CMS-1500 Medicare Crossover and Replacement Plan Billing

HP Provider Relations/October 2013
Agenda

• Session Objectives
• Definition of a Crossover Claim
• Reimbursement Methodology
• Crossover Claims via Web interChange
• Medicare Replacement Plans Payer IDs and Claim Filing Indicator
• Attachment Process
• Crossover Claims via the CMS-1500 Claim Form
• Automatic Crossover
• Common Denials
Session Objectives

Following this session, providers will:

• Know the definition of a crossover claim
• Understand how to report crossover information and Medicare Replacement information via Web interChange
• Understand how to report crossover information on the CMS-1500 claim form
• Understand the difference between crossover and third-party liability (TPL) claims
• Understand how crossover claims are reimbursed
Crossover Claim
Crossover – Defined

The term “crossover claim” is defined as:

• Allowed or covered line items billed to Traditional Medicare or a Medicare Replacement Plan Part A and/or Part B
• When a member has Medicare or a Medicare Replacement Plan as their primary insurance
• Medicare issued a payment of any amount, or the entire payment was applied to the deductible
Non-Crossover – Defined

• A claim is not a crossover claim when:
  - The member’s primary insurance is not Traditional Medicare or a Medicare Replacement Plan
  - Medicare denied the entire claim
    ➢ In this instance the claim is a straight Medicaid claim and is subject to the one-year filing limit
    ➢ These claims are also subject to prior authorization requirements

*Note: Crossover claims are not subject to the one-year filing limit*
Reimbursement Methodology
Reimbursement Methodology

- The Indiana Health Coverage Programs (IHCP) makes payment on crossover claims only when the total Medicaid rate for the entire claim is more than the amount paid by Medicare for the entire claim.

- IHCP reimbursement includes the lesser of the following:
  - Medicare coinsurance and deductible
  - The difference between the IHCP rate and the Medicare paid amount for the entire claim.
# Calculating Crossover Payments

<table>
<thead>
<tr>
<th>SERVICE DATES</th>
<th>MCARE COINS/</th>
<th>MCARE DEDUCT</th>
<th>MCARE PAID</th>
<th>TPL/</th>
<th>MCAID BILLED/</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM THRU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>060713 060713</td>
<td>45.52</td>
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<td>135.21</td>
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<td>1,446.00</td>
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<td></td>
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<td></td>
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<tr>
<td>060713 060713</td>
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<td>768.00</td>
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<td></td>
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<td>27.18</td>
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</table>

- Medicare paid: 135.21
- Medicaid allowed: -94.24
- Balance: 40.97
- Medicaid due to provider: 0.00

Medicaid paid amount: 135.21
Medicaid allowed amount: 94.24
Balance: 40.97
Medicaid due to provider: 0.00
Crossover Claims – Web interChange
Crossover Claims via Web interChange
- Crossover information must be reported for both the header and detail levels

Header information is reported in the *Benefit Information* window
- Header information pertains to the entire claim

Detailed information is reported in the *Detail Benefits Info* window
- Detail information pertains to individual detail lines of the claim
**Professional Claim**

* denotes a required field.

### Billing Information

- **NPI**
- **Postal Code**
- **Taxonomy**
- **Legacy Provider Id**
- **Member ID**
- **Last Name**
- **First Name**
- **Patient Account #**
- **Rendering Provider**
- **Rendering NPI**
- **Rendering Taxonomy**
- **Referring Provider**
- **Referring NPI**
- **Certification Code**
- **Signature Indicator**
- **Medical Record #**

### Service Information

**Claim Type**
- Medical Crossover

**Place of Service**
- 

**Hospital From Date**
- 

**Hospital To Date**
- 

**Pregnancy?**
- Yes
- No

**Last Menstrual Period**
- 

**Accident Related to**
- Auto
- Employment
- Other Accident
- Special Program

### Coordination of Benefits

- **Total TPL**
- **Total Medicare Paid**

### Benefit Information

### Charges

- **Total Charges**
### Other Payer Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer ID</td>
<td></td>
</tr>
<tr>
<td>Payer Name</td>
<td></td>
</tr>
<tr>
<td>TPL / Medicare Paid Amount</td>
<td></td>
</tr>
<tr>
<td>ICN</td>
<td></td>
</tr>
<tr>
<td>Referral Number</td>
<td></td>
</tr>
<tr>
<td>PA Number</td>
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### Other Payer Payment Adjustments

<table>
<thead>
<tr>
<th>Group Code</th>
<th>Reason Code</th>
<th>Amount</th>
<th>Quantity</th>
<th>Reason Code</th>
<th>Amount</th>
<th>Quantity</th>
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</thead>
</table>

### Additional Other Payer Payment Adjustments

### Other Payer Subscriber Information

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<th>Field</th>
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<td>Name</td>
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<tr>
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<td>State</td>
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<td>Zip Code</td>
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</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>SSN</td>
<td></td>
</tr>
<tr>
<td>Group/Policy Number</td>
<td></td>
</tr>
<tr>
<td>Policy Name</td>
<td></td>
</tr>
<tr>
<td>Policy Number</td>
<td></td>
</tr>
</tbody>
</table>

### Other Payer Referring Provider Information

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Crossover Claims via Web interChange
Crossover header information

To report header information, perform the following:

• Click **Benefit Information** on the *Claim Submission* window
  1. Payer ID = **08102 for WPS** or Medicare Replacement Plan Payer ID
  2. Payer Name = **Wisconsin Physician Services (no spaces)** or **WPS** or the name of the Replacement Plan
  3. TPL/Medicare Paid Amount = The total amount paid by Medicare or the Replacement Plan for the claim
  4. Subscriber Name
  5. Primary ID = Medicare number with alpha character
  6. Relationship Code = **18** (self)
  7. Claim Filing Code = MB (Traditional Medicare) or 16 (Replacement Plan)

• Click **Save Benefits** at the bottom of the screen

• Scroll to the top of the screen and click **Save and Close**
Medicare Replacement Plan Claim Submissions

- Effective for claims submitted on or after September 1, 2013, providers must include claim filing indicator code 16 – Health Maintenance Organization (HMO) Medicare Risk when submitting Medicare Replacement Plan claims electronically via 837 or via Web interChange

- Providers should continue to use claim filing indicator code MB for original Part B Medicare claims filed electronically

- Reference IHCP Bulletin BT201339 for additional instructions and information regarding the loops and payer IDs for replacement plans
Medicare Replacement Denied Services

• If a claim for a denied service is submitted via paper, the explanation of Medicare benefits (EOMB) from Medicare or the explanation of benefits (EOB) from the Medicare Replacement Plan must be included with the claim.

• “Medicare Replacement” must be handwritten at the top of the claim and on the corresponding EOB.

• Please note that professional claims for Medicare-denied services are submitted to the regular professional claims address and not the crossover claims address.

• If a claim for a denied service is filed electronically, “Medicare Replacement” must be indicated in the Notes field of the claim and handwritten at the top of the corresponding EOB.
  – The EOMB or EOB must be submitted with the claim using the attachment process.
Crossover Claims Detail
Information – Web interChange
### Other Payer Information

1. **Payer ID**: 08102
2. **TPL / Medicare Paid Amount**: 37.13

<table>
<thead>
<tr>
<th>Payer ID</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>08102</td>
<td>37.13</td>
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### Other Payer Payment Adjustments

<table>
<thead>
<tr>
<th>Group Code</th>
<th>Reason Code</th>
<th>Amount</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR</td>
<td>2</td>
<td>22.13</td>
<td></td>
</tr>
</tbody>
</table>

- **Add Payer**
- **Save Payer**
- **Delete Payer**

- **Add Group Code**
- **Save Group Code**
Crossover Claims via Web interChange

Crossover detail information

To report detail information, perform the following:

• Click **Detail Benefits Info**
  1. Payer ID = **08102** or Medicare Replacement Payer ID
  2. TPL/Medicare Paid Amount = Enter the amount paid by Medicare or the Medicare Replacement Plan for the highlighted detail line only

• Click **Save Payer**
  1. Group Code = Enter **CO** or **PR**
  2. Reason Code = Enter 1 for deductible, 2 for coinsurance, and 122 for psychiatric reduction
     ➢ Do not report write-off or contractual adjustment/discount amounts
  3. Amount = Enter the amount of the deductible and/or coinsurance

• Click **Save Group Code**

• Click **Save and Close**

**Note:** Claims for rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs) that did not cross over electronically should be rebilled with code T1015 added to the claim
Web interChange
Attachment Process
Complete all of the required claim information.
Web - Claim submission – Attachments

- Create the attachment control number (ACN)
  - Unique number assigned by provider
  - Claim- and document-specific
  - Each ACN may only be used one time

- Select the appropriate Report Type Code
  - Report Type describes the document being sent

- Transmission Code defaults to “BM” – by mail
  - Electronic and emailed attachments are not accepted
Crossovers and Replacement – CMS-1500 Claim Form
CMS-1500 Claim Form

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
   FROM MM DD YY TO MM DD YY

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
   FROM MM DD YY TO MM DD YY

20. OUTSIDE LAB?
   YES  NO
   $ CHARGES

22. MEDICAID RESUBMISSION CODE
    ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

F. $ CHARGES
   G. DAYS
   H. EFS/OT
   I. ID.
   J. RENDERING PROVIDER ID. #

NPI

28. TOTAL CHARGE
29. AMOUNT PAID
30. BALANCE DUE
   $   $   $

33. BILLING PROVIDER INFO & PH:

Sum of Coinsurance, Deductible, and Psych Reduction

Payment received from Medicare

Do not enter Medicare payment in field 29
Crossovers

**CMS-1500 claim form**

- Field Locator 22 is used to report crossover information
- Left side – Medicaid Resubmission Code = Sum of the Medicare coinsurance, deductible, and psychiatric reduction
- Right side – Original Ref. No. = Actual amount paid by Medicare
  - When the amount paid is 0.00 due to deductible applied, 0.00 must be entered in this field
- Do not report crossover information in field locator 29; enter 0.00
- Crossover claims are mailed to:
  - HP Medical Crossover Claims
    P O Box 7267
    Indianapolis, IN 46207-7267
Automatic Crossover
Automatic Crossover
Why claims do not cross over automatically

- Failure to establish a one-to-one match of the National Provider Identifier (NPI) and the Legacy Provider Identifier (LPI)
- The Medicare intermediary is not Wisconsin Physician Services (WPS) or is not an intermediary that has a partnership agreement with HP
- Member has a secondary insurer other than Medicaid
- Ambulatory surgical center (ASC) claims billed to Medicare on a CMS-1500 claim form with the SG modifier
- Data errors on the crossover file
- Examples include incorrect Social Security number (SSN) or spelling of member name
- 837P file does not include Medicaid information in the correct loops or segments
Claims Partially Paid by Medicare

• When Medicare allows only some of the services on the claim:
  − Only the Medicare-allowed services apply to crossover logic
    ➢ Allowed services should be billed to Medicaid separately from the Medicare-denied services
    ➢ Providers should not send the Medicare Remittance Notice (MRN) or the Medicare Replacement Plan EOB to Medicaid when billing allowed services
• Only the Medicare-allowed services are exempt from the one-year filing limit
• Services denied by Medicare are subject to the one-year filing limit
  − These services should be billed separately to Medicaid with a copy of the MRN or EOB
  − These services are also subject to all prior authorization (PA) requirements
Most Common Denials
Common Denials
Edit 593 – Medicare denied detail

• Cause:
  − At least one detail submitted contains Medicare coordination of benefits (COB) data resulting in a review of all detail COB data

• Resolution:
  − Review the claim to ensure COB data for detail in question does not contain all zeros or is missing for electronic claims
  − Medicare paid and Medicare denied details cannot be billed on the same claim
    ➢ Medicare allowed details are billed on crossover claims
    ➢ Medicare denied details are not crossover claims; these details must be billed on a separate claim with the attached Medicare EOB
Common Denials
Edit 558 – Coinsurance and deductible amount is missing

• Cause:
  − Claim is received without any deductible or coinsurance listed

• Resolution:
  − Add the coinsurance information to:
    ➢ Paper – Field 22
      o Left side – Enter coinsurance, deductible, and psych reduction
      o Right side – Enter Medicare paid amount
    ➢ Electronic
      o In the *Detail Information* window, enter the payer ID for Medicare and
        Medicare paid and coinsurance, deductible, and/or the psychiatric reduction
        for each individual detail
Common Denials
Edit 5001 – This is a duplicate of another claim

• Cause:
  − The **procedure code** has already been paid by this provider, date of service, and member

• Resolution:
  − Research claim history on Web interChange, using the dates of service and member identification number on the *Claim Inquiry* window to determine when the claim was adjudicated into a paid status
Common Denials
Edit 2505 – This recipient is covered by private insurance, which must be billed prior to Medicaid

• Cause:
  − There is a private insurance or Medicare supplement active on the member file
• Resolution:
  − Review the member eligibility on the Web interChange or other Electronic Verification System (EVS) option to determine what secondary insurance is active for the member
  − After billing the secondary insurance, bill any amount due to Medicaid OR
  − Send a copy of the secondary insurance denial with your claim
Find Help
Helpful Tools

• IHCP website at indianamedicaid.com
• IHCP Provider Manual
• Customer Assistance
  − 1-800-577-1278
• Provider Relations consultant
  − Locate area consultant map on:
    ➢ indianamedicaid.com (provider home page > Contact Us > Provider Relations Field Consultants)
    or
    ➢ Web interChange > Help > Contact Us
• Written Correspondence
  − P.O. Box 7263
    Indianapolis, IN 46207-7263
Q&A