CIF Special Billing Instructions for Inpatient Services

Page updated: August 2020

Claims Inquiry Forms (CIFs) submitted for Share of Cost (SOC) reimbursement and Medicare/Medi-Cal crossover claims for inpatient services 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 *DX* Box 66.

To update an attached *CMS-1500* claim, insert a "0" in the *ICD Ind*. area of Box 21.

Share of Cost (SOC) Claims

Submitting SOC CIFs

In addition to submission requirements in the *CIF Completion* section in 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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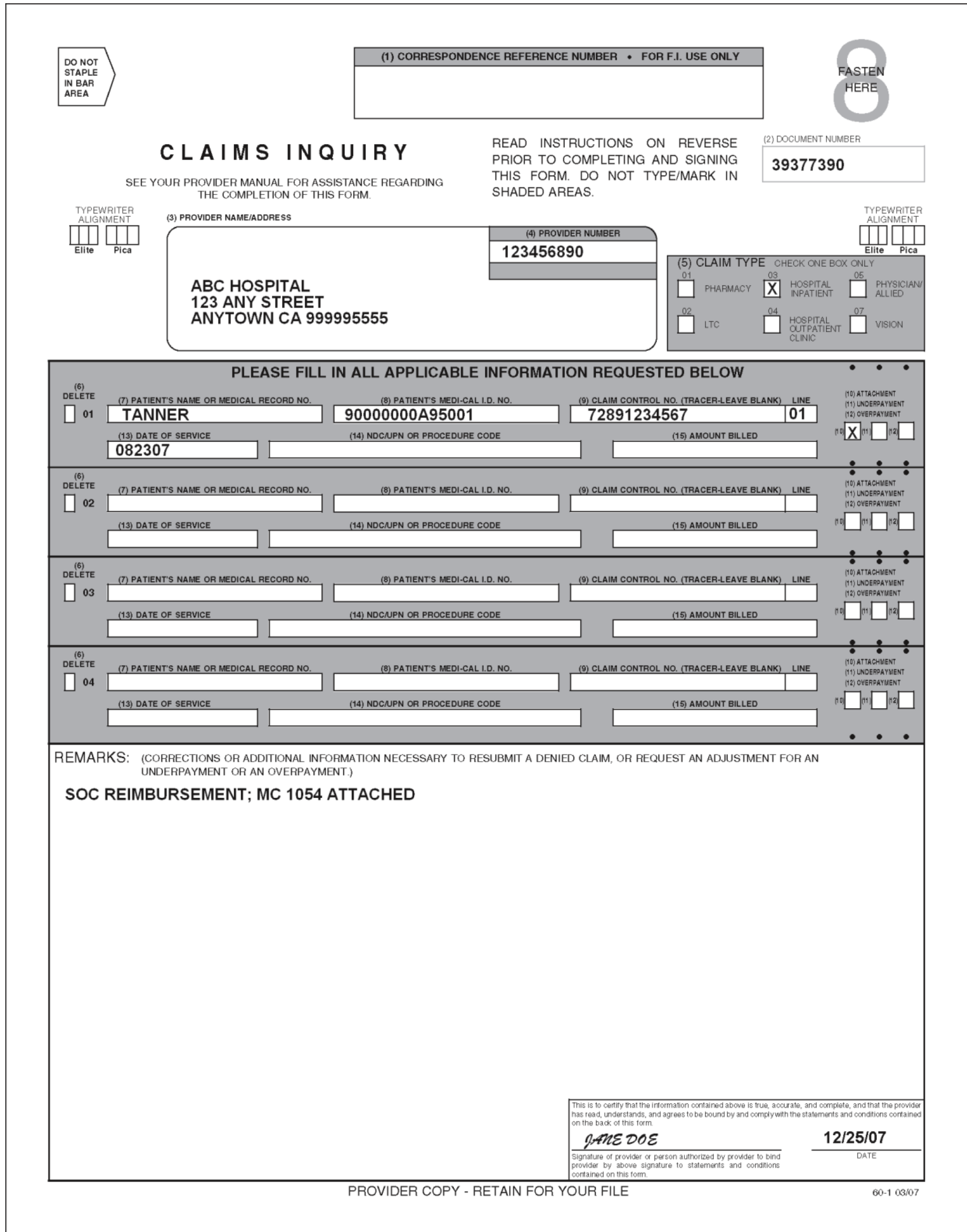

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(1) CORRESPONDENCE REFERENCE NUMBER • FOR F.I. USE ONLY

FASTEN HERE

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
ABC HOSPITAL
123 ANY STREET
ANYTOWN CA 999995555

(4) PROVIDER NUMBER: 123456890

(5) CLAIM TYPE CHECK ONE BOX ONLY
01 PHARMACY; 02 LTC; 03 [X] HOSPITAL INPATIENT; 04 HOSPITAL OUTPATIENT CLINIC; 05 PHYSICIAN/ALLIED; 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	(13) DATE OF SERVICE	(14) NDC/UPN OR PROCEDURE CODE	(15) AMOUNT BILLED	(10) ATTACHMENT	(11) UNDERPAYMENT	(12) OVERPAYMENT
01	TANNER	90000000A95001	72891234567	01	082307			X		
02										
03										
04										

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

12/25/07 — DATE

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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 in 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 (see *Figure 2* on a following page in this section), 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:

- 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 *Remittance Advice Details* (RAD). This number must end with a “99” or “00.”
- Mark *Attachment* in Box 10.

- Attach the following documentation:
  - If a Part A inpatient hospital 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
  - 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.
  - If Part B services are billed to a Part B carrier, submit a clear copy of one of the following:
    - ❖ Original crossover claim form billed to Medi-Cal
    - ❖ Claim form billed to Medicare
    - ❖ Facsimile of the claim form submitted to Medicare (same format as *CMS-1500* claim with visible background)
  - All claims for Part A or Part B services must include a clear copy of both of the following:
    - ❖ *Medicare Remittance Notice* (MRN)/*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:

- 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 *Remittance Advice Details* (RAD). This number must end with a “99” or “00.”
- 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 inpatient hospital 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
  - 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.
  - If Part B services are billed to a Part B carrier, submit a clear copy of one of the following:
    - ❖ Original crossover claim form billed to Medi-Cal
    - ❖ Claim form billed to Medicare
    - ❖ Facsimile of the claim form submitted to Medicare (same format as *CMS-1500* claim with visible background)
  - All claims for Part A or Part B services must include a clear copy of both of the following:
    - ❖ Medicare MRN/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. If a Part A inpatient hospital is requesting that a higher rate be used to price the claim, indicate the actual revenue code(s) and number of days applicable to each revenue code for the inpatient stay (see *Figure 3* on a following page in this section.)

  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 *Remittance Advice Details* (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 *Remittance Advice Details* (RAD). This number must end with a “99” or “00.”
- 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 inpatient hospital 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
  - 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.
  - If Part B services are billed to a Part B carrier, submit a clear copy of the Medicare adjusted claim form and one of the following:
    - ❖ Original crossover claim form billed to Medi-Cal
    - ❖ Original claim form billed to Medicare
    - ❖ Facsimile of the claim form submitted to Medicare (same format as *CMS-1500* claim with visible background)

  - All claims for Part A or Part B services must include a clear copy of both of the following:
    - ❖ Original and adjusted Medicare MRN/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 (*CMS-1500/UB-04* and Medicare MRN/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, refer to “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 “99” or “00.”
- 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.
- If a Part A inpatient hospital is requesting that a higher rate be used to price the claim, indicate in the *Remarks* section of the CIF the actual revenue code(s) and number of days applicable to each revenue code for the inpatient stay.
- To ensure timeliness requirements are met, refer to the *CIF Submission and Timeliness Instructions* section in this manual.

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(2) DOCUMENT NUMBER
39377390

TYPEWRITER ALIGNMENT Elite Pica

(3) PROVIDER NAME/ADDRESS
ABC HOSPITAL
123 ANY STREET
ANYTOWN CA 999995555

(4) PROVIDER NUMBER
7891236540

(5) CLAIM TYPE CHECK ONE BOX ONLY
01 PHARMACY; 03 [X] HOSPITAL INPATIENT; 05 PHYSICIAN/ ALLIED; 02 LTC; 04 HOSPITAL OUTPATIENT CLINIC; 07 VISION

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

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01	BRIGHT	90000000A95001	12345678901	99	081507		25.00	X		
02										
03										
04										

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
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.

12/21/07
DATE

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

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(2) DOCUMENT NUMBER: 52827451

TYPEWRITER ALIGNMENT Elite Pica

(3) PROVIDER NAME/ADDRESS
ABC HOSPITAL
123 ANY STREET
ANYTOWN CA 999995555

(4) PROVIDER NUMBER: 1234567890

(5) CLAIM TYPE CHECK ONE BOX ONLY
01 [ ] PHARMACY
02 [ ] LTC
03 [X] HOSPITAL INPATIENT
04 [ ] HOSPITAL OUTPATIENT CLINIC
05 [ ] PHYSICIAN/ ALLIED
07 [ ] VISION

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01	JONES	90000000A95001	72887170092	99	081507			X	X	
02										
03										
04										

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

LINE 1: CUTBACK 401. SHOULD HAVE BEEN PAID AT A HIGHER RATE FOR REVENUE CODE 201, LIVER TRANSPLANT AT 2 DAYS, AND REVENUE CODE 121 FOR A 3-DAY STAY.

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.

12/25/07
DATE

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Figure 3: Sample *Claims Inquiry Form* (CIF): Adjustment to Medi-Cal Crossover Payment to Part A Contract Inpatient Hospital.

‹‹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.