
CIF Special Billing Instructions for Long Term Care

Page updated: January 2024

Claims Inquiry Forms (CIFs) submitted for Share of Cost (SOC) reimbursement and Medicare/Medi-Cal crossover claims for long term care require unique completion instructions explained in this section. Examples of completed CIFs for these types of inquiries also are included. Refer to the CIF sections in this manual for additional billing information.

Claim Attached to CIF Requires ICD Indicator

CIFs received by the California MMIS Fiscal Intermediary on or after October 1, 2015, require an ICD indicator of "0" in the diagnosis area of the claim only if the initial claim contained an ICD-10-CM diagnosis code. CIFs accompanied by claims (as supporting documentation) without an ICD indicator will not be processed.

<<To update an attached *UB-04* claim form, insert a "0" in the white space below the *DX* field (Box 66).>>

Share of Cost (SOC) Claims

Submitting SOC CIFs

A CIF for SOC may be filed if a recipient's SOC is retroactively reduced by the county. The reimbursement process for SOC usually starts when a recipient returns to a provider and requests a refund due to an adjusted SOC. Upon the provider receiving reimbursement for the adjusted SOC, the previously paid SOC amount, or the difference between the paid amount and the retroactively determined amount, must be refunded to the recipient. Providers use a CIF to bill Medi-Cal for the difference between the original SOC billed amount and the adjusted amount.

In addition to submission requirements in the *CIF Completion* section of this manual, use the following instructions to request SOC reimbursement for previously paid claims (see *Figure 1* on a following page in this section):

- All services on the CIF must be for SOC reimbursement.
- Share of Cost (SOC) CIFs may contain multiple claim lines, but all lines must be for the same recipient. Use each CIF to submit inquiries for only one recipient.
- Complete Boxes 7, 8, 9, 10 and 13.

Note: The CIF must contain the date of service in Box 13. Providers submitting improperly completed CIFs will receive one of four CIF denial letters, numbers 70 through 73.

- In the *Remarks* section, state "SOC reimbursement; MC 1054 attached."
- Attach a *Share-of-Cost Medi-Cal Provider Letter* (MC 1054).

Note: If requesting SOC reimbursement for denied claims or claims not previously submitted, submit the MC 1054 with the new claim.

- If SOC is reduced to other than zero, wait a minimum of 30 days before submitting a CIF.

Note: The *Remittance Advice Details* (RAD) will not display a specific message for an SOC reduced to zero. The RAD will display message 433 for an SOC reduced to other than zero.

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(1) CORRESPONDENCE REFERENCE NUMBER • FOR F.I. USE ONLY

8
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CLAIMS INQUIRY

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

(2) DOCUMENT NUMBER

39377390

(3) PROVIDER NAME/ADDRESS

(4) PROVIDER NUMBER

0123456789

(5) CLAIM TYPE CHECK ONE BOX ONLY

| | | |
|--|--|---|
| <input type="checkbox"/> 01 PHARMACY | <input type="checkbox"/> 03 HOSPITAL INPATIENT | <input type="checkbox"/> 05 PHYSICIAN/ ALLIED |
| <input checked="" type="checkbox"/> 02 LTC | <input type="checkbox"/> 04 HOSPITAL OUTPATIENT CLINIC | <input type="checkbox"/> 07 VISION |

(6) DELETE

| | | |
|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | <input type="checkbox"/> 03 |
| <input type="checkbox"/> 04 | <input type="checkbox"/> 05 | <input type="checkbox"/> 06 |

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

| | (7) PATIENT'S NAME OR MEDICAL RECORD NO. | (8) PATIENT'S MEDI-CAL I.D. NO. | (9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK) LINE | |
|------------|--|---------------------------------|---|--|
| (6) DELETE | <input type="checkbox"/> 01 TANNER | 90000000A95001 | 72911434567 01 | (11) ATTACHMENT (12) UNDERPAYMENT (13) OVERPAYMENT |
| | (13) DATE OF SERVICE | (14) NDC/UPN OR PROCEDURE CODE | (15) AMOUNT BILLED | (11) <input checked="" type="checkbox"/> (12) <input type="checkbox"/> (13) <input type="checkbox"/> |
| | <input type="checkbox"/> 02 | | | (11) <input type="checkbox"/> (12) <input type="checkbox"/> (13) <input type="checkbox"/> |
| | <input type="checkbox"/> 03 | | | (11) <input type="checkbox"/> (12) <input type="checkbox"/> (13) <input type="checkbox"/> |
| | <input type="checkbox"/> 04 | | | (11) <input type="checkbox"/> (12) <input type="checkbox"/> (13) <input type="checkbox"/> |

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT.)

SOC REIMBURSEMENT; MC 1054 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.

JANE DOE
12/25/07

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form. DATE

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60-1 03/07

Figure 1: Sample Claims Inquiry Form (CIF): SOC Reimbursement for a Previously Paid Claim

Medicare/Medi-Cal Crossover Claims

Submitting Crossover CIFs

In addition to submission requirements in the *CIF Completion* section of this manual, use the following instructions to complete a CIF for Medicare/Medi-Cal crossover claims. A CIF may be used to request reconsideration of a denied crossover claim, an adjustment of an underpaid or overpaid Medi-Cal claim, or an adjustment related to a Medicare adjustment. Refer also to the *CIF Submission and Timeliness Instructions* section in this manual for additional requirements.

Reconsideration of Denied Crossover Claims

Follow the instructions below to complete a CIF for reconsideration of a denied crossover claim (see *Figure 2* on a following page in this section):

- Submit only one crossover claim (that is, only one Claim Control Number [CCN]) for each CIF.
- Enter in Box 9 the 13-digit CCN of the most recently denied crossover claim from the RAD. This number must end with a “91,” “92,” “93,” “94,” “95” or “96.”
- Mark *Attachment* in Box 10.
- Attach the following documentation:
 - If a Part A claim is billed to a Part A intermediary, submit a clear copy of one of the following:
 - ❖ Original claim form billed to Medi-Cal
 - ❖ Claim form billed to Medicare
 - ❖ Facsimile of electronic claim billed to Medicare
 - If Part B services are billed to a Part A intermediary, submit a clear copy of the original crossover claim form billed to Medi-Cal.
 - All claims for Part A or Part B services must include a clear copy of both of the following:
 - ❖ *Medicare National Standard Intermediary Remittance Advice* (Medicare RA)
 - ❖ Medi-Cal RAD showing the Medi-Cal crossover denial
- In the *Remarks* section, indicate the denial code and include any additional information needed to correct the claim.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the *Remarks* section is completed.

Adjustments to Medi-Cal Crossover Payments

Follow the instructions below to complete a CIF for an adjustment to a Medi-Cal crossover payment (see *Figure 3* on a following page in this section):

- Submit only one crossover claim (that is, only one Claim Control Number [CCN]) for each CIF.
- Enter in Box 9 the 13-digit CCN of the most recent crossover payment from the RAD. This number must end with a “91,” “92,” “93,” “94,” “95” or “96.”
- Mark *Attachment* in Box 10.
- Mark *Underpayment* in Box 11 or *Overpayment* in Box 12.
- Attach the following documentation for an adjustment not related to a Medicare adjustment:
 - If a Part A claim is billed to a Part A intermediary, submit a clear copy of one of the following:
 - ❖ Original claim form billed to Medi-Cal
 - ❖ Claim form billed to Medicare
 - ❖ Facsimile of electronic claim billed to Medicare
 - If Part B services are billed to a Part A intermediary, submit a clear copy of the original crossover claim form billed to Medi-Cal.
 - All claims for Part A or Part B services must include a clear copy of both of the following:
 - ❖ Medicare RA
 - ❖ Medi-Cal RAD showing the Medi-Cal crossover payment
- In the *Remarks* section, indicate the specific reason for the adjustment and the type of action desired.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the *Remarks* section is completed.

Adjustments Related to Medicare Adjustments

When Medicare automatically crosses over a Medicare adjustment, it does not include the original Medi-Cal Claim Control Number (CCN). As a result, the Medicare adjustment claim number cannot be matched to the originally submitted Medi-Cal crossover claim. These Medicare adjustments will deny as duplicates of the original crossover claim if it was approved and appear as RAD code 010 on a RAD. Therefore, to obtain correct reimbursement, providers must submit all Medicare adjustments on a CIF after they receive a RAD denial.

When completing a CIF for an adjustment as a result of a Medicare adjustment, follow these additional instructions:

- Include only one crossover claim (that is, only one Claim Control Number [CCN]) per CIF.
- Enter in Box 9 the 13-digit CCN of the most recent crossover payment from the RAD. This number must end with a “91,” “92,” “93,” “94,” “95,” or “96.”
- Mark *Attachment* (Box 10).
- Mark *Underpayment* (Box 11) or *Overpayment* (Box 12).
- Attach the following documentation for an adjustment related to a Medicare adjustment:
 - If a Part A claim is billed to a Part A intermediary, submit a clear copy of one of the following:
 - ❖ Original claim form billed to Medi-Cal
 - ❖ Claim form billed to Medicare
 - ❖ Facsimile of electronic claim billed to Medicare
 - If Part B services are billed to a Part A intermediary, submit a clear copy of the original crossover claim form billed to Medi-Cal.
 - All claims for Part A or Part B services must include a clear copy of both of the following:
 - ❖ Original and adjusted Medicare RA
 - ❖ Medi-Cal RAD showing the Medi-Cal crossover payment or denial
- In the *Remarks* section, indicate the specific reason for the adjustment and the type of action desired.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the *Remarks* section is completed.

Tracing Crossover Claims

A CIF must be submitted to trace a crossover claim. «Do not submit a crossover claim (UB-04 for Long Term Care and Medicare RA) to trace crossover claims.»

Billing Tips for Crossover CIFs

Following these billing tips will help prevent rejections, delays, mispayments, 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.

Note: For information about claims that are attached to CIFs submitted on or after October 1, 2015, see the “Claim Attached to CIF Requires ICD Indicator” in this section.

- 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 “91,” “92,” “93,” “94,” “95” or “96.”
- 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.

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HERE

CLAIMS INQUIRY

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

(3) PROVIDER NAME/ADDRESS

SHADYGROVE MANOR
123 ANY STREET
ANYTOWN CA 99999555

(4) PROVIDER NUMBER

0123456789

(2) DOCUMENT NUMBER

39377390

(5) CLAIM TYPE CHECK ONE BOX ONLY

| | | |
|--|--|--|
| <input type="checkbox"/> 01 PHARMACY | <input type="checkbox"/> 03 HOSPITAL INPATIENT | <input type="checkbox"/> 05 PHYSICIAN ALLIED |
| <input checked="" type="checkbox"/> 02 LTC | <input type="checkbox"/> 04 HOSPITAL OUTPATIENT CLINIC | <input type="checkbox"/> 07 VISION |

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

| (6) DELETE | (7) PATIENT'S NAME OR MEDICAL RECORD NO. | (8) PATIENT'S MEDI-CAL I.D. NO. | (9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK) | LINE | (10) ATTACHMENT (11) UNDERPAYMENT (12) OVERPAYMENT |
|--------------------------|--|---------------------------------|--|------|--|
| <input type="checkbox"/> | 01 JONES | 90000000A95001 | 72911434567 | 96 | <input checked="" type="checkbox"/> (1) <input type="checkbox"/> (2) |
| | (13) DATE OF SERVICE | (14) NDC/UPN OR PROCEDURE CODE | (15) AMOUNT BILLED | | |
| | 081524 | | 25.00 | | |
| <input type="checkbox"/> | | | | | <input type="checkbox"/> (1) <input type="checkbox"/> (2) |
| <input type="checkbox"/> | | | | | <input type="checkbox"/> (1) <input type="checkbox"/> (2) |
| <input type="checkbox"/> | | | | | <input type="checkbox"/> (1) <input type="checkbox"/> (2) |

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT.)

CROSSOVER CLAIM DENIED BY MEDI-CAL WITH RAD CODE 001. THE DATE OF SERVICE HAS BEEN CORRECTED. PLEASE RECONSIDER.

ATTACHED ARE:

**UB-04 FOR LONG TERM CARE
MEDICARE RA
MEDI-CAL RAD**

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.

JANE DOE

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

12/25/24

DATE

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Figure 2: Sample Claims Inquiry Form (CIF): Denied Crossover Claim

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CLAIMS INQUIRY

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

(2) DOCUMENT NUMBER

39377390

TYPewriter ALIGNMENT

Elite Pica

(3) PROVIDER NAME/ADDRESS

SHADYGROVE MANOR
123 ANY STREET
ANYTOWN CA 999995555

(4) PROVIDER NUMBER

0123456789

TYPewriter ALIGNMENT

Elite Pica

(5) CLAIM TYPE CHECK ONE BOX ONLY

| | | |
|--|--|--|
| <input type="checkbox"/> 01 PHARMACY | <input type="checkbox"/> 03 HOSPITAL INPATIENT | <input type="checkbox"/> 05 PHYSICIAN ALLIED |
| <input checked="" type="checkbox"/> 02 LTC | <input type="checkbox"/> 04 HOSPITAL OUTPATIENT CLINIC | <input type="checkbox"/> 07 VISION |

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

| (6) DELETE | (7) PATIENT'S NAME OR MEDICAL RECORD NO. | (8) PATIENT'S MEDI-CAL I.D. NO. | (9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK) LINE | (10) ATTACHMENT |
|-----------------------------|--|---------------------------------|---|---|
| <input type="checkbox"/> 01 | JONES | 90000000A95001 | 72911434567 96 | (11) UNDERPAYMENT (12) OVERPAYMENT |
| | (13) DATE OF SERVICE | (14) NDC/UPN OR PROCEDURE CODE | (15) AMOUNT BILLED | <input checked="" type="checkbox"/> 01 <input checked="" type="checkbox"/> 02 |
| | 081524 | | | |

| | | | | |
|-----------------------------|--|--|--|---|
| <input type="checkbox"/> 02 | | | | <input type="checkbox"/> 01 <input type="checkbox"/> 02 |
| <input type="checkbox"/> 03 | | | | <input type="checkbox"/> 01 <input type="checkbox"/> 02 |
| <input type="checkbox"/> 04 | | | | <input type="checkbox"/> 01 <input type="checkbox"/> 02 |

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT.)

CROSSOVER BILLING FOR PART B SERVICES BILLED INCORRECTLY. PLEASE RETRACT AMOUNT OF \$39.07 PAID IN ERROR AND REPROCESS FOR CORRECT PAYMENT OF \$114.07.

ATTACHED ARE:

**UB-04 FOR LONG TERM CARE
MEDICARE RA
MEDI-CAL RAD**

This is to certify that the information contained above is true, accurate, and complete, and that the provider has read, understood, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

JANE DOE 12/25/24

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form. DATE

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Figure 3: Sample Claims Inquiry Form (CIF): Adjustment to Medi-Cal Crossover Payment for Part B Services Billed to Part A Intermediary.

<<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. |