LTC (25-1) Claim Completion

Introduction

Purpose

The purpose of this module is to explain the basic requirements for completing the *Payment Request for Long Term Care* (25-1) claim form. Common billing errors, billing tips and claim timeliness will be explained.

Module Objectives

- Identify general billing guidelines for the *Payment Request for Long Term Care* (25-1) claim form
- Review completion requirements for the *Payment Request for Long Term Care* (25-1) claim form
- Highlight common billing errors and how to avoid them
- Discuss billing tips
- Identify the Medi-Cal provider manual section that describes the *Payment Request for Long Term Care* (25-1) claim form

Acronyms

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

LTC (25-1) Claim Description

The *Payment Request for Long Term Care* (25-1) is used to submit claims for the following services:

- Nursing Facility Level A (NF-A)
- Nursing Facility Level B (NF-B)

LTC (25-1) Claim Completion Guidelines

Claim Form Submission Method

The California MMIS Fiscal Intermediary (FI) uses Optical Character Recognition (OCR) equipment to scan all submitted paper billing forms. Accuracy, completeness and clarity are important. Claim forms cannot be processed if applicable information is not supplied or is illegible. To ensure that claim forms are scanned and processed efficiently, providers must adhere to standard requirements.

Paper Format

The following guidelines apply to claim forms submitted by mail:

Form Completion Instructions

- Submit the original claim form. The FI does not accept carbon copies, photocopies, computer-generated claim form facsimiles or claim forms created on laser printers. Keep a photocopy of the original claim in the patient's record.
- Separate individual claim forms. Do not staple original claims together. Stapling original claims together indicates the second claim is an attachment, not an original claim to be processed separately. Bar codes are also used to separate claims and indicate the beginning of another claim.
- Remove all perforated sides and separate each individual form. Leave a ¼-inch border on both the right and left sides after removing the perforation.
- Do not fold or crease claim forms.
- Enter all dates without slashes. Do not use punctuation, including decimal points (.), dollar signs ($) or plus (+) or minus (-) signs when entering amounts.

Form Completion Instructions Continued

- Handwritten claims should be printed neatly using black ballpoint pen only.
- Type information within the designated area of the field. Ensure the type is completely within the text space. Align type with corresponding information. If using a dot matrix printer, do not print in “draft mode” because the characters will not be clear and distinct enough for OCR to accurately determine the contents.
- For line data corrections for LTC claims, mark an “x” in the delete box and enter the correct information on the next available line.
- Do not type in areas labeled “For FI Use Only”.
- Do not highlight information or use correction tape.
- Submit any attachments by taping them to an 8½ x 11-inch sheet of paper with non-glare tape. Do not use original claims as attachments.

Electronic Format

Most claims for these services may also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the *CMC Enrollment Procedures* section (cmc enroll) in the Part 1 provider manual.

Notes:

LTC (25-1) Claim Form Completion

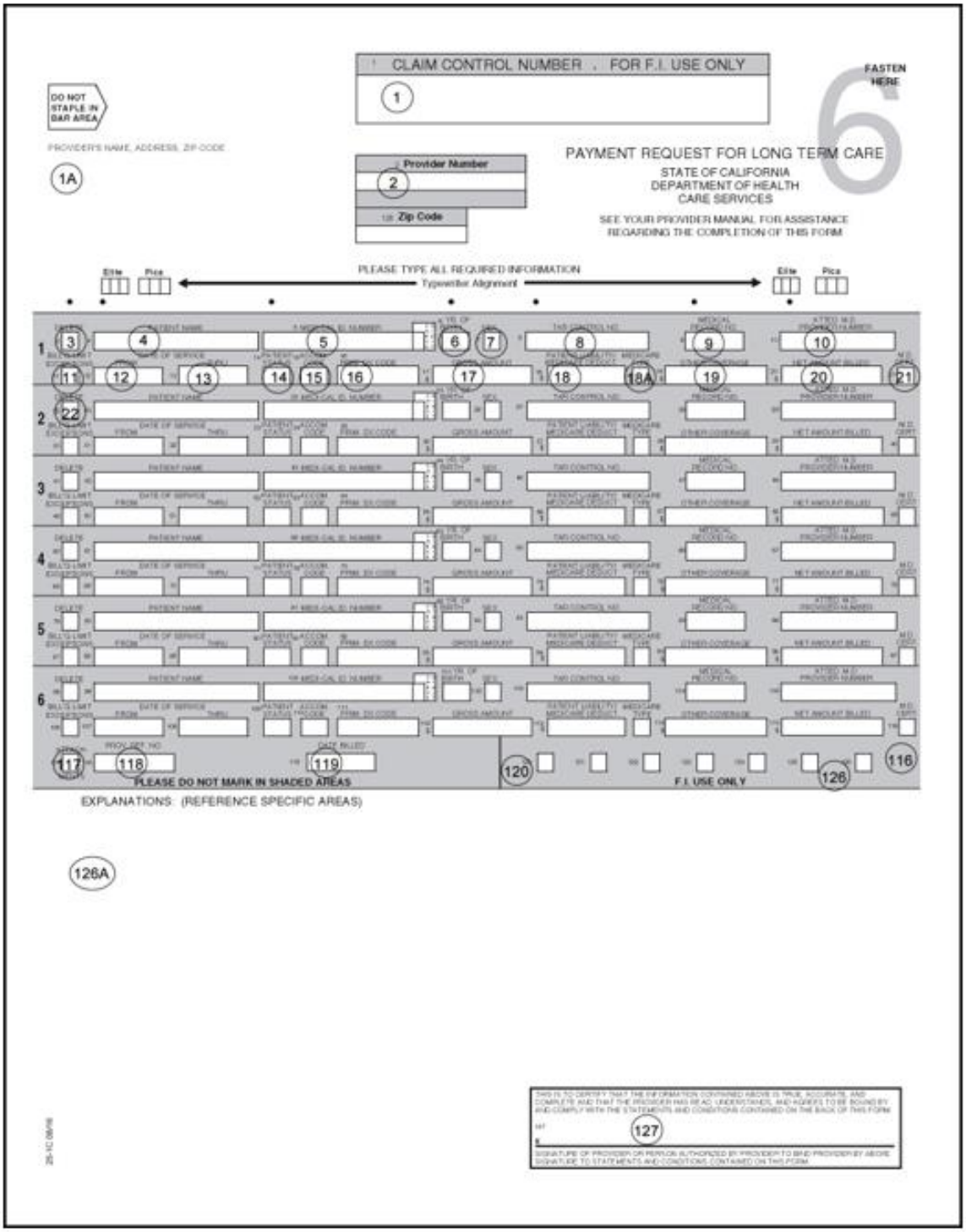

Figure 1: Sample Payment Request Long Term Care (25-1)

LTC (25-1) Field Descriptions: 1 to 2

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Descriptions: 1 to 2

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
1	Claim Control Number For FI use only. **Do not mark in this area**. A unique 13-digit number, assigned by the FI to track each claim, will be entered here when the FI receives the claim.	Same as Medi-Cal	Same as Medi-Cal
1A	Provider's Name, Address Enter your name and address (of the facility) if this information is not pre-imprinted. Please confirm that this information is correct before submitting claims.	Same as Medi-Cal	Same as Medi-Cal
1A	Zip Code (Box 128) **Enter the nine-digit ZIP code of the facility.** **Note:** The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.	Same as Medi-Cal	Same as Medi-Cal
2	Provider Number Enter the National Provider Identifier (NPI) if not pre-imprinted. Be sure to include all 10 characters of the NPI. Do not submit claims using a Medicare provider number (if different from the Medi-Cal number). Claims from providers and/or billing services that bill with anything other than the NPI/provider number will be denied.	Same as Medi-Cal	Same as Medi-Cal

LTC (25-1) Field Descriptions: 3 to 7

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Descriptions: 3 to 7

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
3	Delete If an error has been made for a particular patient, enter an “X” in this space to delete both the upper and lower lines. Enter the correct billing information on another line. When the *Delete* field is marked “X,” the information on both lines will be ignored by the system and will not be entered as a claim line.	Same as Medi-Cal	Same as Medi-Cal
4	Patient Name Enter the patient’s name with commas between each segment of the patient’s name: last, first, middle initial (without a period). Avoid nicknames or aliases. For example, for a patient named James T. Smith Jr., enter: Smith, James, T, Jr	Same as Medi-Cal	Same as Medi-Cal
5	Medi-Cal ID Number Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC).	Same as Medi-Cal	Same as Medi-Cal
6	Year of Birth Enter the patient’s year of birth in a two-digit format (YY) from the BIC. If the recipient is 100 years of age or older, enter the recipient’s age and the full four-digit year of birth (CCYY) in the *Explanations* field (Box 126A).	Same as Medi-Cal	Same as Medi-Cal
7	Sex Use the capital letter “M” for male or “F” for female.	Same as Medi-Cal	Same as Medi-Cal

LTC (25-1) Field Descriptions: 8 to 10

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Descriptions: 8 to 10

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
8	TAR Control Number For services requiring a *Treatment Authorization Request* (TAR), enter the nine-digit TAR Control Number (TCN). It is not necessary to attach a copy of the TAR to the claim. Recipient information on the TAR must match the claim. **Be sure the billed dates fall within the TAR-authorized dates**.	Leave Blank	Leave Blank
9	Medical Record Number This is an optional field that will help providers easily identify a recipient on *Remittance Advice Details* (RAD). Enter the patient's medical record number, account number or other identifier in this field (maximum of five characters-either numbers or letters may be used). Whatever you enter here will appear on the RAD. Refer to the *Remittance Advice Details (RAD) Examples: Long Term Care* (remit ex ltc) section of the Part 2 provider manual for more information.	Same as Medi-Cal	Same as Medi-Cal
10	Attending M.D. Provider Number Enter the physician's NPI/provider number. Be sure the attending physician's NPI number is entered on: An admit claim An initial Medi-Cal claim for a Medicare/ Medi-Cal crossover patient A claim when there is a change in the attending physician's NPI/ provider number	Same as Medi-Cal	Same as Medi-Cal

LTC (25-1) Field Descriptions: 11 to 13

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Descriptions: 11 to 13

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
11	Billing Limit Exceptions (Delay Reason Code) If there is an exception to the six-month billing limitation from the month of service, enter the appropriate delay reason code and include the required documentation. See the *Payment Request for Long Term Care (25-1): Submission and Timeliness Instructions* section (pay ltc sub) in the Part 2 *Long Term Care* manual for a complete listing of delay reason codes. The appropriate documentation must be supplied to justify the exception to the billing limitations.	Enter delay reason code 7 in this box if the Medi-Cal claim is submitted more than six months from the month of service. Attach a copy of the Medicare EOMB/RA.	Same as Part A coinsurance
12, 13	Date of Service Enter the period billed using a six-digit MMDDYY (month/day/year) format for the *From* and *Thru* dates. Bill only one calendar month of service at a time. Be sure the authorization dates on the TAR cover the period billed. For example, April 5, 2018 is written “040518”. **Note:** When a patient is discharged, the thru-date of service must be the discharge date. When a patient expires, the thru-date of service must be the date of death.	Same as Medi-Cal **Note:** Dates of service reflect only those days covered by coinsurance. A TAR is not required.	Only a one-month period may be billed on any one billing line. If the Part B Medi-Cal crossover service involves only one day, enter the same date in both the *From* and *Thru* boxes. If the services were performed over a range of dates in the same month, the “From” date is the first service date and the “Thru” date is the last service date as it appears on the Medicare claim form.

LTC (25-1) Field Descriptions: 14

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Description: 14

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
14	Patient Status Enter the appropriate patient status code from the list below: Code — Patient Status 00 Still under care 01 Admitted 02 Expired 03 Discharged to acute hospital 04 Discharged to home 05 Discharged to another LTC facility 06 Leave of absence to acute hospital (bed hold) 07 Leave of absence to home 08 Leave of absence to acute hospital/discharged 09 Leave of absence to home/discharged 10 Admitted/expired 11 Admitted/discharged to acute hospital 12 Admitted/discharged to home 13 Admitted/discharged to another LTC facility 32 Transferred to LTC status in same facility **The patient status code must agree with the accommodation code**. (For example, if the status code indicates leave days, the accommodation code must also indicate leave days.) **Note:** The FI does not require a copy of the *Notification of Patient Admission, Discharge or Death* form (MC-171) to be attached to the *Payment Request for Long Term Care* (25-1) claim form.	Same as Medi-Cal	Same as Medi-Cal

LTC (25-1) Field Descriptions: 15 to 16

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Descriptions: 15 to 16

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
15	Accommodation Code Enter the appropriate accommodation code for the type of care billed, as listed in the *Accommodation Codes for Long Term Care* section (accom cd ltc) in the Part 2 *Long Term Care* manual. **Note:** The FI does not require that a copy of the *Certification for Special Program Services* form (HS 231) be attached to the LTC 25-1 claim form. The HS 231 form should be attached to the LTC TAR sent to the TAR Processing Center.	Same as Medi-Cal	Leave Blank
16	Primary DX Diagnosis Code Enter the primary ICD-10-CM diagnosis code for the following: • Admit claims • Initial Medi-Cal claim for Medicare/Medi-Cal crossover patient • Change in diagnosis All claims require an ICD indicator of “0” when billing any diagnosis code. Enter an ICD indicator for each claim. **Note:** ICD-10-CM diagnosis codes must be three, four, five, six or seven digits, with the fourth through seventh digits included, if present. The vertical line serves as the decimal point. Do not enter the decimal point when entering this code. Current copies of the ICD-10-CM diagnosis codes may be ordered from: PMIC 4727 Wilshire Boulevard, Suite 300 Los Angeles, CA 90010 1-800-633-7467 *www.pmiconline.com*	Same as Medi-Cal	Leave Blank

LTC (25-1) Field Descriptions: 17

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Description: 17

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
17	Gross Amount When billing for full Medi-Cal coverage, compute the gross amount by multiplying the number of days by the appropriate Medi-Cal daily rate for the accommodation code listed. When entering the gross amount, do not use the symbols ($) or (.). The pre-imprinted vertical line serves as the decimal point. Use this method when entering all dollar amounts on the LTC 25-1 claim form.	Multiply the per-diem rate allowed by Medicare, by the total coinsurance days being billed and enter the total.	Enter the amount allowed by Medicare for these services directly from the Medicare EOMB/RA.

LTC (25-1) Field Descriptions: 18

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Description: 18

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
18	Patient Liability/Medicare Deduct Enter the recipient's net Share of Cost (SOC) liability. The recipient's net SOC liability is the amount billed to the recipient. The recipient's net SOC liability is determined by subtracting from the recipient's original SOC (listed on the Medi-Cal eligibility verification system) the amount expended by the recipient that qualifies under Medi-Cal rules to reduce the patient's SOC liability. For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items not covered by Medi-Cal. A description of non-covered services is included in the *Share of Cost (SOC): 25-1 for Long Term Care* section (share ltc) of the Part 2 *Long Term Care* manual. The "Patient Liability" (SOC) entered in this box must agree with the "Total SOC Deducted from LTC Claim" entered on the DHS 6114 form, Item 15 (*See the Share of Cost (SOC): 25-1 for Long Term Care* section [share ltc] in the Part 2 *Long Term Care* manual for an example). When billing the recipient for less than the SOC amount indicated by the Medi-Cal eligibility verification system, explain why in the *Explanations* field.	Same as Medi-Cal Exception: May leave blank if SOC is zero.	**Medicare Deductible:** For a Part B crossover claim, this field is for Medicare deductible information only. Enter the deductible found on the Medicare EOMB/RA. If the Medicare deductible has already been met, leave this area blank. **Share of Cost (SOC):** For Part B crossover claims, do not include SOC (patient liability) information in this box. When the Medi-Cal eligibility verification system shows the recipient has an SOC, enter that information in the *Explanations* field of the claim. Refer to the *Medicare/ Medi-Cal Crossover Claims: Long Term Care Billing Examples* section (medi cr ltc ex) in the Part 2 *Long Term Care* provider manual

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LTC (25-1) Field Descriptions: 18A to 19

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Descriptions: 18A to 19

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
18A	Medicare Type Leave blank for Medi-Cal-only claims.	Enter the capital letter “A” to indicate that the claim is for a Part A coinsurance billing. **Note:** A copy of the Medicare EOMB/RA must be attached to the payment request form.	Enter the capital letter “B” to indicate that the claim is for a Part B coinsurance billing. **Note:** A copy of the Medicare EOMB/RA must be attached to the payment request form.
19	Other Coverage Enter the amount paid by the other insurance carrier(s) for the period billed, if applicable. Other Health Coverage (OHC) includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient’s health care needs. **Note:** If the Medi-Cal eligibility verification system indicates a scope of coverage code “L” for the recipient, providers must bill other insurance carriers prior to billing Medi-Cal. For more information about OHC, refer to the *Other Health Coverage* (OHC) section (oth hlth) in the Part 2 *Long Term Care* provider manual.	Enter the amount actually paid by the Medicare intermediary for the coinsurance days being billed. Attach a copy of the EOMB/RA to the payment request form.	Enter the amount Medicare paid for service(s) as shown on the Medicare EOMB/RA. Attach a copy of the EOMB/RA to the payment request form. Do not attach a copy of the *UB-04* claim form. If there is a “contract adjusted amount” on the EOMB/RA, add this figure to the Medicare paid amount and enter the total in the *Other Coverage* field.

LTC (25-1) Field Descriptions: 20 to 117

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Descriptions: 20 to 117

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
20	Net Amount Billed Enter the amount requested for this billing. To compute the net amount, subtract patient liability and OHC (if any) from the gross amount billed. If the net amount billed computes to $00.00, enter the amount as "0000." **Do not leave blank**. • Gross Amount • Patient Liability • Other Coverage • Net Amount	Enter the total amount billed to Medi-Cal (coinsurance) as shown on the EOMB/RA from the Medicare Intermediary, less any patient liability applied to this billing line.	Enter the portion to be billed to Medi-Cal (coinsurance plus any Medicare deductible as shown on EOMB/RA from the Medicare Intermediary, minus any patient liability as shown in the *Explanations* field).
21	M.D. Certification	Not required	Not required
22 to 116	Additional Claim Lines The payment request form may be used to bill services for as many as six patients. Bill only one month's services on each line.	Same as Medi-Cal	Same as Medi-Cal
117	Attachments Enter an "X" if attachments are included with the claim. Leave blank if not applicable. Reminder: If this box is not marked, attachments may not be seen by the examiner, which may cause the claim to be denied. For more information regarding attachment submission, refer to the Billing Instructions of the *California Medicaid (Medi-Cal) Companion Guide Transaction Information* on the Medi-Cal website (*www.medi-cal.ca.gov*).	Same as Medi-Cal	Same as Medi-Cal

LTC (25-1) Field Descriptions: 118 to 127

The following table is a field-by-field description of the LTC 25-1 claim form:

Table of LTC (25-1) Field Descriptions: 118 to 127

Field	Medi-Cal Claim Description	Part A Coinsurance Claim Description	Part B Crossover Claim Description
118	Provider Reference Number Enter any number, up to seven digits, to identify this claim form in your filing system. Any combination of alpha or numeric characters may be used. The FI will reference this number on any forms sent to you that pertain to the billing data on the form. It will not be included on the RAD.	Same as Medi-Cal	Same as Medi-Cal
119	Date Billed In six-digit format, enter the date the claim is submitted for Medi-Cal payment.	Same as Medi-Cal	Same as Medi-Cal
120 to 126	Fi Use Only Leave blank.	Same as Medi-Cal	Same as Medi-Cal
126A	Explanations Use this area for procedures that require additional information or justification. It is essential to clearly indicate the billing line number in this area.	Same as Medi-Cal Use for explanations of SOC adjustments	Same as Medi-Cal Enter Medi-Cal SOC amount here.
127	Signature of Provider or Person Authorized By Provider (Representative) **The claim must be signed and dated** by the provider or a representative assigned by the provider. **Use black ballpoint pen only. An original signature is required** on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file with the FI.	Same as Medi-Cal	Same as Medi-Cal

Required Claim Form Information Table

Table of Required Claim Form Information

Form Fields	Medi-Cal Per Diem	Part A Coinsurance	Part B Crossover
3 (Delete Box)	When necessary	When necessary	When necessary
4 (Patient Name)	Required	Required	Required
5 (Recipient ID No.)	Required	Required	Required
6 (Year of Birth)	Required	Required	Required
7 (Sex)	Required	Required	Required
8 (TAR Control No.)	Required	Leave blank	Leave blank
9 (Medical Record No.)	Optional	Optional	Optional
10 (Attending M.D. No.)	Required for admit/change	Required for admit/change	Valid Medi-Cal NPI is required
11 (Reason Code)	When necessary	When necessary	When necessary
12, 13 (Date of Service)	Required	Required	Required
14 (Patient Status	Required	Required	Leave blank
15 (Accommodation Code)	Required	Required	Leave blank
16 (Primary DX Code)	Required for admit/change	Required for admit/change	Leave blank
17 (Gross Amount)	Required	Required	Required
18 (Patient Liability Medicare Deduct)	Medi-Cal liability SOC amount or “0”. Do not leave blank.	Medi-Cal liability (SOC) when not zero.	Medicare deductible only. Enter SOC in *Explanations* area of claim.
18A (Medicare Type)	Leave blank	Required (A)	Required (B)
19 (Other Coverage)	Blank unless other health insurance billed	Required	Required
20 (Net Amt. Billed)	Required	Required	Required

Additional Forms (Attachments)

Medi-Cal Claim Attachment Control Form (ACF)

An ACF validates the process of linking paper attachments to electronic claims.

For each electronically submitted claim requiring an attachment, a single and unique ACF must be submitted via mail or fax. Providers are required to use the 11-digit Attachment Control Number (ACN) from the ACF to populate the PWK segment of the 837 HIPAA transaction.

Attachments must be mailed or faxed to the FI at the following address:

California MMIS Fiscal Intermediary
P.O. Box 526022
Sacramento, CA 95852
Fax: 1-866-438-9377

Note: The method of transmission, by mail or by fax, must be indicated in the appropriate PWK segment and must match the method of transmission used.

Refer to the *California Medicaid (Medi-Cal) Companion Guide Transaction Information* available on the Medi-Cal Provider website (www.medi-cal.ca.gov) for instructions on how to submit attachments to 837 v.5010A1 claims.

Attachment Policies

- All attachments must be received within 30 days of the electronic claim submission.
- The original ACF must accompany the attachments.
- To ensure accurate processing, only one ACN value (found on the ACF) will be accepted per single electronic claim and only one set of attachments will be assigned to a claim.

Denied Claim Reasons

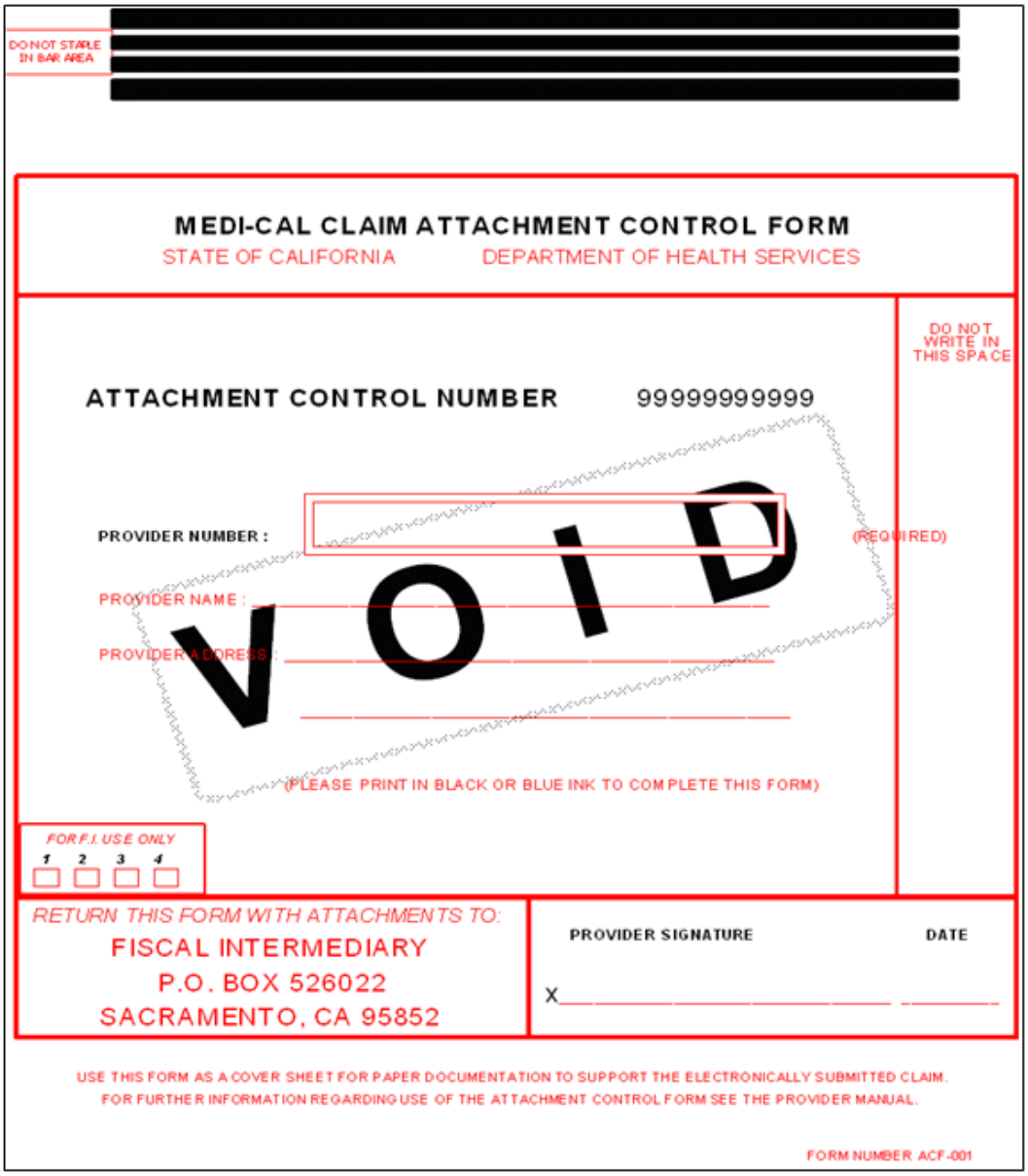
- If an 837 v.5010A1 electronic transaction is received that requires an attachment and there is no ACN, the claim will be denied.
- If no ACF or a non-original ACF is submitted, the attachments or documentation will be returned with a reject letter to the provider or submitter.
- No photocopies of the ACF will be accepted.
- ACF with attachments must be mailed or faxed.

ACF Order/Reorder Instructions

To place an order for ACFs or to reorder forms, follow the instructions below:

- To order ACF documents, call Telephone Service Center (TSC) at 1-800-541-5555.
- To reorder forms, complete and mail the hard copy reorder form.

ACFs and envelopes will be provided FREE of charge to all providers submitting 837 v.5010A1 electronic transactions. For further information, refer to the Medi-Cal website (*www.medi-cal.ca.gov*) or call TSC.


DO NOT STAPLE IN BAR AREA

MEDI-CAL CLAIM ATTACHMENT CONTROL FORM
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

DO NOT WRITE IN THIS SPACE

ATTACHMENT CONTROL NUMBER 99999999999

PROVIDER NUMBER : (REQUIRED)

PROVIDER NAME :

PROVIDER ADDRESS :

VOID

(PLEASE PRINT IN BLACK OR BLUE INK TO COMPLETE THIS FORM)

FOR F.I. USE ONLY
1 2 3 4

RETURN THIS FORM WITH ATTACHMENTS TO:
FISCAL INTERMEDIARY
P.O. BOX 526022
SACRAMENTO, CA 95852

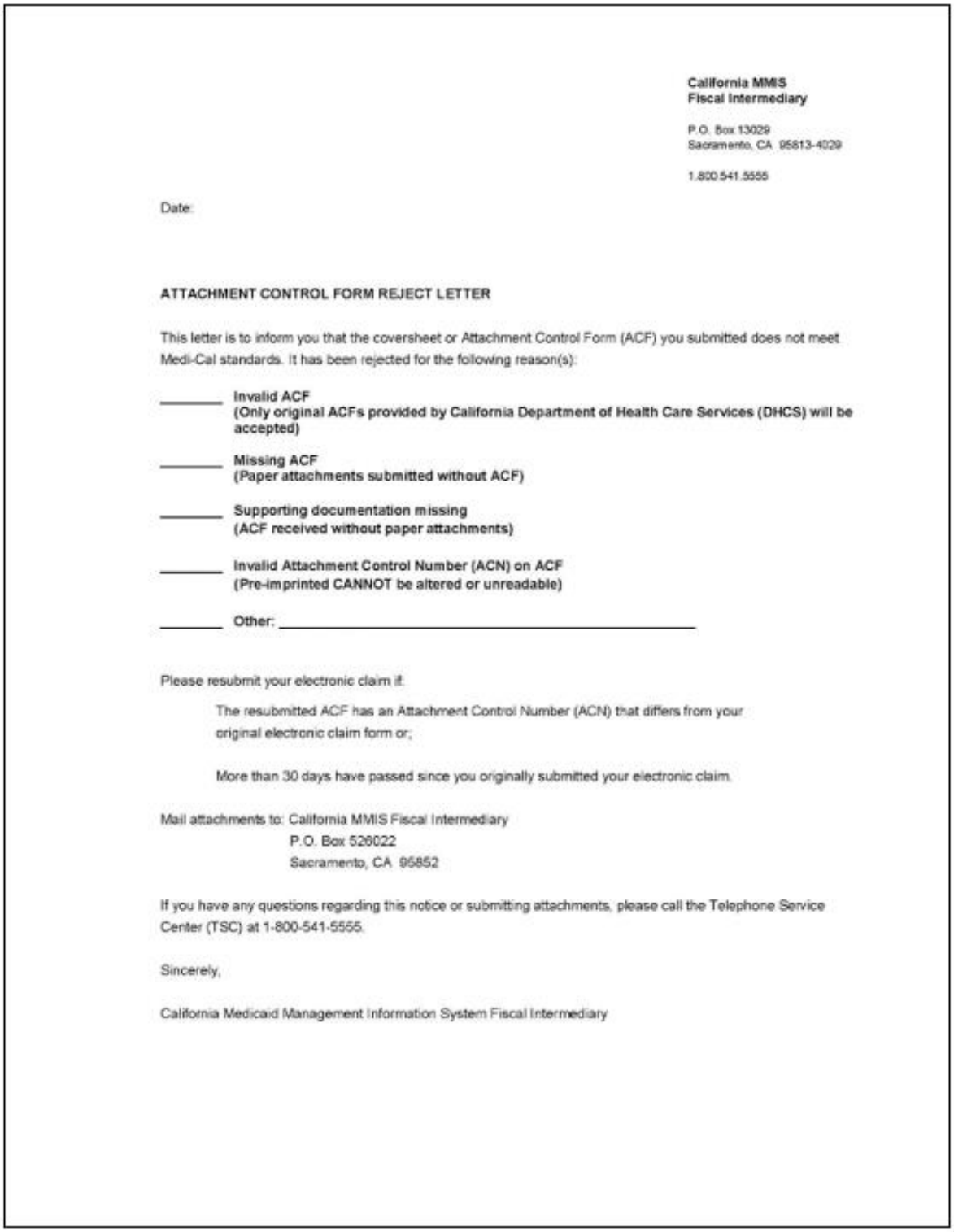
PROVIDER SIGNATURE DATE

X

USE THIS FORM AS A COVER SHEET FOR PAPER DOCUMENTATION TO SUPPORT THE ELECTRONICALLY SUBMITTED CLAIM.
FOR FURTHER INFORMATION REGARDING USE OF THE ATTACHMENT CONTROL FORM SEE THE PROVIDER MANUAL.

FORM NUMBER ACF-001

Figure 2: Sample *Medi-Cal Claim Attachment Control Form*



California MMIS
Fiscal Intermediary

P.O. Box 13029
Sacramento, CA 95813-4029

1.800.541.5555

Date:

ATTACHMENT CONTROL FORM REJECT LETTER

This letter is to inform you that the coversheet or Attachment Control Form (ACF) you submitted does not meet Medi-Cal standards. It has been rejected for the following reason(s):

_____ **Invalid ACF**
(Only original ACFs provided by California Department of Health Care Services (DHCS) will be accepted)

_____ **Missing ACF**
(Paper attachments submitted without ACF)

_____ **Supporting documentation missing**
(ACF received without paper attachments)

_____ **Invalid Attachment Control Number (ACN) on ACF**
(Pre-imprinted CANNOT be altered or unreadable)

_____ **Other:** _____

Please resubmit your electronic claim if:

The resubmitted ACF has an Attachment Control Number (ACN) that differs from your original electronic claim form or;

More than 30 days have passed since you originally submitted your electronic claim.

Mail attachments to: California MMIS Fiscal Intermediary
P.O. Box 526022
Sacramento, CA 95852

If you have any questions regarding this notice or submitting attachments, please call the Telephone Service Center (TSC) at 1-800-541-5555.

Sincerely,

California Medicaid Management Information System Fiscal Intermediary

Figure 3: Sample *Attachment Control Form Rejection Letter*

Common Billing Errors

The following fields must be completed accurately and completely on the LTC 25-1 claim form to avoid claim suspense or denial. The following table can be found in the *Payment Request for Long Term Care (25-1): Tips for Billing* section (pay ltc tips) in the Part 2 *Long Term Care* provider manual.

Common Billing Errors Table

Field(s)	Description	Errors
Explanations	Medicare Part B, Duplicate Claim	Billing two Part B Medicare claim lines for the same recipient with overlapping dates of service. **Billing Tip:** Enter the reason for the overlapping dates of service in the *Explanations* field. For example, “Line 1: This is not a duplicate claim. This claim is for speech therapy. Line 2: The physical therapy claim (same recipient for overlapping dates of service was billed on an earlier date [give specific date]). A copy of the claim is attached.”
Explanations	Share of Cost	Failure to identify the reason for reduction in a recipient’s SOC. **Billing Tip:** Identify the SOC for the patient, minus the non-covered services in the *Explanations* field. For example, “Share of Cost 300.00 (–) non-covered services 27.70 = Pat Liab/Medicare Deduct 272.30.”

Common Billing Errors Table (continued)

Field(s)	Description	Errors
11, 30, 49, 68, 87, 106	Billing Limit Exceptions	Omitting valid delay reason codes for claims submitted more than six months from the date of service. **Billing Tip:** Enter the delay reason code in the designated field.
14, 33, 52, 71, 90, 109	Patient Status	Entering the patient status code in the wrong field. **Billing Tip:** Enter the status code in the *Patient Status* field.
15, 34, 53, 72, 91, 110	Accommodation Code	Entering the accommodation code in the wrong field. **Billing Tip:** Enter accommodation code in *Accommodation Code* field.
19, 38, 57, 76, 95, 114	Other Health Coverage	Claim submitted to Medi-Cal with a billing limit exception code or delay reason code or attachment indicating that the claim was submitted to Medicare and/or OHC more than one year from the month of service. **Billing Tip:** Bill Medicare or the OHC within one year of the month of service to meet Medi-Cal timeliness requirements. Submit claim to the FI within 60 days of Medicare or OHC carrier's resolution. Use the OHC *Explanation of Benefits* date or Medicare *Remittance Advice* (RA) date to calculate timeliness.

Common Billing Errors Table (continued)

Field(s)	Description	Errors
12,13, 31, 32, 50, 51, 69, 70, 88, 89, 107, 108	Date of Services (From – Thru)	From-Thru dates of service do not correspond with the authorized from-through dates of service on the TAR. **Billing Tip:** Verify that the dates of service on the claim match the approved dates on the TAR, or obtain a revised TAR.
14, 15, 33, 34, 52, 53, 71, 72, 90, 91, 109, 110	Patient Status/ Accommodation Code	Entering an accommodation code and status code combination that is inappropriate. **Billing Tip:** Confirm that the patient status code agrees with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days).

Learning Activities

Learning Activity 1: Review

Use the information below to complete the following LTC 25-1 claim form for a Medi-Cal claim.

Patient Information

- Patient (Recipient): Sharon Sharealike
- Birth date: March 3, 2004
- Address: 123 Summertime Street, Anywhere, CA
- Zip Code: 98870-4567
- Medi-Cal ID Number: 912345678A4365

Service Provided

- TAR Control Number: 12345678911
- Attending Physician ID: 1234567897
- Date of Service: 05/01/21

Notes:

Learning Activity 1: Review (continued)

Billing Information

- Date Billed: 06/01/21
- Gross Amount: 450.00
- Patient Liability: 50.00
- OHC Payment: 100.00
- Net Amount Billed: 300.00
- Billing Limit Exceptions (Delay Reason Code): “7” in Box 11

Notes:

Learning Activity 1: LTC 25-1 Claim Form

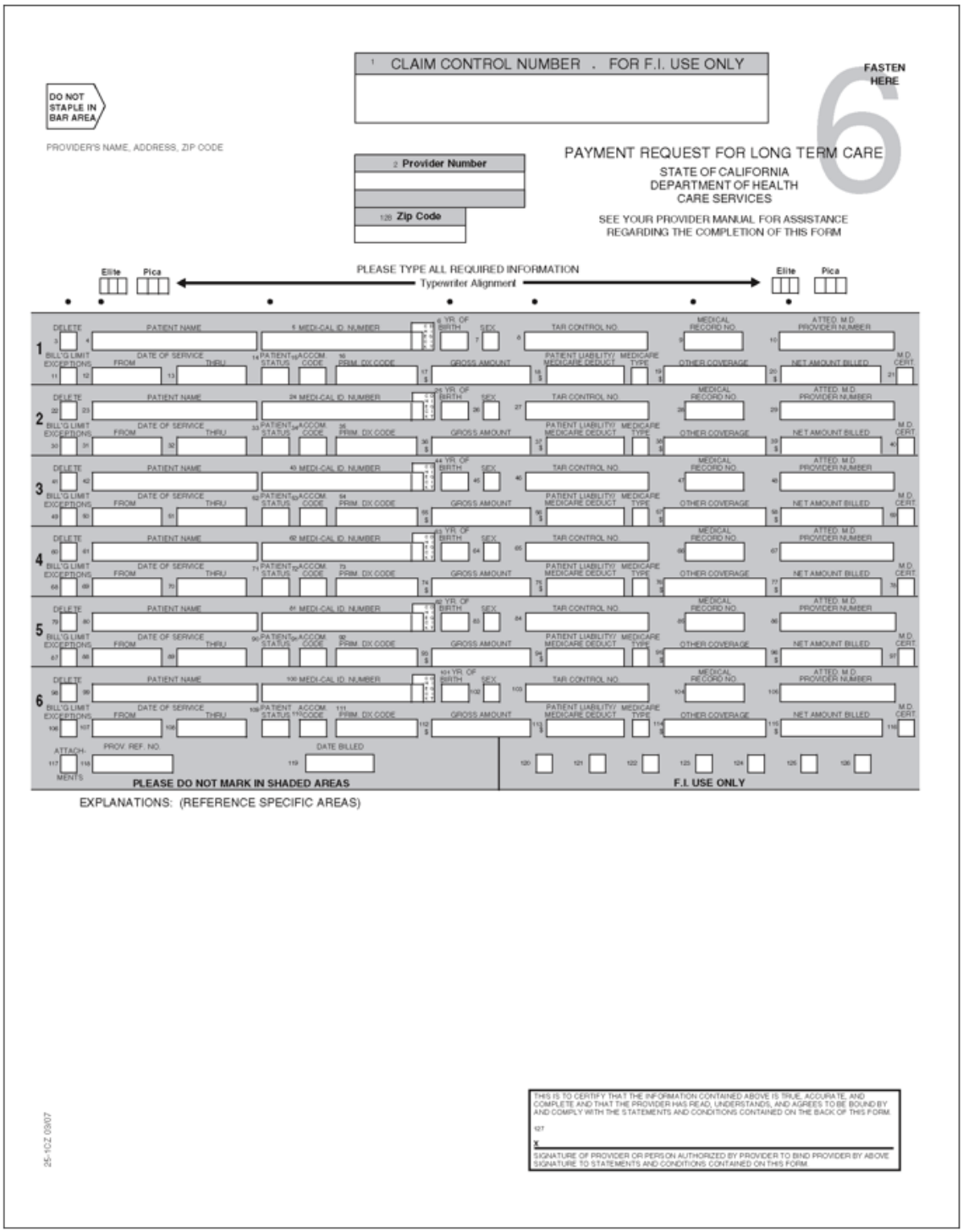


Figure 4: Blank LTC 25-1 claim form

Learning Activity 1: Answer Key

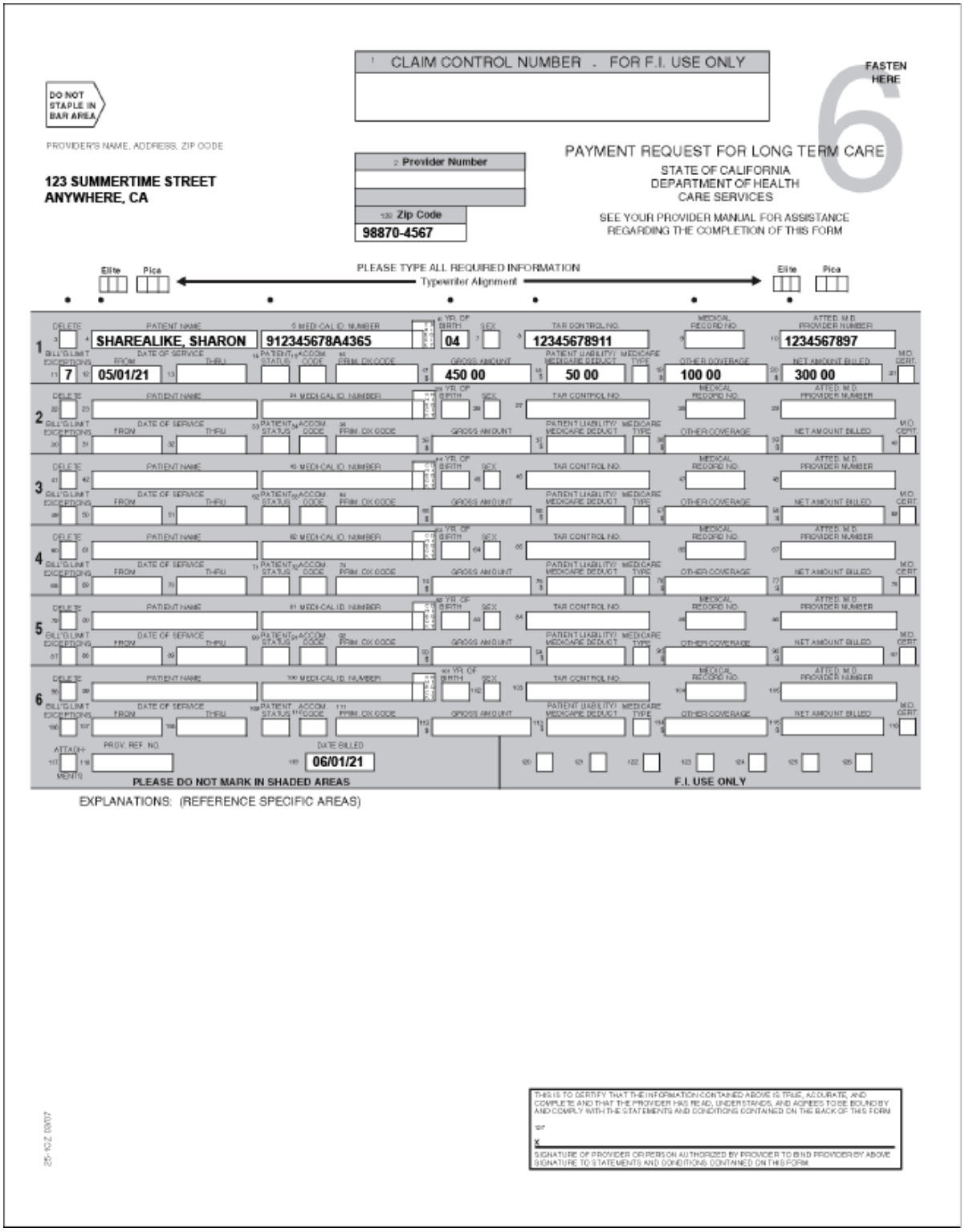


Figure 5: Learning Activity 1 Answer Key

Review Exercise

1. To receive 100 percent of the Medi-Cal maximum reimbursement, claims should be submitted within _____ _____ from the _____ of service.
2. Enter delay reason code ___ in Box 11 if the Medi-Cal claim is submitted more than six months from the month of service.
3. If the subscriber/recipient has OHC, Medicare and Medi-Cal, what is the order in which you bill?_____
4. What is the “Patient Liability?”_____
5. Patient status codes must agree with the accommodation code on each claim.

   True □ False □

Learning Activity 2

Unscramble the following words:

1. TCL _____
2. RSNUIGN FIYCAILT _____
3. TAHELH ACRE _____
4. PISNIAYCH _____
5. TATNANTED _____
6. PIETATN _____
7. MALIDEC- _____
8. TIBLYIIILEG _____
9. OCS _____
10. OIREDVPR _____
11. IP _____
12. CDI IITRDCOAN _____

See Appendix for the Answer Key.

Resource Information

References

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

Provider Manual References

Part 1

CMC Enrollment Procedures (cmc enroll)

Part 2

Accommodation Codes for Long Term Care (accom cd ltc)

Forms Reorder Request: Guidelines (forms reo)

Other Health Coverage (OHC) (oth hlth)

Payment Request for Long Term Care (25-1) Completion (pay ltc comp)

Payment Request for Long Term Care (25-1): Submission and Timeliness Instructions (pay ltc sub)

Payment Request for Long Term Care (25-1): Tips for Billing (pay ltc tips)

Share of Cost (SOC): 25-1 for Long Term Care (share ltc)

TAR Completion for Long Term Care (tar comp ltc)

Other References

Medi-Cal Provider website: (*www.medi-cal.ca.gov*)