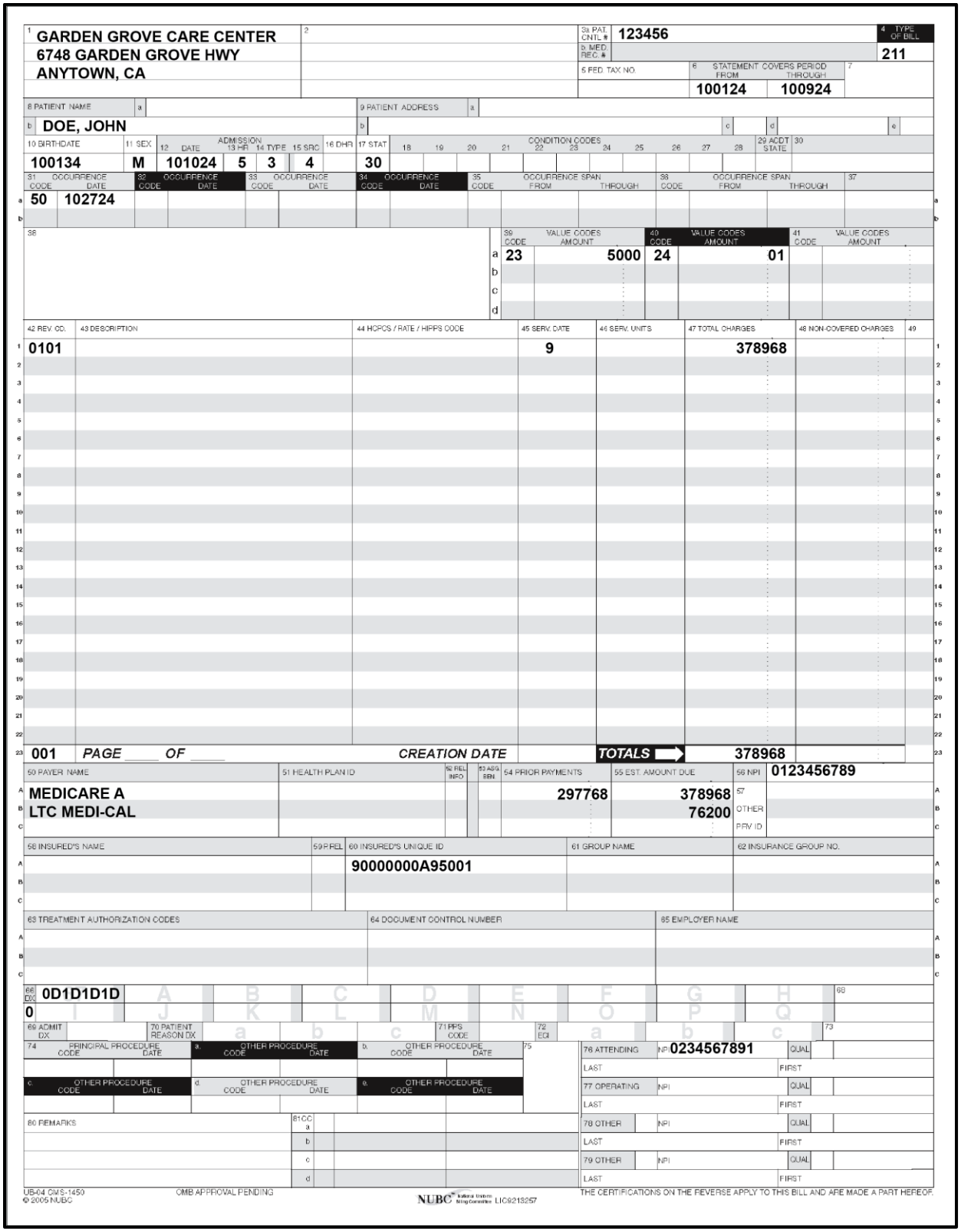
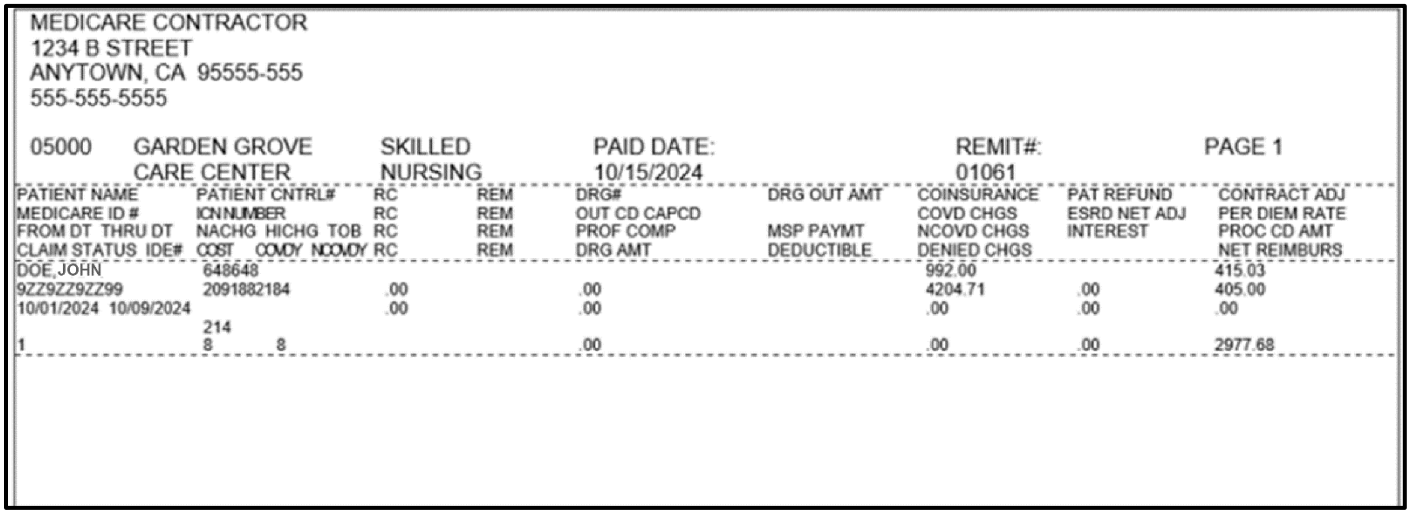


Figure 1.2: Billing Medi-Cal for Part A Services to a Part A Contractor.

Medicare Remittance (RA) for Part A Billing Example (Figure 1.2)



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 / MEDICARE ID # / FROM DT THRU DT / CLAIM STATUS IDE#	PATIENT CNTRL# / ICN NUMBER / NACHG HICHG TOB / COST COVDY NCOVDY	RC / RC / RC	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	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
1	214 8 8			.00		.00	.00	2977.68

Figure 1.3: Medicare RA Part A.

Claim Example: Billing Medi-Cal for 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 *Prior Payments* field (Box 54a), 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).

Notes:

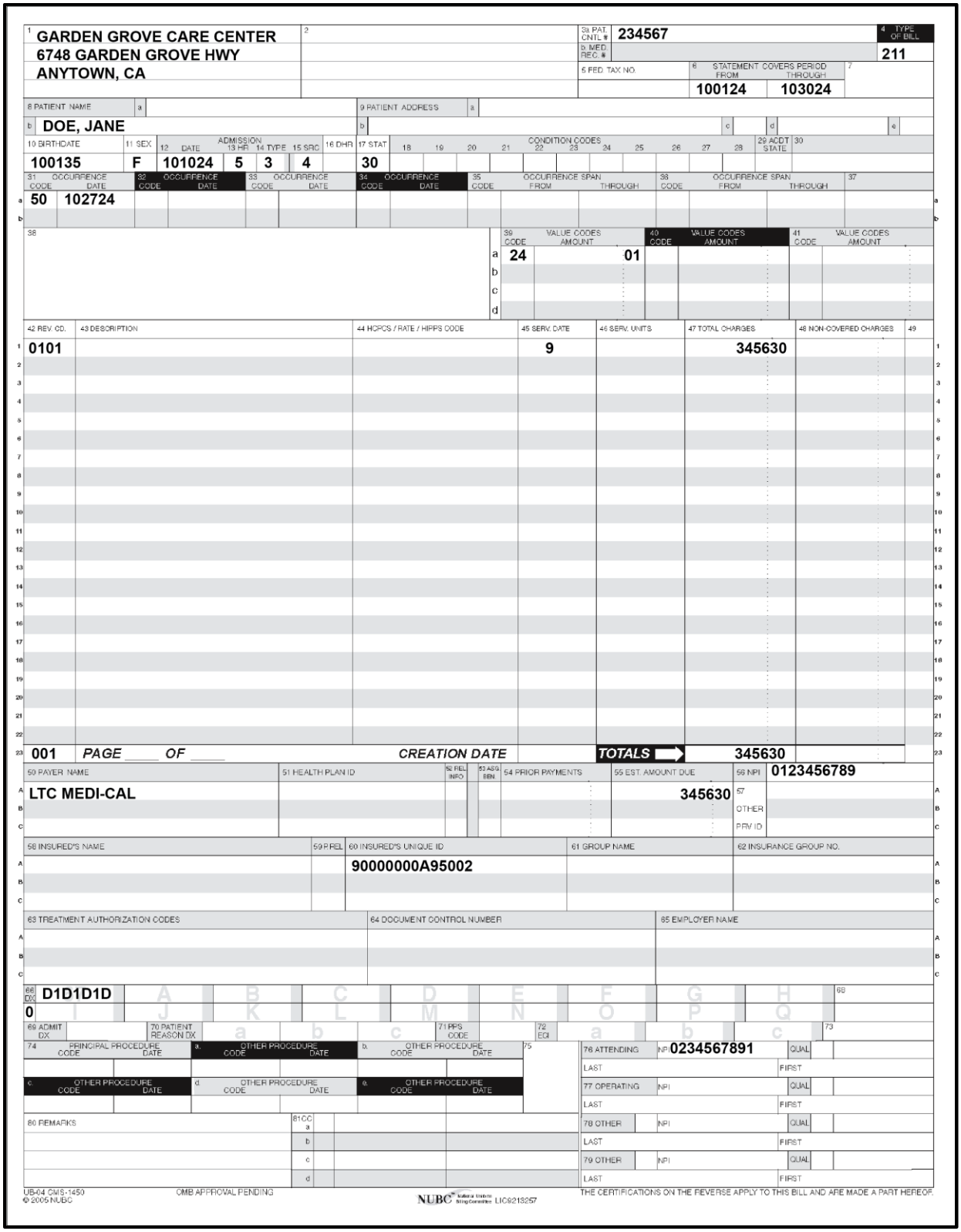


Figure 1.4: Billing Medi-Cal whose Part A Services Have Been Exhausted.

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:

- Submit a *UB-04* claim form according to the instructions listed below.
- 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.

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).

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 2.1: Estimated Amount Due (Box 55) Calculation for Part B Payment.

Claim Example: Billing Medi-Cal for Part B to 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).

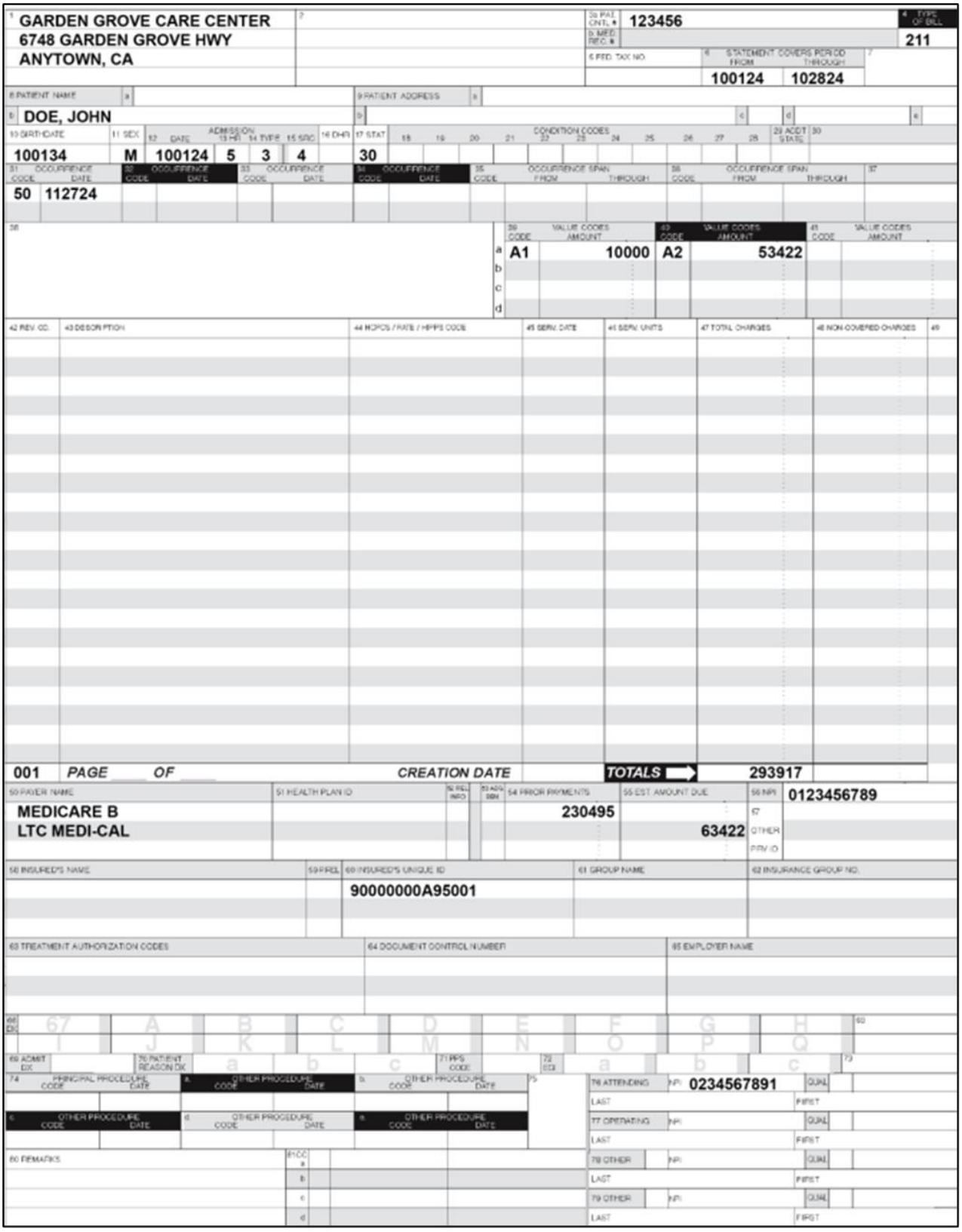


Figure 2.2: Billing Medi-Cal for Part B Services Billed to Part A Contractor.

Medicare Remittance (RA) for Part B Billing Example (Figure 2.2)

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 COMOY NCOMOY	RC 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	RC			534.22		77.56
9ZZ9ZZ9ZZ99	202071029402	REM			2939.17		.85
10/01/2024 10/28/2024	QC N221	RC		100.00			2861.61
		REM					2227.39
DOE, JANE	654811	RC			138.26		77.56
9ZZ99Z9ZZ99	20207102890602	REM			959.25		.85
10/01/2024 10/28/2024	QC N221	RC		100.00			881.69
		REM					643.43

Figure 2.3: Medicare Remittance Advice (RA) for Part B Figure 2.2

Claim Example: Billing Medi-Cal for Part B Services Billed to Part A Contractor with Share of Cost (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)

Notes:

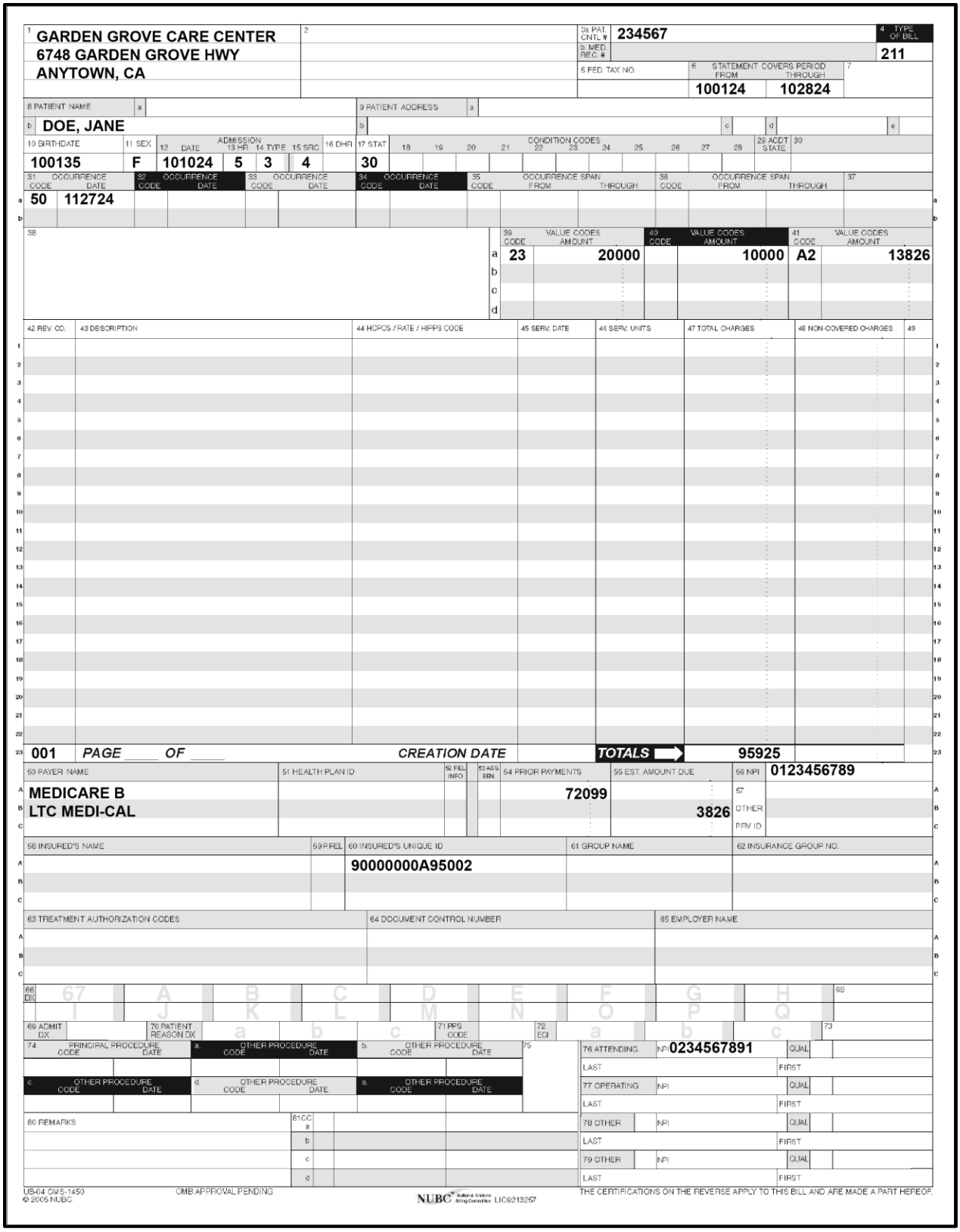


Figure 2.3: Billing Medi-Cal for Part B Services Billed to Part A Contractor with SOC.

Medicare Remittance (RA) for Part B Billing Example (Figures 2.2 and 2.3)

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	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 COMDY NCOMDY	RC	REM	DRG AMT	DEDUCTIBLE	DENIED CHGS		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 2.4: Medicare Advice (RA) for Part B Figures 2.2 and 2.3 Examples.

Claim Examples 1 and 2: Billing Medi-Cal for Part B Overlapping Dates of Service

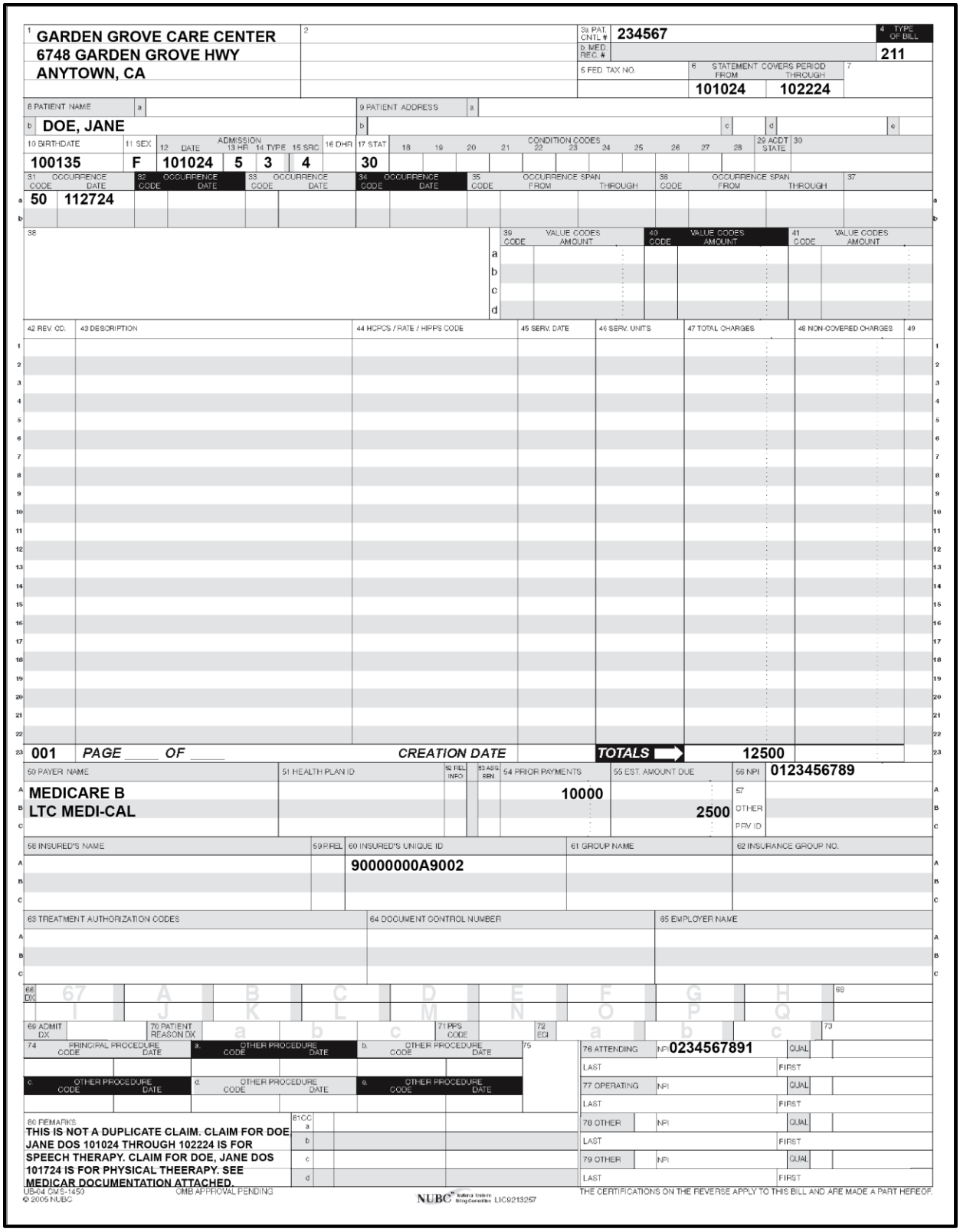
This is a sample only. Please adapt to your billing situation.

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 2.4) and physical therapy on Claim #2 (Figure 2.5). The recipient is the same and the dates of service overlap.

In the *Remarks* area Box 80, the biller writes: “This is not a duplicate claim. Claim 1 for DOE, JANE DOS 10/10/2024 through 10/22/2024 is for speech therapy. Claim 2 for DOE, JANE, DOS 10/01/2024 through 10/17/2024 is for physical therapy. See Medicare documentation attached.”

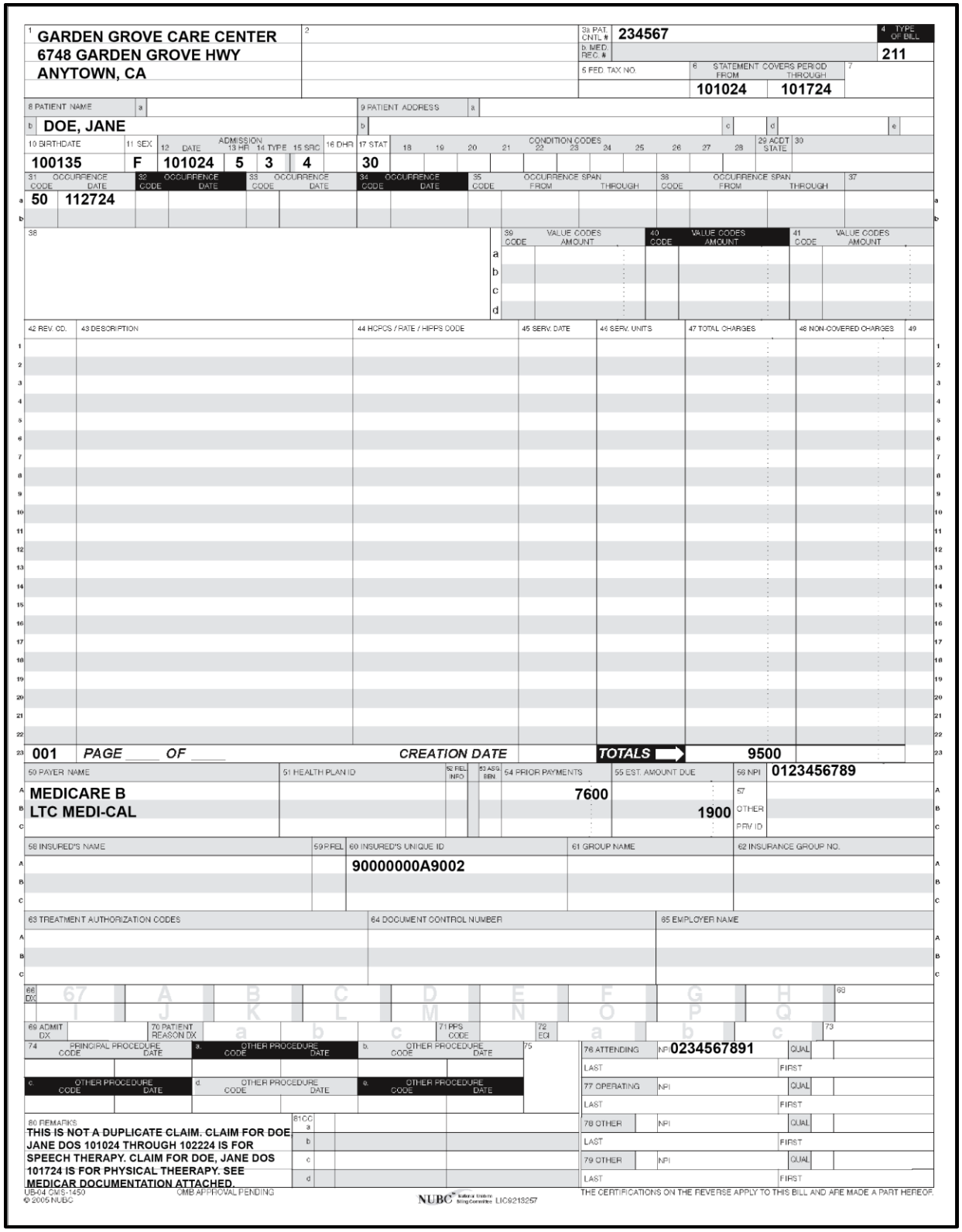
Similarly, if the provider is billing the speech therapy and physical therapy claims at different times and one claim has already been processed by Medi-Cal, instead of attaching the Medicare documentation, the provider can attach a copy of the previously submitted/processed claim.



1	GARDEN GROVE CARE CENTER 6748 GARDEN GROVE HWY ANYTOWN, CA
3a PAT. CNTL #	234567
4 TYPE OF BILL	211
6 STATEMENT COVERS PERIOD FROM	101024
THROUGH	102224
8 PATIENT NAME	DOE, JANE
10 BIRTHDATE	100135
11 SEX	F
12 ADMISSION DATE	101024
13 HR	5
14 TYPE	3
15 SRC	4
17 STAT	30
31 OCCURRENCE CODE / DATE	50 / 112724
42 REV. CD.	001
43 DESCRIPTION	PAGE ____ OF ____
44 HCPCS / RATE / HIPPS CODE	CREATION DATE
46 SERV. UNITS	TOTALS
47 TOTAL CHARGES	12500
50 PAYER NAME	A MEDICARE B B LTC MEDI-CAL
54 PRIOR PAYMENTS	10000
55 EST. AMOUNT DUE	2500
56 NPI	0123456789
60 INSURED'S UNIQUE ID	90000000A9002
76 ATTENDING NPI	0234567891
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 101724 IS FOR PHYSICAL THEERAPY. SEE MEDICAR DOCUMENTATION ATTACHED.

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 2.5: Billing Med-Cal Part B Overlapping DOS (Claim 1).



1	GARDEN GROVE CARE CENTER 6748 GARDEN GROVE HWY ANYTOWN, CA
3a PAT. CNTL #	234567
4 TYPE OF BILL	211
6 STATEMENT COVERS PERIOD FROM	101024
THROUGH	101724
8 PATIENT NAME	DOE, JANE
10 BIRTHDATE	100135
11 SEX	F
12 ADMISSION DATE	101024
13 HR	5
14 TYPE	3
15 SRC	4
17 STAT	30
31 OCCURRENCE CODE / DATE	50 / 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	9500	

	50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	MEDICARE B		7600	
B	LTC MEDI-CAL			1900

58 INSURED'S NAME	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	90000000A9002		

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

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

Figure 2.6: Billing Med-Cal Part B Overlapping DOS (Claim 2).

Crossover Claims Inquiry Forms (CIFs)

CIF for All Crossover Claims

Refer to the *CIF Special Billing Instructions for Long Term Care* section in the Medicare/Medi-Cal Crossover Claims: Long Term Care

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 Tips for Crossover CIFs

Following these billing tips will help prevent rejections, delays, missed payments and/or denials of crossover CIFs:

- Only one crossover claim (that is, only one Claim Control Number [CCN]) can be processed on a single CIF. Additional crossover claims submitted on the same CIF will be rejected.
- Always include supporting documentation with a CIF, or the claim will be denied.
- All supporting documentation must be clear, concise, and complete.
- Failure to mark Attachment (Box 10) may cause the claim to be denied.
- Verify that the CCN in Box 9 of the CIF has 13 digits and ends with “00” or “99.”

- If requesting adjustment of a crossover claim, use the approved CCN that is being requested for adjustment.
- If requesting reconsideration of a denied crossover claim, use the CCN that matches the most recently adjudicated claim.
- Failure to mark Underpayment (Box 11) or Overpayment (Box 12), when applicable, may cause a delay in claim processing.
- Do not mark Underpayment (Box 11) or Overpayment (Box 12) if submitting a CIF for reconsideration of a denial.
- Failure to complete the Remarks section of the CIF may cause claim denial or delayed processing.
- To ensure timeliness requirements are met, refer to the CIF Submission and Timeliness Instructions section in this manual.

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
- 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 UB-04 Submission and Timeliness Instructions*.

Crossover Claim Submission

Timeliness

Original Medi-Cal claims must be received by the Medi-Cal Fiscal Intermediary within six months following the month in which services were rendered.

Note: If the crossover claim has a date of service beyond six months from the month of service, the crossover claim may be submitted within 60 days from the *Medicare Remittance Advice* (RA) date.

Claims received beyond the timeliness guidelines require a delay reason code, justification in the *Remarks* section of the claim and the necessary attachments in order to receive full reimbursement.

Mailing Instructions

Medicare/Medi-Cal crossover claims for Medicare paid services that do not automatically cross over, or that cross over but cannot be processed and are rejected, may be billed by hard copy directly to Medi-Cal. Providers must submit hard copy crossover claims to:

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

Knowledge Review

1. The effective date of service LTC providers will need to begin to use the *UB-04* claim form:
   A. January 2, 2024
   B. February 2, 2024
   C. February 1, 2024
2. Medicare services are divided into four specific classifications:
   1. _____
   2. _____
   3. _____
   4. _____
5. A *Treatment Authorization Request* (TAR) is required for Medicare Part A covered days, including crossover days, or Part B covered services which would not otherwise require a TAR.
   True □ False □
6. What circumstance can a provider bill a straight Medi-Cal claim:
   A. Medicare has denied the claim
   B. Recipient is not eligible for Medicare
   C. Services are not covered by Medicare
   D. Medicare benefits have been exhausted
   E. All of the above
7. A crossover is a claim billed to Medi-Cal for the Medicare deductible and coinsurance and is called a crossover claim.
   True □ False □

See the Appendix for the Answer Key.

Resource Information

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1
Medicare/Medi-Cal Crossover Claims Overview (medicare)

Part 2
CIF Special Billing Instructions for Long Term Care Completion (cif sp co)

Medicare/Medi-Cal Crossover Claims: Long Term Care (medi cr ltc)

Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples
(medi cr ltc ex)

Additional References

LTC Code and Claim Conversion: Forthcoming Crossover Claims Changes

LTC Code and Claim Form Conversion: Frequently Asked Questions (FAQs)

LTC Code and Claim Conversion: *UB-04* Completion

LTC Code and Claim Form Conversion: LTC 25-1 to UB-04 Claim Form Crosswalk

LTC Code and Claim Form Conversion: LTC Accommodation Code to Revenue Code, Value Code and Value Code Amount Crosswalk

LTC Code and Claim Form Conversion: LTC Patient Status Code to Patient Discharge Status Code Crosswalk

Medi-Cal Providers website