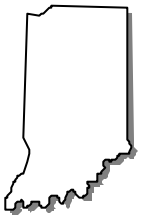
Indiana Health Coverage Programs



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

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To: All Providers

Subject: 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 locater 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 Indiana*AIM*, 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 locater 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 Medicaid 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.**

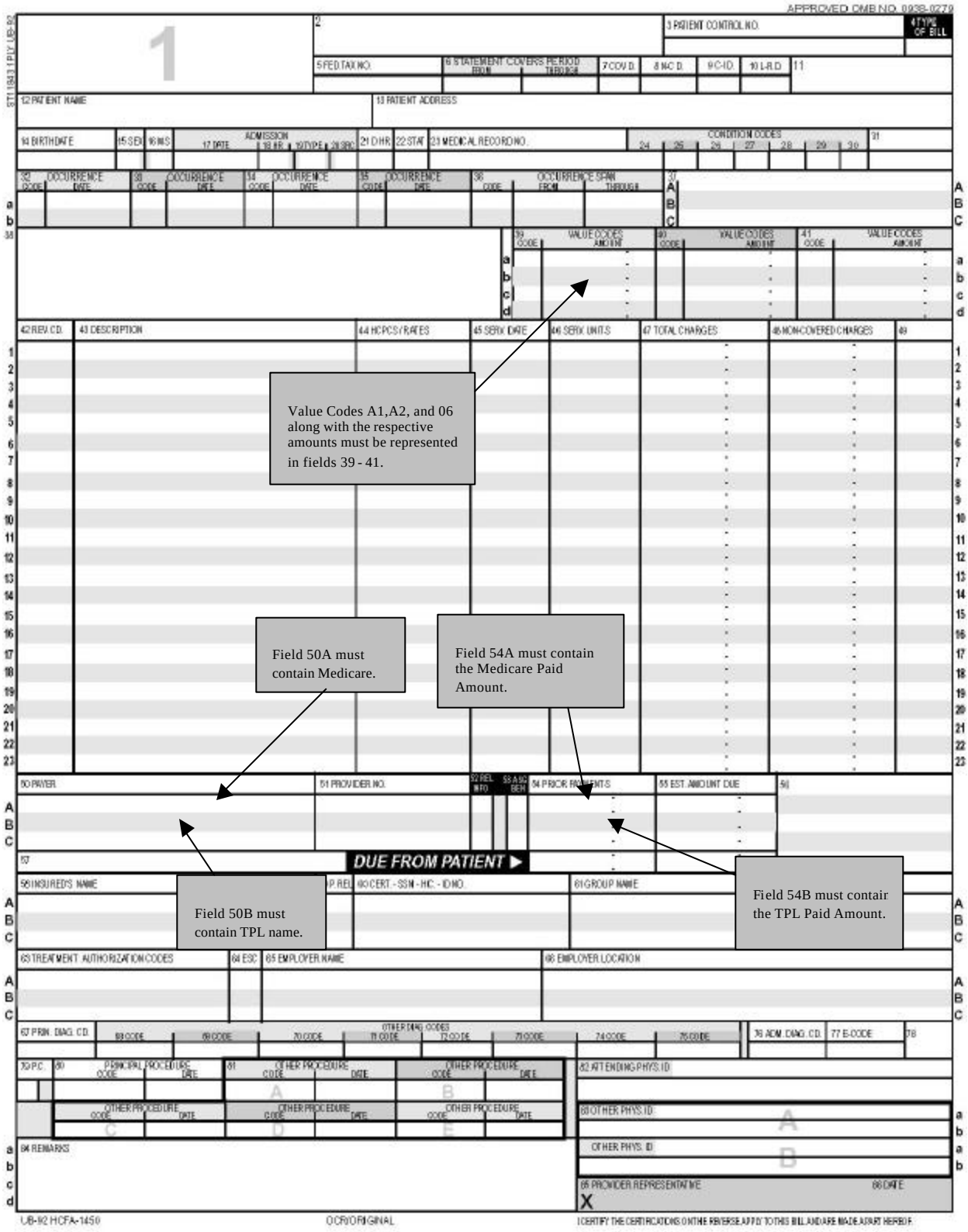

Figure 1.1 - Crossover Claim Form

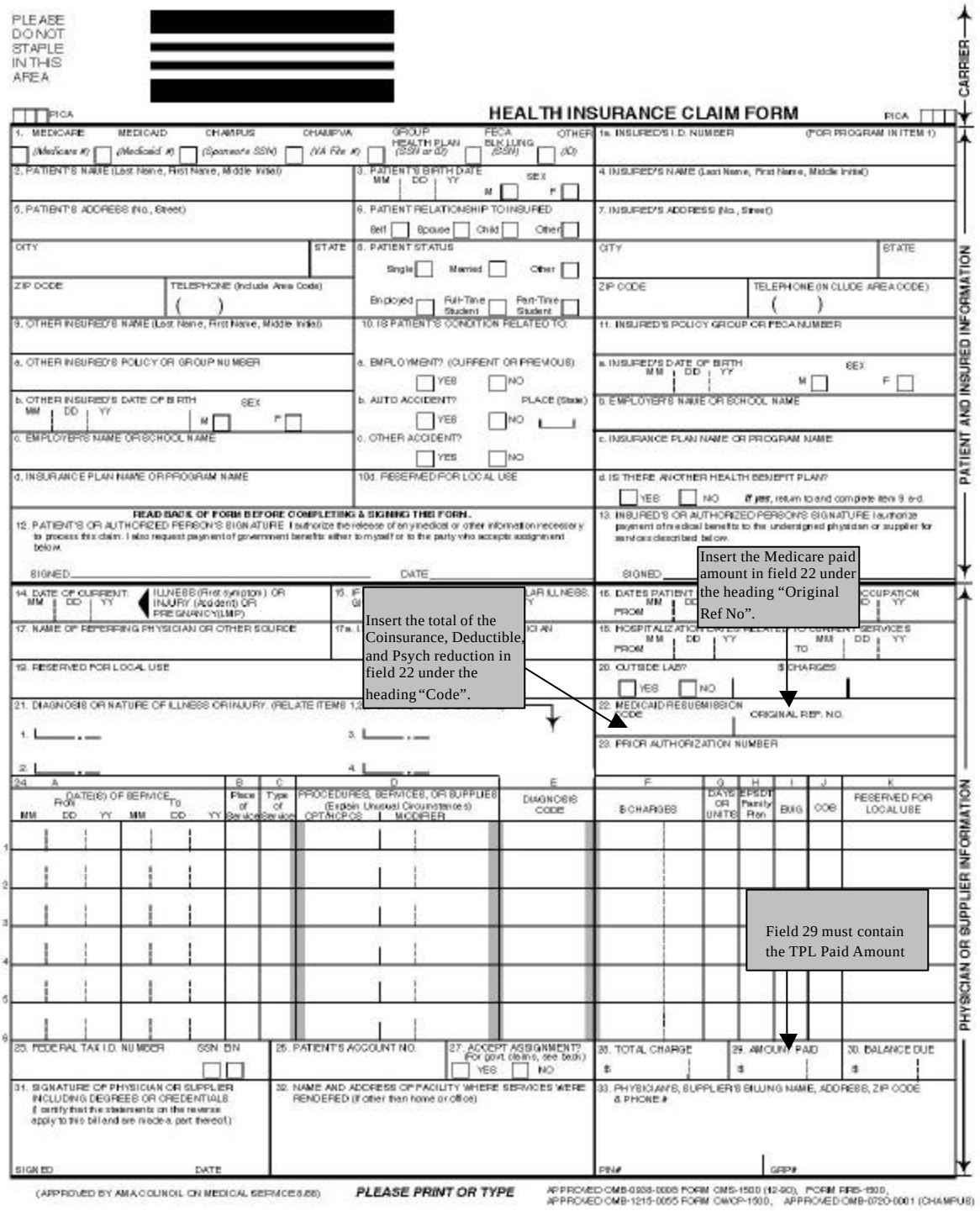

Figure 1.2 - Health Insurance Claim Form