IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201339 JULY 30, 2013

Medicare Replacement Plan claim filing indicator code corrected

Indiana Health Coverage Programs (IHCP) Bulletin BT201225 notified providers of changes related to the submission of Medicare Replacement Plan claims. Specifically, effective for claims with dates of service (DOS) on or after August 9, 2012, the IHCP began treating Medicare Replacement Plan claims in the same manner as original Medicare claims. However, Indiana*AIM* did not accept the claim filing indicator code for Health Maintenance Organization (HMO) Medicare Risk on claims submitted electronically, and providers were subsequently notified to hold these claims. The issue has now been resolved.

Effective for claims submitted on or after September 1, 2013, providers must include claim filing indicator code 16 – *Health Maintenance Organization (HMO) Medicare Risk* when submitting Medicare Replacement Plan claims electronically via 837 or via Web interChange. Providers should continue to use claim filing indicator codes MA and MB for original Part A and Part B Medicare claims filed electronically.

The following sections provide information regarding the appropriate use of claim filing indicator code 16, as well as reminders about completing certain data fields and general requirements for submitting Medicare/Medicare Replacement Plan claims. The data fields and requirements have not changed.

Filing claims for services paid by Medicare/Medicare Replacement Plan

I. Claim submission type – Professional – Paper

Professional crossover claims submitted on paper *CMS-1500* claim forms, including Medicare Replacement Plan claims, must contain information regarding the Medicare/Medicare Replacement Plan payment amount, coinsurance and/or deductibles. Failure to include this information results in claims being denied or processed incorrectly.

Providers must include the amount allocated by Medicare/Medicare Replacement Plans to the coinsurance and/or deductibles. This information is added and entered in the left side of Field 22 Medicaid Resubmission (Code). The amount paid by Medicare/Medicare Replacement Plan must be entered in the right side of Field 22 (Original Ref No.). The Medicare/Medicare Replacement Plan "payment amount" is the actual dollar amount paid to the provider for the services rendered. This amount does not include contractual adjustments and is not the "allowed" amount. Neither of these figures should be included on the claim form. It is not necessary to include a copy of the Medicare Remittance Notice (MRN) or explanation of benefits (EOB) from the Medicare/Medicare Replacement Plan as an attachment to the claim.

II. Claim submission type – Professional – Web interChange

Professional crossover claims submitted via Web interChange, including Medicare Replacement Plan claims, must contain information regarding the payment amount, coinsurance and/or deductibles. Failure to include this information in the correct fields results in claims being denied or processed incorrectly. To submit Medicare/Medicare Replacement Plan claims for professional services via Web interChange:

- Select **Medical Crossover** on the Claim Processing Menu.
- In the *Coordination of Benefits* section at the claim header, click **Benefit Information** to display the *Coordination of Benefits* window.
  - In the *Other Payer Information* section of the window, enter the appropriate payer ID of the Medicare Replacement Plan or original Medicare in the Payer ID field.
  - In the Payer Name field, enter the name of the Medicare Replacement Plan or original Medicare.
  - In the TPL/Medicare Paid Amount field, enter the paid amount for the entire claim.
  - In the *Other Payer Subscriber Information* section of the window, complete the required fields: Member Name, Primary ID, Relationship Code, and Claim Filing Code. Enter **16** − *Health Maintenance Organization (HMO) Medicare Risk* for a Medicare Replacement Plan. Use MA for original Medicare Part A and MB for original Medicare Part B.

For full instructions about completing professional claims in Web interChange, see the *Quick Reference for Billing Medical Claims* in the Reference Materials section of the Web interChange Help function.

III. Claim submission type – Professional – 837P electronic data file

The 837P transaction contains the following segments to submit coordination of benefits information:

- Loop 2320, SBR09 – Claim Filing Indicator Code – Enter **16** – *Health Maintenance Organization (HMO) Medicare Risk* or MA for original *Medicare Part A* or MB for original *Medicare Part B*.

- Loop 2330B, NM109 – Payer ID – Enter the appropriate Medicare Replacement Plan or original Medicare payer ID.
- Loop 2430, SVD01 – Payer ID – Enter the appropriate Medicare Replacement Plan or original Medicare payer ID – must match the payer ID in Loop 2330B, NM109.
- Loop 2330B, NM109 – Payer ID – Enter the appropriate Medicare Replacement Plan or original Medicare payer ID.
- Loop 2430, SVD01 – Payer ID – Enter the appropriate Medicare Replacement Plan or original Medicare payer ID – must match the payer ID in Loop 2330B, NM109.
- Loop 2430, SVD02 – Service Line Paid Amount – Enter the amount paid by the Medicare Replacement Plan or original Medicare.

NOTE

- All original Medicare and Medicare Replacement Plan coinsurance and/or deductibles must be submitted on the service line in the CAS segment for payment by the IHCP.
- The original Medicare or Medicare Replacement Plan Paid Amounts should be submitted at the service line in the SVD segment for payment by the IHCP.

- Loop 2430, CAS – Line Adjustment – Enter Medicare Replacement Plan or original Medicare coinsurance and/or deductible adjustment amounts.

For full instructions regarding electronic transactions for professional claims, see the 837P companion guide on the IHCP Companion Guides page at indianamedicaid.com.

IV. Claim submission type – Institutional/Outpatient – Paper

Institutional/outpatient crossover claims submitted on paper *UB-04* claim forms, including Medicare Replacement Plan claims, must contain the same information regarding the payment amount, coinsurance and/or deductibles in Fields 39a – 41d as required for original Medicare claims. Failure to include this information results in claims being denied or processed incorrectly.

Providers must use the following value codes along with the appropriate dollar or unit amount for each of the following (these fields are required, if applicable):

- Field 39a-41d: Value Code A1 – Medicare deductible amount
- Field 39a-41d: Value Code A2 – Medicare coinsurance amount
- Field 39a-41d: Value Code 06 – Medicare blood deductible amount
- Field 50A – Must indicate Medicare as the payer
- Field 54A – Must contain the amount paid by the Medicare Replacement Plan or original Medicare. The paid amount is the actual dollar amount paid to the provider for services rendered and does **not** include the Medicare-allowed amount or contractual adjustment amount. These amounts are not entered on the claim. It is not necessary to include a copy of the Medicare Remittance Notice (MRN) or explanation of benefits (EOB) from the Medicare/Medicare Replacement Plan as an attachment to the claim.

V. Claim submission type – Institutional/Outpatient – Web interChange

Institutional/outpatient crossover claims submitted electronically via Web interChange, including Medicare Replacement Plan claims, must contain information regarding the Medicare Replacement Plan or original Medicare payment amount, coinsurance and/or deductibles. Failure to include this information results in claims being denied or processed incorrectly. To submit Medicare/Medicare Replacement Plan institutional/outpatient crossover claims via Web interChange:

- Select Institutional Crossover or Outpatient Crossover on the Claim Processing Menu, as applicable.
- Under the *Coordination of Benefits* section, click **Benefit Information** to display the *Coordination of Benefits* window.
  - In the *Other Payer Information* section of the window, enter the appropriate payer ID of the Medicare Replacement Plan or original Medicare in the Payer ID field.
  - In the Payer Name field, enter the name of the Medicare Replacement Plan or original Medicare.
  - In the TPL/Medicare Paid Amount field, enter the amount that the Medicare Replacement Plan or original Medicare paid for the entire claim.
  - In the *Other Payer Payment Adjustments* section, complete the group code, reason code, and amount information.
  - In the *Other Payer Subscriber Information* section of the window, complete the required fields: Member Name, Primary ID, Relationship Code, and the Claim Filing Code. Enter **16** – *Health Maintenance Organization (HMO) Medicare Risk* for Medicare Replacement Plans or MA for original Medicare Part A or MB for original Medicare Part B.

For full instructions regarding Web interChange claim completion for institutional and outpatient claims, see the *Quick Reference for Billing Institutional Claims* in the Reference Materials section of Web interChange Help function.

VI. Claim submission type – Institutional/Outpatient – 837I – Electronic data file

The 837I transaction contains the following segments to submit coordination of benefits information:

- Loop 2320, SBR09 – Claim Filing Indicator Code – Enter **16** – *Health Maintenance Organization (HMO) Medicare Risk* or MA for original Medicare Part A or MB for Original Medicare Part B.
- Loop 2320, CAS – Claim Level Adjustment – Enter Medicare Replacement Plan or original Medicare coinsurance and/or deductible adjustment amounts.
- Loop 2320, AMT – COB Payer Paid Amount – Enter the amount paid by the Medicare Replacement Plan or original Medicare.
- Loop 2330B, NM103 – Other Payer Name – Enter the name of the Medicare Replacement Plan or original Medicare.
- Loop 2330B, NM109 – Other Payer ID – Enter the appropriate Medicare Replacement Plan or original Medicare payer ID.

- Loop 2430, SVD01 – Other Payer ID – Enter the appropriate Medicare Replacement Plan or original Medicare payer ID.
- Loop 2430, SVD02 – Service Line Paid Amount – Enter the amount paid by the Medicare Replacement Plan or original Medicare.
- Loop 2430, CAS – Line Adjustment – Enter Medicare Replacement Plan or original Medicare coinsurance and/or deductible adjustment amounts.

For full instructions regarding electronic transactions for Institutional/Outpatient claims, see the 837I companion guide on the IHCP Companion Guides page at indianamedicaid.com.

Filing claims for services denied by Medicare/Medicare Replacement Plan

Medicare/Medicare Replacement Plan paid and denied services must continue to be separated and submitted on separate claims. Only paid services, including those paid zero due to deductibles, are considered crossovers subject to the previous instructions. Denied services are **not** considered crossovers. They are considered regular third-party liability (TPL) claims.

Because of the differences in handling, providers need to split claims for covered and noncovered Medicare/Medicare Replacement Plan services and submit two Medicaid claims for a single date of service: one claim as a crossover for the service covered by Medicare/Medicare Replacement Plan, and one claim as a regular professional or institutional claim for service denied by Medicare/Medicare Replacement Plan. Failure to split covered and noncovered Medicare/ Medicare Replacement Plan services into two separate Medicaid claims may result in claims being denied or processed incorrectly.

If a claim for a denied service is submitted via paper, the Explanation of Medicare Benefits (EOMB) from Medicare OR the EOB from the Medicare Replacement Plan must be included with the claim. "**Medicare Replacement**" must be handwritten at the top of the claim **and** on the corresponding EOB. Please note that professional claims for Medicare-denied services are submitted to the regular professional claims address and not the crossover claims address.

If a claim for a denied service is filed electronically, "**Medicare Replacement**" must be indicated in the Notes field of the claim and handwritten at the top of the corresponding EOB. The EOMB or EOB must be submitted with the claim using the attachment procedures described in *Chapter 8: Billing Instructions* of the *IHCP Provider Manual.*

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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