Medicare/Medi-Cal Crossover Claims: Inpatient Services

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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. (Refer to the *UB-04 Completion: Inpatient Services* section in this manual for complete billing instructions.) The procedures/policies in this section apply to all inpatient providers, regardless of contract status, unless otherwise specified. 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: Inpatient Services Billing Examples* section in this manual for claim form billing examples. Information in this section is organized as follows:

- Reimbursement Guidelines
- Hard copy Submission Requirements of Medicare Approved Services
- Crossover *Claims Inquiry Forms* (CIFs)
- Billing for Medicare Non-Covered, Exhausted or Denied Services, or Medicare Non-Eligible Recipients
- Patient Liability for Medi-Cal Payment for Automatic Submissions

NPI Used to Bill Medicare

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

Reimbursement Guidelines

Cost-Sharing

Section 4717 of the federal Balanced Budget Act of 1997 (BBA) clarified state liability for Medicare cost-sharing for Medi-Cal recipients. The Centers for Medicare & Medicaid Services (CMS) has interpreted these new provisions of federal law to require a “service by service” comparison of the rate payable by a state Medicaid agency to the amount paid under the Medicare program for the same service.

Restrictions Affecting Recipients in Mental Health Facilities

Reimbursement will be denied for inpatient hospital services rendered to recipients 22 – 64 years of age who reside in Institutions for Mental Diseases (IMDs), that is, private acute psychiatric hospitals and state mental health hospitals. More information is available under the "Reimbursement Restrictions" heading in the *Inpatient Mental Health Services Program* section of this manual.

Comparative Pricing

All recipient Part A acute care inpatient hospital crossover claims are priced at an amount equal to what Medi-Cal would pay for a Medi-Cal only claim. Claims for services will be subject to all existing edits and audits for inpatient claims, where applicable. In addition, reimbursement will reflect payments already made by Medicare, the patient's Share of Cost (SOC) and any Other Health Coverage (OHC) payments, as applicable. In any case, the total Medi-Cal reimbursement on these claims will not exceed the coinsurance and/or deductible amount(s) billed on the claim.

This payment methodology is referred to as "comparative pricing methodology." Comparative pricing methodology changes the hard copy billing requirements for <u>all</u> inpatient Medicare/Medi-Cal crossover claims, regardless of a recipient's aid code.

Hard Copy Submission Requirements of 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 at the following address:

Attn: Crossover Unit

California MMIS Fiscal Intermediary

P.O. Box 15500

Sacramento, CA 95852-1500

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

Part A-Only Services Billed to Part A Intermediaries

Claims denied by Medicare for no Part A coverage will not cross over automatically. Direct billing by the provider is required. 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 (current version only). Complete according to Figure 1 in the Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples section of this manual.
- Do not complete claim detail lines.
- When billing inpatient claims with Part A payments, the following items must be completed as applicable:

  Occurence 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).

  BLOOD DEDUCTIBLE

  - Enter code 06 and the Medicare blood deductible amount.
  - Leave blank if not applicable.

  PATIENTS' SHARE OF COST

  - Enter code 23 and the patients' Share of Cost for the claim.
  - Leave blank if not applicable.

PINTS OF BLOOD

- Enter code 38 and the number of pints of blood billed.
- 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

Medicare Lifetime Reserve Days

If the Medicare RA shows separate amounts for any Lifetime Reserve (LTR) days coinsurance and regular coinsurance, enter the sum of the two amounts in the *Value Codes and Amount* field (Boxes 39 – 41). Refer to "Medicare Lifetime Reserve (LTR) Days Coinsurance" in the *Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples* section of this manual.

Revenue Code (Box 42), Description (Box 43), and Total Charges (Box 47).

Box 42, Line 23: Enter "001" to indicate that this is the total charge line.

Box 47, Line 23: Enter the total amount of all charges billed to Medicare.

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” on line A and “I/P 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” on line B, and enter “I/P MEDI-CAL” on line C.

Medicare Supplemental Insurance Payers

If Medicare supplemental insurance is involved, it is secondary to Medicare. Enter “MEDICARE” on line A, enter the name of the Medicare supplemental insurance on line B, and enter “I/P MEDI-CAL” on line C.

Health Plan ID (Box 51).

Enter the Medicare carrier code on the line that corresponds to Medicare in Box 50.

Prior Payments (Boxes 54 A thru C).

Enter the OHC, Medicare or supplemental payments, if applicable, on the line that corresponds to the payer in Box 50.

Medicare Contractual Write-off Amounts

Medicare provider contractual write-off amounts for Part A covered inpatient stays do not affect Medi-Cal reimbursement of the crossover claim and should not be indicated on the claim form.

NPI (Box 56).

Enter the National Provider Identifier (NPI).

Other Provider ID (Box 57).

Box 57 is required when the NPI is not used in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.

Estimated Amount Due (Box 55).

Note: Do not enter a decimal point (.) or dollar sign ($).

On the corresponding Medicare line, enter the total charges from Box 47, line 23.

On the corresponding Medi-Cal line, follow the instructions below:

Add the blood deductible (value code 06), Medicare deductible (value code A1 or B1), Medicare coinsurance (value code A2 or B2), and take-home drugs (if applicable). (See Boxes 39 41.)

For example:

‹‹**Estimated Amount Due Example Table 1**››

Blood Deductible	40 00
Medicare Deductible	60 00
Medicare Coinsurance	+ 20 00
Total	120 00

Add the SOC (Boxes 39-41 [value code 23]), the OHC (Box 54) and the Medicare supplemental insurance (Box 54).

For example:

‹‹**Estimated Amount Due Example Table 2**››

SOC	50 00
OHC	25 00
Supplemental insurance	+25 00
Total	100 00

Then subtract that total (100 00) from the deductible(s) and coinsurance total (120 00). The difference equals the Estimated Amount Due. Enter this amount in Box 55 on the Medi-Cal line.

For example:

‹‹**Estimated Amount Due Example Table 3**››

Sum of Deductible + Coinsurance	120 00
Sum of SOC/OHC/Supplemental	–100 00
Estimated Amount Due	20 00

- 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 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 Long Term Care Part A and B crossovers; inpatient crossovers, if applicable; and straight Medi-Cal Long Term Care and inpatient claims)
    - ❖ Claim type, bill type or Type of Bill (TOB) (that is, inpatient, outpatient and Nursing Facilities Level B [NF-Bs])
- Do not obtain a *Treatment Authorization Request* (TAR).

With Part A Benefits Exhausted

Submit the UB-04 claim including each of the appropriate accommodation and ancillary services. See *Figure 2* in the *Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples* section of this manual.

- Attach documentation to the claim for proof of exhausted Part A benefits.
- Obtain a TAR.

Note: For all RAs showing a Medicare denial, if the Medicare denial description is not printed on the front of the RA, providers should 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-Only Services Billed to Part A Intermediaries

Follow the instructions below when billing for Medicare/Medi-Cal crossover recipients with Part B-only eligibility:

- Submit the *UB-04* claim including each of the appropriate accommodation and ancillary services. Refer to *Figure 3* in the *Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples* section of this manual.
- When Part B payment appears on a Medicare RA, enter the payment amount in the appropriate *Prior Payments* field (Box 54).
- Attach the Medicare RA labeled “ancillary” or “Part B” to the claim.
  - Providers who receive electronic RAs may submit a printout. This printout must include the following fields:
    - Date of Medicare 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 Long Term Care Part A and B crossovers; inpatient crossovers, if applicable; and straight Medi-Cal long term care and inpatient claims)
- ❖ Claim type, bill type or Type of Bill (TOB) (that is, inpatient, outpatient or Nursing Facility Level B [NF-B])

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

- When Part B payment appears on a *Medicare Remittance Notice* (MRN) for outpatient services, refer to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* section in the appropriate Part 2 manual.
- If no Part B payment is being reported, submit a Part B denial or acceptable ineligibility documentation.
- Obtain a TAR.

Note: Do not submit a crossover claim for Part B deductible and/or coinsurance for an inpatient stay.

Psychiatric Services for HCP-Enrolled Recipients

Medicare/Medi-Cal crossover claims for psychiatric services must be hard copy billed if the recipient is enrolled in a Health Care Plan (HCP) that is not capitated for psychiatric services. To facilitate prompt and appropriate payment, the rendering provider NPI number must be entered in the *Operating* field (Box 77) of the *UB-04* claim.

Part A and Part B Services Billed to Part A Intermediaries

Follow the instructions below when billing for Medicare/Medi-Cal recipients with Part A and Part B eligibility.

With Part A Payment (Crossover Claims)

Follow the instructions under "Part A-Only Services Billed to Part A Intermediaries – With Part A Payment" on a previous page.

Without Part A Payment (With or Without Part B Payment)

- Submit the *UB-04* claim including each of the appropriate accommodation and ancillary services. Refer to Figures 2 and 3 in the *Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples* section of this manual.
- Attach Medicare Part A denial or proof of Part A benefits exhausted or acceptable ineligibility documentation.
- When Part B payment appears on a Medicare RA, enter the payment amount in the appropriate *Prior Payment* field (Box 54).
- Attach the Medicare RA labeled "ancillary" or "Part B" to the claim. When Part B payment appears on an MRN for outpatient services, refer to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* section in the appropriate Part 2 manual.
- If no Part B payment is reported, submit Part B denial or acceptable ineligibility documentation.
- Obtain a TAR.

Split Billing

Split billing, or using multiple claim forms, is required when there is a Medicare Part B payment and more than 22 line items are being billed. (Refer to "Split Billing: More Than 22 Line Items With Part B Payment" in the *Medicare/Medi-Cal Crossover Claims: Inpatient Services Billing Examples* section of this manual.)

Each split-billed claim is processed as an individual claim. To prevent a split-billed claim from being denied payment for insufficient information or duplicate billing, it is necessary to:

- Complete all mandatory fields of the claim.
- Indicate in the *Remarks* field (Box 80) that the claim is one of two or more claims (for example, "Claim 1 of 2," "Claim 2 of 3").
- Attach a copy of the Medicare RA to each split-billed claim.

Day of Discharge or Death

The day of discharge or death is not reimbursable unless the day of discharge or death is the same day of admission. Refer to the *UB-04 Completion: Inpatient Services* section in this manual for further information about day of discharge or death reimbursement policy.

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 RA, include a copy of the description from the back of the RA or from the Medicare manual when billing for a Medicare-denied claim.

Acceptable Medicare Documentation

Examples of acceptable Medicare eligibility documentation are:

- Medicare Health Insurance Card indicating Part A or Part B benefits after the date of service billed
- Any document signed, dated and stamped by a Social Security Administration (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

- Screen printout of electronic RA:
  - Date of 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 LTC Part A and B crossovers; inpatient crossovers, if applicable, and straight Medi-Cal LTC and inpatient claims)
  - Claim type, bill type or Type of Bill (TOB) (that is, inpatient, outpatient or Nursing Facility Level B [NF-B])

Note: For all RAs showing a Medicare denial, if 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.

Denied Days Documentation

Utilization Review (UR) denial letters are acceptable as proof of denial of Part A-only benefits for inpatient claims for dates of service after the denial date specified on the letter.

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

Crossover Claims Inquiry Forms (CIFs)

CIF for all Crossover Claims

Refer to the *CIF Special Billing Instructions for Inpatient Services* 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 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 must 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: Inpatient Services* and *UB-04 Submission and Timeliness Instructions* sections of this manual.

Medicare Non-Covered Services

Medicare non-covered services must be included with the covered services billed to Medi-Cal on Part A inpatient crossover claims. See “Part A-Only Services Billed to Part A Intermediaries” – “With Part A Payment,” 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, enter "Y6" in the *Medicare Status* box and attach the appropriate documentation.

Note: Medicare status indicators should not be confused with Medicare status codes Y0 – Y9 and Z1 – Z3 used on the claim form to distinguish a recipient's eligibility. 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. Refer to the *UB-04 Completion: Inpatient Services* section in this manual for more information about Medicare status codes.

Patient Liability for Medi-Cal Payment for Automatic Submissions

Share of Cost (Patient Liability)

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

Example: The Medicare Part A claim totals $10,000 for a five-day acute stay. The patient's SOC liability is $500 and the patient wants this amount applied against the $592 Medicare deductible claim for this benefit period that will cross over to Medi-Cal.

In this situation, enter value code 23 and the corresponding value amount of $500 on the Medicare claim. In this instance, Medi-Cal pays $92.

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* claim, following the hard copy billing instructions on a previous page.
- 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.)

‹‹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.