CMS-1500
Medicare Crossover Claim Billing

HP Provider Relations
October 2012
Agenda

– Session Objectives
– Crossover Claim – Defined
– Reimbursement Methodology
– Crossover Claims via Web interChange
– Crossover Claims via CMS-1500 Claim Form
– Automatic Crossover
– Common Denials
Objectives

Following this session, providers will:

– Know the definition of a crossover claim
– Understand how to report crossover information on 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
Define
Crossover Claim
Crossover Claim – Defined

- The term “crossover claim” is defined as:
  - Allowed line items billed to Traditional Medicare or a Medicare Replacement Plan Part A and/or Part B
  - When a member has Medicare or Medicare Replacement Plan as the primary insurance
  - Medicare issued a payment of any amount, or the entire payment was applied to the deductible
Crossover Claim – 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

– IHCP makes payment on crossover claims only when the total Medicaid rate for the entire claim exceeds the amount paid by Medicare for the entire claim.

– IHCP reimbursement includes the lesser of the:
  • Medicare coinsurance and deductible
  OR
  Difference between the IHCP rate and the Medicare paid amount for the entire claim.
Learn
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
## Coordination of Benefits

### Other Payer Information
- **Payer ID**
- **Payer Name**
- **TPL / Medicare Paid Amount**
- **ICN**
- **Referral Number**
- **PA Number**

### Other Payer Payment Adjustments
- **Group Code**
- **Reason Code**
- **Amount**
- **Quantity**
- **Reason Code**
- **Amount**
- **Quantity**

### Additional Other Payer Payment Adjustments

### Other Payer Subscriber Information
- **Name**
- **Primary ID**
- **Relationship Code**
- **Address**
- **City**
- **State**
- **Zip Code**
- **Country**
- **SSN**
- **Group/Policy Number**
- **Policy Name**
- **Policy Number**
- **Claim Filing Code**
### Other Payer Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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<tbody>
<tr>
<td>* Payer ID</td>
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<tr>
<td>* Payer Name</td>
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### Other Payer Referring Provider Information
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
2. Payer Name = Wisconsin Physician Services (*no spaces*) or WPS or the name of the Medicare 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

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

Scroll to the top of the screen and click **Save and Close**
Understand
Crossover Claims Detail Information – Web interChange
# Coordination of Benefits Detail

**Detail # 1**

**Other Payer Information**

- **Payer ID**: 1
- **TPL / Medicare Paid Amount**: 
- **Adjudication/Payment Date**: 

<table>
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**Buttons**
- Add Payer
- Save Payer
- Delete Payer
Crossover Claims via Web interChange

Crossover detail information

To report detail information, perform the following:

1. Click **Detail Benefits Info**
   1. Payer ID = 08102
   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**

3. Group Code = Enter CO or PR

4. Reason Code = Enter 1 for deductible, 2 for coinsurance, and 122 for psychiatric reduction
   - Do not report write-off or contractual adjustment/discount amounts

5. 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
Crossovers – CMS-1500 Claim Form
**CMS-1500 Claim Form**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tbody>
<tr>
<td>16. DATES PATIENT UNABLE TO WORK</td>
<td>Enter dates from which patient was unable to work in current occupation.</td>
</tr>
<tr>
<td>18. HOSPITALIZATION DATES RELATED TO</td>
<td>Enter dates related to current hospitalization.</td>
</tr>
<tr>
<td>CURRENT SERVICES</td>
<td></td>
</tr>
<tr>
<td>20. OUTSIDE LAB?</td>
<td>Enter 'YES' if outside laboratory services were provided.</td>
</tr>
<tr>
<td>22. MEDICAID RESUBMISSION CODE</td>
<td>Enter original reference number.</td>
</tr>
<tr>
<td>17. TOTAL CHARGE</td>
<td>Enter total charge.</td>
</tr>
<tr>
<td>29. AMOUNT PAID</td>
<td>Enter amount paid.</td>
</tr>
<tr>
<td>30. BALANCE DUE</td>
<td>Enter balance due.</td>
</tr>
</tbody>
</table>

- **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
– Do not report crossover information in field locator 29, enter .00
– Crossover claims are mailed to:
  • HP Medical Crossover Claims
    P O Box 7267
    Indianapolis, IN 46207-7267
Describe Automatic Crossover
Automatic Crossover
Why claims do not cross over automatically

– Following are some of the reasons why claims fail to cross over from Medicare 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
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 PA requirements
Denial

Most common denials
Common Denials

Edit 593 – Medicare Denied Detail

– Cause:
  • At least one detail submitted contains Medicare 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 – Co-insurance and Deductible amount is missing

- **Cause:**
  - Claim is received without any deductible or co-insurance listed

- **Resolution:**
  - Add the co-insurance information to
    - Paper – field 22
      - Left side enter co-insurance, deductible and psych reduction
      - Right side enter Medicare paid amount
    - Electronic
      - In the DETAIL INFORMATION window enter the payor ID for Medicare and Medicare paid and co-insurance, 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 using the dates of service and member identification number using Web interChange on the Claim Inquiry screen to determine when the claim has been 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 EVS system 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
Helpful Tools
Avenues of resolution

- IHCP website at [indianamedicaid.com](http://indianamedicaid.com)
- IHCP Provider Manual (web, CD, or paper)
- Customer Assistance
  - 1-800-577-1278, or (317) 655-3240 in the Indianapolis local area
- Written Correspondence
  - P.O. Box 7263
    Indianapolis, IN 46207-7263
- Locate area consultant map on:
  - indianamedicaid.com (provider home page> Contact Us> Provider Relations Field Consultants)
  - Web interChange > Help > Contact Us
Q&A