Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200143 NOVEMBER 7, 2001

To: All Providers Billing Medicare Crossover Claims

Subject: Medical and Institutional Crossover Claim Forms Update

Overview

This bulletin includes the following information about the new crossover claim forms and copies of the forms and instructions:

- Identification of the benefits when using the new voluntary crossover claim forms
- Elimination of the Explanation of Medicare Benefits (EOMB) attachment effective September 1, 2001, when submitting crossover claims on the new forms
- Implementation of electronic submission of crossover claims using EDS Provider Electronic Solutions on November 26, 2001. (Watch for a bulletin announcing this feature.)
- Clarification of how to properly submit crossover claims using crossover claim forms
- Identification of actions providers can take to increase the number of claims automatically crossing over from Medicare to Indiana Health Coverage Programs (IHCP)
- Listing of common billing errors and helpful hints for proper crossover claim completion

Benefits of New Crossover Claim Forms

Bulletin *BT200101*, dated January 12, 2001, introduced the new crossover claim forms for submission of crossover claims and indicated that these forms will be mandatory. However, as stated in banner page *BR200129*, these forms are voluntary. There are benefits to using the new crossover claim forms. Benefits include the following:

- Instant recognition of crossover claims by the EDS mailroom

- Elimination of the need to submit an EOMB as an attachment
- Decreased processing time for paper claims; therefore, an increased volume of adjudicated claims

Elimination of the EOMB Attachment

Effective September 1, 2001, EOMBs are no longer required as attachments to the new crossover claim forms. However, *Form 8A* for spenddown and EOB attachments for other insurance continue to be required when necessary.

> *Note: EOMBs will continue to be required when submitting crossover claims on a HCFA-1500 or UB-92 claim form.*

Vendor Submission of Crossover Claim Forms

EDS is working with vendors to help modify their billing systems so data from providers can be electronically formatted for the crossover forms. These forms can be completed, printed, and mailed to EDS for processing. The following is a list of vendors that have completed the upgrades:

- Computer Programs and Systems, Inc. (CPSI)
- National Healthcare Technology, Inc. (NHTI)
- National Data Corporation (NDC) Health
- Ranac Corporation
- VersaCom, Inc. (MedMate Systems)

Submitting Crossover Claims

Submission of Crossover Claim Forms

Medical and institutional crossover claim forms can be used to submit claims for Medicaid covered services that were paid by Medicare, but did not automatically cross over to the IHCP.

Claims should be submitted to one of the following addresses, depending on the crossover claim type:

EDS Medical Crossover Claims
P.O. Box 7267
Indianapolis, IN 46207-7267

or

EDS Institutional Crossover Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

Submission of HCFA-1500 or UB-92 Claim Form

Providers can continue to submit crossover claims using a HCFA-1500 or UB-92 claim form. However, when using these forms to submit crossover claims, EOMBs must be attached to the HCFA-1500 or UB-92. The attached EOMBs must match the claim forms for which they are being submitted for claims to be processed. The HCFA-1500 and UB-92 claim forms do not independently contain all of the information required to process crossover claims.

> *Note: EOMBs, applicable third party EOBs, and Form 8A for spenddown will continue to be required when submitting crossover claims on a HCFA-1500 or UB-92 claim form.*

Submitting Medicare Denied Services

If Medicare does not pay details, they are not considered crossover claims and they must be billed separately using a **HCFA-1500 or UB-92 claim form**. These claims must not be submitted on the crossover forms.

Copies of the EOMB and any applicable third party EOBs or 8As must be attached when submitting these types of claims. Claims should be submitted to one of the following addresses, depending on the claim type:

EDS HCFA-1500 Claims
P.O. Box 7269
Indianapolis, IN 46207-7269

or

EDS UB-92 Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

> *Note: Paid and denied charges cannot be submitted on the same claim form. The paid portion of the Medicare charges must be submitted as a crossover claim. Denied Medicare charges must be submitted as a separate claim using the HCFA-1500 or UB-92 claim form.* ***Line items submitted on incorrect claim forms will be denied.***

Increasing Automatic Crossovers

One of the most frequent reasons that claims do not cross over from Medicare is that the current Medicare number for the provider is not in the Medicaid provider file. To increase the number of claims that automatically crossover from Medicare, EDS must have the current Medicare provider number on file for providers. **Attached to this bulletin is the *Medicare/Indiana Health Coverage Programs Provider Number Cross Reference Data Sheet.*** Updates to both rendering and billing Medicare numbers should be included on the form. **This form should be completed and mailed to the EDS Provider Enrollment Unit even if the provider believes EDS has the correct Medicare number.** Providers submitting a high volume of paper crossover claims should complete the form. Mail completed forms to the following address:

EDS Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

Additional information about updating provider files is available in the IHCP provider bulletin, *BT200115*, dated April 15, 2001, or on the IHCP Web site at www.indianamedicaid.com.

Additionally, claims will not automatically cross over from Medicare to IHCP if the member's name is listed differently in each system. Providers should encourage members to work with county caseworkers to ensure that member names are listed the same for the IHCP and Medicare.

IHCP Trading Partnership Agreements

EDS currently receives electronic Medicare crossover data from the following trading partners:

- AdminaStar – Part A, B, C, and Durable Medical Equipment Regional Carrier (DMERC)
- Blue Cross Blue Shield of Florida – First Coast Service – Part B
- Blue Cross Blue Shield of South Carolina – Palmetto Government Benefit Administrator – Part B
- Blue Cross Blue Shield of Alabama/Mississippi – Cahaba Government Benefit Administrator – Part B
- Minnesota – Wisconsin Physician Service – Part B
- Omaha – Part A and C
- Railroad Benefits for South Carolina – Palmetto Government Benefits Administrator – Part B
- Riverbend of Tennessee – Part A and C

- Wisconsin – United Government Service – Part A and C

Providers using these Medicare trading partners should allow six weeks for EDS to receive and adjudicate claims from these partners. If the claim does not automatically crossover within six weeks, complete the appropriate claim form and submit crossover claims directly to EDS.

If a Medicare trading partner is not listed above, please contact your EDS provider field consultant and provide the trading partner's company name and a contact person. EDS will pursue Medicare trading partner agreements with these companies. New partnership agreements will be announced in RA banner page articles.

Helpful Hints

When billing crossover claims using one of the new crossover claim forms, consider the following:

- Refer to the step-by-step billing instructions included on each crossover claim form or on the IHCP Web site.
- Complete all applicable information on the claim form.
- When billing multiple units of the same procedure code for multiple date spans please combine all units with one procedure code and bill on one line item.
- Ensure that the box in the upper right hand corner of the institutional claim form is checked and corresponds with the type of bill indicated in field 2 when billing inpatient, long-term care, outpatient, and home health crossover claims.

Common Billing Errors

Review of claims received using the new crossover claim forms indicates that common billing errors occur in the following areas:

- Spenddown amount in the wrong field
- Crossover data missing
- Psych amount missing
- Medicare member information and IHCP information discrepancies

The following subsections provide information about avoiding these common billing errors when submitting medical and institutional crossover claims.

Spenddown Amount in the Wrong Field

Medical crossover claims – Field 5b must include the sum of the spenddown, total Medicare, and TPL payments.

Institutional crossover claims – Spenddown amounts must be indicated in field 14b, if applicable.

Crossover Data Missing

Medical crossover claims – Fields 12 through 15 and 16, if applicable, should be consistent with the detail lines on the Medicare EOMB. The sum of fields 18 through 21 and 22, must equal the total amount of all details for reimbursement. These fields determine the dollar amount of coinsurance, deductible, and psych amounts for provider reimbursement.

Institutional crossover claims – Fields 7 through 12 should be completed for outpatient and home health crossover claims. Fields 20a, 20b, and 20c establish the dollar amounts of coinsurance, deductible, and blood deductible, if applicable, for provider reimbursement.

Psych Amount Missing

Medical crossover claims – The psych amount for each detail should be listed in field 16. The total psych amount should be listed in field 22.

Medicare Member Information and IHCP Information Discrepancies

At times, Medicare may indicate a member's name differently from the IHCP. Member information must be verified using Provider Electronic Solutions, OMNI, or automated voice-response system (AVR). These systems indicate the correct member identification number, spelling, and format of a member's name. Claims should be submitted to the IHCP with the member information exactly as given by Provider Electronic Solutions, OMNI, or AVR.

Obtaining Crossover Claim Forms

Copies of the crossover claim forms are included with this bulletin. Additional forms can be obtained in one of the following ways:

- Visit the IHCP Web site at www.indianamedicaid.com.
- Call the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278, option 3.
- Photocopy the claim forms included in this bulletin.

Additional Information

Questions about this bulletin can be directed to the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

MEDICAL/PHYSICIAN MEDICARE/MEDICAID CROSSOVER

1a Billing Provider Number	1b Location Code	2a Patient's Last Name	2b Patient's First Name

3 RID Number	4 Diagnosis Codes			

5a Total Charge	5b Total Prior Payments	5c Net Charge

Dates of Service							Medicare Information					
6a	6b	7	8	9	10	11	12	13	14	15	16	17
From	Through	POS	Procedure Code	Modifiers	Detail Charge	Units	Allowed Amount	Deductible Amount	Co-Ins. Amt.	Amt. Paid to Provider	Psych L/PR122 Amount	Rendering Physician's Number
MEDICARE EOMB TOTALS:							Allowed Amount 18	Deductible Amount 19	Co-Ins. Amount 20	Amt. Paid to Provider. 21	L/Pr122 Amount 22	

23 Patient's Account Number

24 Signature	25 Bill Date

Third Party Payment Attachment:

26 TPL Amount

Provider Name and Mailing Address Required in block below:

Additional Comments:

Submit Completed Claim to:

EDS – Indiana Health Coverage Programs

P.O. Box 7267

Indianapolis, IN 46207-7267

MEDICAL/PHYSICIAN MEDICARE/MEDICAID CROSSOVER

Instructions for Claim Form Completion

FIELD New Form	NUMBER HCFA1500	DESCRIPTION
1a	**33**	***Billing*** Provider Number (9 digit numeric field). ***REQUIRED***
1b	**33**	Location code (1 alpha character field to denote location of service). ***REQUIRED***
2a	2	Patient's Last Name. ***REQUIRED***
2b	2	Patient's First Name. ***REQUIRED***
3	1a	RID Number (12-digit numeric number). Recipient Medicaid ID number. ***REQUIRED***
4	21	Diagnosis Code. ***REQUIRED*** (Can include 1 – 4 codes)
5a	28	Total Charge (Total of all Detail lines). ***REQUIRED***
5b	29	All Prior Payments (Total Medicare and TPL Prior Payments). ***REQUIRED IF APPLICABLE***
5c	30	Net Charge (Balance Remaining). ***REQUIRED*** (Helpful Hint: 5a-5b=5c)
		Detail:
6a	24a	From Date of Service. MM/DD/YY format. ***REQUIRED***
6b	24a	To Date of Service. MM/DD/YY format. ***REQUIRED***
7	24b	Place of Service (2-digit field). ***REQUIRED***
8	24d	Procedure Code (5-digit HCPC procedure code). ***REQUIRED***
9	24d	Modifiers (2 two-digit fields). ***REQUIRED IF APPLICABLE***
10	24f	Detail Charge (amount billed for the procedure code). ***REQUIRED***
11	24g	Units (# of visits, trips, units). ***REQUIRED***
		Medicare EOMB: (please attach)
12		Medicare Allowed Amount (amount allowed by Medicare for each detail line). Helpful Hint: Must have an amount to be a crossover claim. ***REQUIRED***
13		Medicare Deductible Amount (deductible amount for each detail line). ***REQUIRED IF APPLICABLE***
14		Medicare Co-Insurance Amount (co-insurance amount for each detail line). ***REQUIRED IF APPLICABLE***
15		Medicare Provider Paid Amount (amount paid to provider for each detail line). ***REQUIRED***
16		Medicare L/PR122 Amount (Psych amount for each detail line). ***REQUIRED IF APPLICABLE***
17	**24k**	***Rendering*** Physician's Number. Provider number of the physician rendering the service. ***REQUIRED***
		Medicare EOMB:
18		Medicare EOMB Total Allowed Amount (total amount allowed from Medicare EOMB). Must equal the sum of the detail lines. Must have an amount to be a crossover claim. ***REQUIRED***
19		Medicare EOMB Total Deductible Amount (total deductible amount from Medicare EOMB). Must equal the sum of the detail lines. ***REQUIRED IF APPLICABLE***
20		Medicare EOMB Total Co-Insurance Amount (total co-insurance amount from Medicare EOMB). Must equal the sum of the detail lines. ***REQUIRED IF APPLICABLE***
21		Medicare EOMB Total Provider Paid Amount (total provider payment amount from Medicare EOMB). Must equal the sum of the detail lines. ***REQUIRED***
22		Medicare EOMB Total L/PR122 Amount (total psych amount from Medicare EOMB). Must equal the sum of the detail lines. ***REQUIRED IF APPLICABLE***
23	26	Patient's Account Number. ***REQUIRED***
24	31	Signature. Signature of provider or authorized person. ***REQUIRED***
25	31	Bill Date. Date claim is billed to Medicaid. MM/DD/YY format. ***REQUIRED***
		Third Party Attachment: (Please attach if applicable)
26	EOMB	TPL Amount (Third Party Liability Payment). ***REQUIRED IF APPLICABLE***

Additional Information:

Include Provider Name and Mailing Address in address block.

Submit completed claim to correct address and post office box.

INSTITUTIONAL MEDICARE/MEDICAID CROSSOVER

"x" appropriate box corresponding to the type of bill listed in field 2:

INPATIENT/LONG TERM CARE ☐

OUTPATIENT/HOME HEALTH ☐

1 PATIENT CONTROL NO.	2 TYPE OF BILL

STATEMENT COVERS PERIOD	
3a FROM	3b THROUGH

Detail: (Inpatient / LTC Crossovers Only)

4 REV 001 TOTAL CHARGE	5 BASE REV CODE	6 UNITS
$		

Details: (Outpatient/Home Health Crossovers Only)

Detail Number	7 REV CODE	8 HCPCS	9 MODIFIERS			10 SERVICE DATE	11 SERVICE UNITS	12 TOTAL CHARGES	Detail Number
1								$	1
2								$	2
3								$	3
4								$	4
5								$	5
6								$	6
7								$	7
8								$	8
9								$	9
10								$	10
11								$	11
12								$	12

Payer	Other Insurance		Prior Payments	
A	13a	MEDICARE	13b	$
B – TPL	14a		14b	$

	15a Medicaid Billing Provider Number	15b Loc. Code	15c Prior Payment	15d Estimate Amount Due
C - Medicaid			$	$

16a Patient's Last Name	16b First Name	16c RID Number

17 Principal Diagnosis Code (5-digit field)

18 Signature	19 Bill Date

Medicare EOMB Data:

20a Deductible Amount	20b Co-Insurance Amount	20c Blood Deductible Amount
$	$	$

Submit completed claim to:

EDS – Indiana Health Coverage Programs
P.O. Box 7271
Indianapolis, Indiana 46207-7271

Additional Comments:

Provider Name and Mailing Address Required in block below:

INSTITUTIONAL MEDICARE/MEDICAID CROSSOVER

Instructions for Claim Form Completion

FIELD New Form	NUMBER UB-92 Form	DESCRIPTION
1	3	Patient Control Number. ***REQUIRED***
2	4	Type of Bill (three-digit numeric field and must correspond with the box marked in the upper right corner). ***REQUIRED***
3a	6	From Date of Service. MM/DD/YY format. ***REQUIRED***
3b	6	Through Date of Service. MM/DD/YY format. ***REQUIRED***
4	42 & 47	REV 001 Total Charge. Total charge of claim (sum of all detail lines). ***REQUIRED***
		Detail: **(Inpatient/Long Term Care Crossovers Only)**
5	42	Base Revenue Code (Service provided). Indicate base Revenue Code service. ***REQUIRED***
6	47	Units. Number of units billed. ***REQUIRED***
		Details: **(Outpatient/Home Health Crossovers Only)**
7	42	REV Code. Indicate service provided. ***REQUIRED***
8	44	HCPCS. Indicate the common procedure code for the treatment or service provided. ***REQUIRED***
9		Modifiers (three two-digit fields). ***REQUIRED IF APPLICABLE***
10	45	Service Date. Indicate the date service or treatment was provided. MM/DD/YY format. ***REQUIRED***
11	46	Service Units. Indicate the number of service units billed in relation to the service or treatment provided. ***REQUIRED***
12	47	Total Charges. Indicate the total charge for all service units per detail line. ***REQUIRED***
13a	50	Payer A – ***MEDICARE***
13b	54	Prior Payments. Indicate payment from Medicare. ***REQUIRED***
14a	50	Payer B – TPL. Indicate secondary insurance company ***REQUIRED IF APPLICABLE***
14b	54	Prior Payments. Indicate secondary insurance payment ***REQUIRED IF APPLICABLE***
15a	51	Medicaid Billing Provider Number (nine-digit numeric number). ***REQUIRED***
15b	51	Location Code (one-digit alpha character). ***REQUIRED***
15c	54	Prior Payment. Indicate spenddown amount ***REQUIRED IF APPLICABLE***
15d	55	Estimate Amount Due. (Balance Remaining). Helpful Hint: Field 4 – 13b – 14b – 15c = Field 15d ***REQUIRED***
16a	58	Patient's Last Name. ***REQUIRED***
16b	58	Patient's First Name. ***REQUIRED***
16c	60	RID Number (12-digit numeric number). Indicate recipient's Medicaid ID number. ***REQUIRED***
17	67	Principal Diagnosis Code (five-digit field). Primary reason recipient is receiving services or treatment. ***REQUIRED***
18	85	Signature. Signature of provider or authorized person. ***REQUIRED***
19	86	Bill Date. Indicate the date claim is billed to Medicaid. MM/DD/YY format. ***REQUIRED***
		MEDICARE EOMB INFORMATION:
20a	EOMB	Deductible Amount (from Medicare EOMB). ***REQUIRED IF APPLICABLE***
20b	EOMB	Co-Insurance Amount (from Medicare EOMB). ***REQUIRED IF APPLICABLE***
20c	EOMB	Blood Deductible Amount (from Medicare EOMB). ***REQUIRED IF APPLICABLE***
		Helpful Hint: Must have an amount in one of the above fields to be a crossover claim.

Additional Information:

Include Provider Name and Mailing Address in address block.

Submit completed claim to correct address and post office box.

Indicate the appropriate box at the top of the claim form based on bill type in field 2.

Medicare / Indiana Health Coverage Programs (IHCP) Provider Number Cross Reference Data Sheet

IHCP Billing Provider Information Section

Note: Provider Enrollment will not link a Medicare Billing Number to a Rendering IHCP Provider Number.

Note: A copy of the HCFA Medicare Number Assignment Letter or a Medicare EOMB for the billing Medicare number must be submitted with this form.

1. Provider Name _____ 2. Federal EIN _____

3. IHCP Provider Number _____ 4. Service Location ____

5. Medicare Billing Provider Number _____

6. Service Location Address _____
Street Address

_____
City, State, ZIP Code

Rendering (Group Member) Practitioner Information Section

7. Practitioner's Name	8. IHCP Rendering Provider Number	9. Medicare Provider Number	10. Medicare Effective Date	11. Medicare Expiration Date

12. Signature of Authorized Officer / Owner _____

13. Printed Name of Authorized Officer / Owner _____

14. Title of Authorized Officer / Owner _____

15. Signature Date _____ 16. Contact Phone Number _____

Send To:
EDS Provider Enrollment
P.O. Box 7263
Indanapolis, IN 46207-7263

Medicare/Indiana Health Coverage Programs (IHCP) Provider Number Cross Reference Data Sheet Instructions

IHCP Billing Provider Information Section

1. Provider Name – The provider name must be a business name unless a practitioner is a sole practitioner working under a unique Federal Employer Identification Number (EIN). If two or more practitioners are working under a shared EIN, then the providers must enroll a group provider number in the IHCP.
2. Federal EIN – The EIN submitted on this form must be the EIN under which taxes will be filed for the services billed. The EIN submitted on this form must be identical to the EIN listed on the IHCP provider file for the provider number and service location listed in items three and four on this form.
3. Medicaid Provider Number – Please enter your nine-digit numerical provider number for the IHCP.
4. Service Location – Enter the alpha-character associated with the service location address listed in item six on this form.
5. Medicare Billing Provider Number – Enter the Medicare billing provider number associated with the service location address listed in item six on this form.
6. Service Location Address – Enter the address for the service location where services are rendered. This address must match the service location listed on the IHCP provider file for the IHCP Provider Number and Service Location listed in items three and four.

Rendering (Group Member) Practitioner Information Section – Provider Groups Only

7. Practitioner's Name – Enter the name of all the IHCP enrolled individual practitioners rendering services at the service location listed in item six.
8. Enter the IHCP Provider Number associated with the individual practitioners listed in item seven.
9. Enter the Medicare provider number associated with the individual practitioners listed in item seven.
10. Enter the effective date for the Medicare provider number listed in item nine.
11. Enter the expiration date for the Medicare provider number listed in item nine.
12. The signature of an authorized officer or owner of the billing provider entity is required.
13. Print the name of the authorized officer or owner listed in item 12.
14. Print the title of the authorized officer or owner listed in item 12.
15. Print the date the form was signed by the authorized officer or owner listed in item 12.
16. Print the contact phone number for the authorized officer or owner listed in item 12.