IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201225 JULY 10, 2012

IHCP changes submission policy for Medicare Replacement Plan claims

Effective August 9, 2012, Medicare Replacement Plan claims submitted to the Indiana Health Coverage Programs (IHCP) for reimbursement will no longer be processed as third-party liability (TPL) claims and will no longer require that the Medicare Replacement Plan explanation of benefit (EOB) be attached to the claim when a payment has been made by the Medicare Replacement Plan. This change eliminates the need for paper claim submissions. In addition, if paper claims are submitted, providers are no longer required to handwrite "Medicare Replacement" on the face of the claim or add "Medicare Replacement" in the claim note field. (For current claim submission procedures, see *Chapter 5* of the *IHCP Provider Manual*.)

Medicare Replacement Plan claims will be processed as Medicare crossover claims. The IHCP reimburses covered services for Medicare crossover claims only when the Medicaid-allowed amount exceeds the amount paid by Medicare. If the Medicaid-allowed amount exceeds the Medicare Replacement Plan paid amount, the IHCP reimburses using the lesser of the coinsurance plus deductible or the Medicaid-allowed amount minus the Medicare Replacement Plan paid amount. This change also affects claims paid at zero when the amount allowed has been allocated to the member's deductible. (See *Chapter 7* of the *IHCP Provider Manual*.)

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Parts A and C crossover claims

Institutional and outpatient (UB-04) claims received with dates of service on or after August 9, 2012, must be submitted to the IHCP as crossover claims for reimbursement consideration. UB-04 claims may be submitted via the following methods:

- 837I transaction
- Web interChange – For billing instructions when submitting institutional and outpatient crossover claims, see the *Quick Reference for Billing Institutional Claims* on the Web interChange help page. The payer identification (ID) will continue to be Medicare's payer ID with the appropriate Medicare Replacement Plan name in the Payer Name field.
- Paper UB-04 claim form

Note: UB-04 crossover claims submitted without the Medicare-paid amount in field 54A and the value codes in fields 39a-41d will be processed as standard UB-04 claims and will be denied for edit 2500 (Part A) or 2502 (Part C) with explanation of benefit (EOB) 2055 – *The claim has been denied. Please resubmit the Medicare Replacement Plan claim as a crossover claim for reimbursement consideration.*

All institutional and outpatient UB-04 claims must identify information from the Medicare Replacement Plan explanation of benefit (EOB) in Fields 39a-41d. The following value codes must be used, along with the appropriate dollar or unit amounts for each. These fields are required, if applicable:

- Value Code A1 – Medicare deductible amount
- Value Code A2 – Medicare coinsurance amount
- Value Code 06 – Medicare blood deductible amount
- Field 50A must indicate Medicare as the payer
- Field 54A must contain the Medicare Replacement Plan paid amount, meaning the actual dollars received from Medicare. (Do not include the Medicare-allowed amount or contractual adjustment amount in field 54A.)
- TPL payments will continue to be reported in field 54B.

Part B crossover claims

Professional (CMS-1500) claims received with dates of service on or after August 9, 2012, must be submitted to the IHCP as crossover claims for reimbursement consideration. CMS-1500 claims may be submitted via the following methods:

- 837P transaction
- Web interChange – For billing instructions when submitting professional crossover claims, see the *Quick Reference for Billing Medical Claims* on the Web interChange help page. The payer ID will continue to be Medicare's payer ID with the appropriate Medicare Replacement Plan identified in the Payer Name field.
- Paper CMS-1500 claim form

To process as a crossover claim, providers must include additional information on

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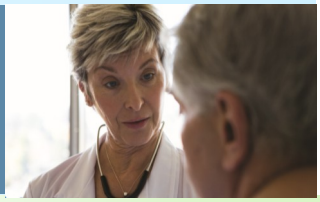
the CMS-1500 claim form. The combined total of the Medicare coinsurance, deductible, and psychiatric reduction must be reported on the left side of field 22 under the heading *Code*. The Medicare Replacement Plan paid amount, meaning the actual dollars received from Medicare, must be indicated in field 22 on the right side under the heading *Original Ref No*.

Medicare Replacement Plan denials

Please note that Medicare-denied services are not crossover services, and the submission procedures for Medicare-denied services have not changed. If a claim has been denied by the Medicare Replacement Plan, the explanation of benefit (EOB) or Remittance Advice (RA) must be attached to the claim with "Medicare Replacement Plan" written on the top of the attachment. Medicare-denied services must be filed on a separate claim form from paid services, and the appropriate EOB or RA must be attached for reimbursement consideration. Medicare-denied services may be submitted via Web interChange. Follow the "Attachments" instructions to send the Medicare Replacement Plan EOB.

Medicare Replacement Plan claims that have been paid at zero and the dollars allocated to the member's coinsurance or deductible are considered paid and must be submitted to the IHCP as crossover claims.



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