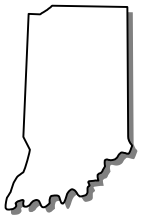
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: All Providers

Subject: Changes for Medicare Part A, B, and C Crossover Claims

Overview

This bulletin is designed to highlight the requirements for claim submission as detailed in the Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200245*, dated August 13, 2002. It provides a list of the most frequently asked questions about the new crossover policy. It also provides several Centers for Medicare and Medicaid Services (CMS)-1500 claim examples demonstrating the proper billing and reimbursement for both CMS-1500, formerly the HCFA-1500, and UB-92 crossover claims.

Claim Submission Requirements

Only Medicare Part A, Part B, and Part C claims that have an allowable amount noted on the Medicare remittance notice (MRN) are considered crossover claims. Crossover claims can be submitted in the following ways:

- Direct electronic submission from a Medicare intermediary, such as AdminaStar.
- Direct electronic submission from a provider or vendor using Provider Electronic Solutions crossover short form. This submission method can be used for CMS-1500, and outpatient UB-92 claims only.
- Paper submission using the *EDS Crossover Short Form*. This submission can be used for CMS-1500, and outpatient UB-92 claims only.
- Paper submission using a standard CMS-1500 or UB-92 claim form.

When submitting CMS-1500 crossover claims, box 22 must contain the information listed in Table 1.

Table 1 – CMS-1500 Claim Form, Box 22

Box 22	Description
Left side	Combined total of the Medicare coinsurance, patient deductible, and psych reduction.
Right side	Total Medicare paid amount or "cash in hand from Medicare." A $0 must be entered if the entire amount is applied to the patient deductible.

Box 22 should **not** be used in the following situations:

- When Medicare is not the member's primary insurance, for example a member has a commercial insurance carrier as the primary insurance, not Medicare.
- To report the provider's Medicare contractual or write-off amount.
- To report Medicare's allowed amount.
- When Medicare has denied the entire claim, box 22 should be blank.
- If one or more of the details on the claim are denied, the services being submitted must be separate from the paid details.

The following steps should be taken when completing boxes 28, 29, and 30 on the CMS-1500 form.

Table 2 – CMS-1500 Claim Form, Boxes 28, 29, and 30

Box	Description
28	The total of all claim details.
29	The total amount received by a commercial payer or Medicare supplemental insurance. • **Do not enter the Medicare contractual or write-off amount.** • **Do not enter the Medicare paid amount.**
30	The difference in the amount entered in box 28 minus the amount entered in box 29, if any. Box 28 minus box 29 must equal the amount entered in box 30.

The following information must be reported on the UB-92 crossover claim form in boxes 39 through 41, 50A, and 54A.

The following information must be contained in boxes 39 through 41:
- Value Code A1 – Medicare deductible
- Value Code A2 – Medicare coinsurance
- Value Code 06 – Medicare blood deductible

Box 50A must indicate Medicare as the payer.

Box 54A must indicate the Medicare paid amount, which is the *cash in hand* amount from Medicare.

Do not include the Medicare contractual or write-off amount on the claim.

CMS-1500 Crossover Claim Examples

Tables 3, 4, and 5 are provided as examples to demonstrate the reimbursement methodology used with CMS-1500 crossover claims.

Note: These examples may not reflect the actual Medicare allowable amount for each Healthcare Common Procedure Coding System (HCPCS) code.

Table 3 – Example 1 of Reimbursement Methodology

HCPCS Code	Billed Amount	Medicare Allowable	Medicare Deductible	Medicare Coinsurance	Medicare Psych Reduction	Medicare Paid
99213	$40.00	$32.24	$32.24	$0.00	$0.00	$0.00

- The left side of box 22 equals $32.24.
- The right side of box 22 equals $0.
- The provider should attach the MRN.
- The IHCP allowable amount for 99213 equals $25.98.
- The IHCP amount paid to provider equals $25.98.

Table 4 – Example 2 of Reimbursement Methodology

HCPCS Code	Billed Amount	Medicare Allowable	Medicare Deductible	Medicare Coinsurance	Medicare Psych Reduction	Medicare Paid
99212	$40.00	$34.02	$0.00	$6.80	$0.00	$27.22

- The left side of box 22 equals $6.80.
- The right side of box 22 equals $27.22.
- The provider **should not** attach the MRN.
- The IHCP allowable amount for 99212 equals $18.20.
- The IHCP amount paid to provider equals $0.

Table 5 – Example 3 of Reimbursement Methodology

HCPCS Code	Billed Amount	Medicare Allowable	Medicare Deductible	Medicare Coinsurance	Medicare Psych Reduction	Medicare Paid
99214	$65.00	$40.55	$0.00	$8.11	$0.00	$32.44

- The left side of box 22 equals $8.11.
- The right side of box 22 equals $32.44.
- The provider **should not** attach the MRN.
- The IHCP allowable amount for 99214 equals $40.43.
- The IHCP amount paid to provider equals $7.99.

Most Frequently Asked Questions

The following is a list of frequently asked questions about crossover billing:

1. Can I bill the member for the remaining Medicare coinsurance and deductible amount after the IHCP has made payment?

   No, once Medicaid has processed the claim and applied the reimbursement calculation as outlined in the IHCP provider bulletin, *BT200245*, the member cannot be billed for the remaining balance.

2. If I know that Medicare pays more on a claim than the IHCP allows, am I required to bill the IHCP before the balance can be a write-off?

No, providers are not required to bill the IHCP when Medicare, or a commercial insurance, pays more than the IHCP allows. Providers are prohibited from balance billing a member when Medicare, the IHCP, or a commercial insurance has made payment on a claim. Providers are not considered in violation of Medicare regulations with regard to crossover claims when the remaining balance is written off. Refer to the *IHCP Provider Manual*, *Chapter 4*, for a sample of the *IHCP Provider Agreement*, as well as how and when a member can be billed.

3. When do I need to send the MRN?

   Providers must submit a copy of the MRN when Medicare denies the service or Medicare applies the total allowable amount to the member's deductible.

4. Am I required to use these new boxes and to reflect the Medicare coinsurance and deductible amounts for dates of service before July 1, 2002?

   Yes, all Medicare Part A, Part B, and Part C crossover claims must be submitted in accordance with the direction outlined in the IHCP provider bulletin, *BT200245*.

5. With respect to CMS-1500 crossover claims, does the IHCP compare Medicare's paid amount to the IHCP allowed amount on a detail-to-detail basis or is it claim total-to-claim total?

   Medicare provides the line item detail, such as the HCPCS code, date of service, and units of service. Medicare's allowed amount, paid amount, coinsurance, deductible, psych reduction, and blood deductible is not provided at the detail level, but rather at the claim level. The Indiana Family and Social Services Administration (IFSSA) *Emergency Rule LSA #02-121*, requires that claims be compared at the claim total level. Therefore, the following information should be considered when reviewing claim payments.

   - Submit Medicare denied services separately from the paid services.
   - Compare the total payment on the claim from Medicare to the total allowed amount for all details by the IHCP.

Additional Information

Direct additional questions about this bulletin to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.