



PROVIDER BULLETIN

BT 200245

AUGUST 13, 2002

To: All Providers

Subject: Crossover Claims Updates

Overview

The purpose of this bulletin is to inform providers of submission changes for Medicare Part A, Part B, and Part C crossover claims that must be submitted to EDS due to the implementation of Family and Social Services Administration (FSSA) Emergency Rule *LSA #02-121*. EDS originally provided notification of the submission changes for UB-92 crossover claims in banner page *BR200230* dated July 23, 2002.

Part A and C Crossover Claims

Effective August 15, 2002, crossover claims received on the UB-92 claim form must contain additional information on the claim form and must be submitted on the *Original Red UB-92 Claim Form* which can be purchased from any medical office supply store. The information in the required fields will be used to process claims once the system changes are in place on October 1, 2002.

- Fields 39 - 41 must contain value code A1 to reflect the Medicare deductible amount; value code A2 to reflect the Medicare coinsurance amount; and value code 06 to reflect the blood deductible amount.
- Field 50A must now show Medicare as the payer.
- Field 54A must contain the Medicare paid amount (actual dollars received from Medicare). Do not include the Medicare allowed amount or contract adjustment in the amount in field 54A.

Please note that UB-92 crossover claims submitted without the Medicare paid amount in field 54A and the value codes in fields 39 – 41 will be processed as standard UB-92 claims and will be denied for edit 2500 (Part A) or 2502 (Part C) – Claim submitted without Medicare payment information in fields 39 – 41 and 50 A and 54 A.

- TPL payments will continue to be reported in field 54B.

Figure 1.1 includes a visual diagram representing this information.

The following four conditions apply to the submission of attachments with Part A and Part C Crossover claims with the implementation of the submission changes for UB-92 crossover claims:

- If the Medicare payment amount in form locator 54A is greater than zero, do not send the Medicare Remittance Notice (MRN) with the claim. MRN was formerly known as the Explanation of Medicare Benefits (EOMB).
- If a member is eligible for TPL payment, and the TPL amount indicated in form locator 54B is greater than zero, do not submit the TPL Explanation of Benefits (EOB) with the claim.
- If the Medicare paid amount in form locator 54A is zero, the claim must be submitted with the MRN.
- If a member is eligible for TPL payment, and the TPL amount indicated in 54B is zero, the EOB must be submitted with the claim.

If zero dollars are indicated in this field, the MRN must be attached to the claim. Please note that Medicare denied services are not defined as crossovers and the submission procedures for Medicare denied services has not changed. The service must be filed on a separate claim form and the MRN must be attached.

Providers may continue to use the Crossover Short Form and Provider Electronic Solutions for UB-92 crossover claims with the exception of Inpatient crossover claims (claim types 110, 111, and 115). Inpatient crossover claims must be submitted on the UB-92 claim form with all of the necessary information to establish DRG pricing. This change renders the *Crossover Short Form* and EDS Provider Electronic Solutions obsolete for inpatient crossover claims. Therefore, inpatient crossover claims submitted on the Crossover Short Form will be returned to the provider. Inpatient crossover claims submitted through Provider Electronic Solutions will be denied with *EOB 0580 - Inpatient Crossover Claims must be billed on the UB-92 form or sent directly from Medicare*. These changes will also be effective for claims received on or after August 15, 2002.

The system changes necessary to process UB-92 claims based on the new logic will be implemented on October 1, 2002. All Medicare Part A inpatient hospital claims (both paper and electronic) with dates of service on or after July 1, 2002, but received on or before August 14, 2002, will not be mass adjusted since the system is unable to determine the DRG in order to reprice the claims. Paper and electronic UB-92 claims with dates of service on or after July 1, 2002, received on or after August 15, 2002, will be entered into IndianaAIM, but the claims will not be processed until the system changes are implemented on October 1, 2002. The decision to hold the claims and process them after the system changes are implemented was made in collaboration with provider associations, who strongly protested the burden placed on providers by the mass adjustment that would be needed if claims continued to be processed before the system changes could be implemented. UB-92 claims for dates of service on or after July 1, 2002, received on or after August 15, 2002, will be reimbursed as follows:

- If the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero. See Table 1 for an example of this.

Table 1 - Payment example

Category	Amount
Medicare Payment	100.00
Medicaid Allowable	95.00
Medicaid Reimbursement	0.00

- If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of (1) the difference between the Medicaid allowable minus the Medicare payment or (2) the Medicare coinsurance, deductible, and blood deductible, if any, for the claim. See Table 2 for two examples of this.

Table 2 - Payment and Reimbursement Examples

Category	Example One	Example Two
	Amount	Amount
Medicare Payment	\$100.00	\$100.00
Medicaid Allowable	\$110.00	\$120.00
Deductible	\$7.00	\$7.00
Copayment	\$5.00	\$5.00
Medicaid Reimbursement	\$10.00	\$12.00

Medicare Part B Claims

Effective September 1, 2002, the system changes necessary to process Medicare Part B crossover claims in accordance with FSSA Emergency Rule *LSA #02-121* will be implemented. All Medicare Part B claims (both paper and electronic) with dates of service on or after July 1, 2002, received on and after August 12, 2002, will be held for processing until September 1, 2002. The decision to hold the claims and process them after the system changes are implemented was made in collaboration with provider associations, who strongly protested the burden placed on providers by the mass adjustment that would be needed if claims continued to be processed before the system changes could be implemented. Any claims received prior to August 12, 2002, will be mass adjusted. Part B crossover claims for dates of service on or after July 1, 2002, will be reimbursed as follows:

- If the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero.
- If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of (1) the difference between the Medicaid allowable minus the Medicare payment or (2) the Medicare coinsurance, deductible, and psych reductions, if any for the claim.

Please refer to Tables 1 and 2 above for examples of payment.

Effective November 1, 2002, crossover claims received on the HCFA-1500 claim form must contain additional information on the claim form. The combined total of the Medicare coinsurance, deductible, and psych reduction must be reported on the left hand side of field 22 under the heading *Code*. The Medicare paid amount (actual dollars received from Medicare) must be submitted in field 22 on the right hand side under the heading *Original Ref No*. HCFA-1500 crossover claims received without the information in fields 22 will be processed as standard Medicaid claims, and will deny with an *EOB 2502 – Claim submitted without Medicare payment in Field 22 - Please resubmit*. Additionally, field 29 must only contain a total payment amount received from a TPL if applicable. Do not include the Medicare paid amount or contract adjustment in field 29.

Figure 1.2 contains a visual representation of this information.

The following four conditions apply to the submission of attachments Part B Crossover claims effective November 1, 2002, with the implementation of the submission changes for HCFA-1500 crossover claims:

- If the Medicare payment amount in form locator 22 under the heading *Original Ref No* is greater than zero, do not submit the MRN with the claim. MRN was formerly called the Explanation of Medicare Benefits (EOMB).
- If a member is eligible for TPL payment, and the TPL amount indicated in form locator 29 is greater than zero, do not submit the TPL Explanation of Benefits (EOB) with the claim.
- If the Medicare paid amount in form locator 22 is zero, the claim must be submitted with the MRN.
- If a member is eligible for TPL payment, and the TPL amount indicated in 29 is zero, the TPL EOB must be submitted with the claim.

Effective November 1, 2002, The MRN will no longer be required for HCFA-1500 crossover claims when the Medicare paid amount in field 22 under the heading *Original Ref No* is greater than zero dollars. If zero dollars are indicated in this field, the MRN must be attached to the claim. Please note that Medicare denied services are not defined as crossovers and the submission procedures for Medicare denied services has not changed. The service must be filed on a separate claim form and the MRN must be attached. Providers may continue to use the *Crossover Short Form* and Provider Electronic Solutions for HCFA-1500 crossover claims.

Medicare Denials

The Medicare denial process will not change. Medicare denied charges are not crossover claims. Medicare denied charges must still be submitted to the address listed below, and must include the MRN for the denied charges.

The address for HCFA-1500 claims is: **EDS
PO Box 7269
Indianapolis, IN 46207**

The address for UB-92 claims is: **EDS
P O Box 7271
Indianapolis, IN 46207**

If your claims never automatically cross over to the Medicaid for a Medicare billing provider number, please access the Web site at <http://www.indianamedicaid.com/> and download the *Billing Provider Update Form* from the Provider Enrollment link. After completing this form, submit the updated information to the post office box at the bottom of the form with an MRN for that number or a Medicare assignment letter. If you do not have access to the Web site, please contact EDS Provider Enrollment at 1-877-707-5750.

If your claims never automatically cross over to the Medi caid for a Medicare performing provider number, please access the Web site at <http://www.indianamedicaid.com/> and download the *Group Member Update Form* from the Provider Enrollment link. After completing this form, submit the updated information to the post office box at the bottom of the form with an MRN for that number or a Medicare assignment letter. If you do not have access to the Web site, please contact EDS Provider Enrollment at 1-877-707-5750.

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PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA OTHER
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE
MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)

8. PATIENT STATUS
Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
Employed Full-Time Student Part-Time Student

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP)
MM DD YY

15. DATE PATIENT BECAME ELIGIBLE FOR THIS COVERAGE
MM DD YY

16. HOSPITALIZATION PERIOD
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. OUTSIDE LAB? YES NO

19. RESERVED FOR LOCAL USE

20. MEDICAID RESUBMISSION CODE ORIGINAL REP. NO.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 14 AND 15)
1. _____ 2. _____ 3. _____ 4. _____

22. PRIOR AUTHORIZATION NUMBER

DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) OPT/N/C/S/MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS PERIOD OR UNITS	PERIOD	BUG	COB	RESERVED FOR LOCAL USE

23. FEDERAL TAX I.D. NUMBER SSN ID#

24. PATIENT'S ACCOUNT NO.

25. ACCEPT ASSIGNMENT? FOR GOV. CLAIMS, SEE BACK)
 YES NO

26. TOTAL CHARGE \$

27. AMOUNT PAID \$

28. BALANCE DUE \$

29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS. If only that the statements on the reverse apply to this bill and are not a part thereof)

30. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

31. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 0-88) PLEASE PRINT OR TYPE APPROVED CMB-033-005 FORM CMS-1500 (12-90), FORM FFB-190, APPROVED CMB-1215-005 FORM CMCP-1900, APPROVED CMB-0750-0001 (CHAMPUS)

Figure 1.2 - Health Insurance Claim Form