SECTION 16 - MEDICARE/MEDICAID CROSSOVER CLAIMS

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16.1 GENERAL INFORMATION

This section includes general information about the Medicare and Medicaid Programs, comparisons between them, and how they relate to one another in cases in which an individual has concurrent entitlement to medical care benefits under both programs.

- Both Medicare and Medicaid are part of the Social Security Act.
- Medicare is an insurance program designed and administered by the federal government. Medicare is also called Title XVIII (18) of the Social Security Act. Medicare services and rules for payment are the same for all states in the United States. Applications for this program can be made at local Social Security Offices, which can also provide some details regarding services.

  Medicare claims are processed by federally contracted private insurance organizations called carriers and intermediaries located throughout the U.S.
- Medicaid is an assistance program that is a federal-state partnership. Some services, as established by the federal government, are required to be provided. Additional services may be provided at the option of individual states. Medicaid is also called Title XIX (19) of the Social Security Act. Each state designs and operates its own Medicaid Program within federal guidelines; therefore, programs vary among states. In Missouri, an individual may apply for Medicaid benefits by completing an application form at a Family Support Division (FSD) office. Each county in Missouri has an FSD office.

  In Missouri, Medicaid claims are processed by a state-contracted fiscal agent that operates according to the policies and guidelines of the Division of Medical Services within the Department of Social Services, which is the single state agency for the administration of the Medicaid Program.
- For recipients having both Medicare and Medicaid eligibility, the state Medicaid Program pays the amounts indicated by Medicare to be deductible and/or coinsurance due on the Medicare allowed amount. These payments are referred to as “Crossovers."

16.2 BILLING PROCEDURES FOR MEDICARE/MEDICAID CLAIMS (CROSSOVERS)

When a recipient has both Medicare and Medicaid coverage, a claim *must* be filed with Medicare first. The provider should indicate on the claim form to Medicare that the individual is eligible for Medicaid by checking “Medicaid,” in Field #1 and entering “Missouri Medicaid” and the recipient’s Medicaid

number in Field #9a of the HCFA-1500 claim form. For Medicare Part B claims submitted on the HCFA-1500, providers should enter their Medicaid provider number in Field #33. After making payment, the Medicare carrier or intermediary forwards the claim information to Medicaid for payment of deductible and coinsurance amounts. (Reference Section 16.5 for instructions to bill Medicaid when Medicare denies a service.)

The Medicaid payment of a deductible and/or coinsurance appears on the provider's Medicaid Remittance Advice (RA). There is an example of how a crossover payment is posted on an RA in Section 17 of this manual.

Some crossover claims *cannot* be processed in the usual manner for one of the following reasons:

- The carrier does *not* send crossovers to Missouri Medicaid.
- The provider did *not* indicate on his claim to Medicare that the beneficiary was eligible for Missouri Medicaid.
- The recipient information on the crossover claim does *not* match the fiscal agent's recipient file.
- The provider's Medicare ID number is *not* on file in the Division of Medical Services' provider files.

Crossover claims that *cannot* be processed in the usual manner *must* be paper-filed by the provider.

16.2.A CROSSOVER CLAIMS FOR RAILROAD BENEFICIARIES

Part B Medicare claims for Railroad beneficiaries are processed by United HealthCare.

Claims for the deductible and coinsurance portion can be electronically crossed over to Missouri Medicaid for processing when the individual is eligible for Missouri Medicaid or MC+.

Some crossover claims *cannot* be processed electronically. Review the following for reasons that claims do *not* cross over electronically.

- The provider did *not* indicate on the claim to United HealthCare that the beneficiary was eligible for Missouri Medicaid.
- The recipient information on the crossover claim does *not* match the fiscal agent's recipient file.
- The provider's Medicare ID number is *not* on file in the Division of Medical Services' provider files. Providers *must* notify the DMS provider enrollment unit of their Medicare ID number. In order for the RR beneficiary claim to crossover, the provider *must* submit the following information to the Provider Enrollment Unit (PEU).
    1) Documentation of the United HealthCare Part B provider number (RA or approval letter);
    2) Medicaid provider number; and

3) Medicaid provider name

Crossover claims that *cannot* be processed in the usual manner *must* be paper-filed.

16.3 INSTRUCTIONS FOR FILING MEDICARE PART B PAPER CLAIMS

A provider should file a paper crossover claim to Medicaid if:

- Sixty days have elapsed since receiving a Medicare payment without receiving a payment from Medicaid; or
- The provider knows his intermediary or carrier does *not* forward claims to Missouri Medicaid.

Mail crossover claims to:

Infocrossing Healthcare Services
P.O. Box 5600
Jefferson City, MO 65102

To submit a Medicare Part B paper crossover claim, the provider should attach a Part B crossover sticker to a copy of the Medicare Remittance Advice (RA) or the recipient's Explanation of Medicare Benefits (EOMB) that indicates Medicare payment. The Part B sticker is identified with blue ink and is titled Medicare Part B/Medicaid-Title XIX. Place the sticker so it does *not* cover the recipient's identifying information or the claim payment information on the RA/EOMB. Legible photocopies are acceptable (but *not* preferred) and *must* be securely affixed (*NOT* stapled) to the Medicare RA or EOMB.

16.3.A MULTIPLE CLAIMS

If more than one Medicare/Medicaid recipient is shown on the same RA/EOMB, then a separate paper crossover claim *must* be submitted for each recipient. For example, the names of John Jones and Robert Smith, who are both Medicaid eligible, appear on the same RA/EOMB. If the provider needs to file a paper crossover claim for both of them, the provider *must* complete a Part B sticker for John Jones and affix it to a copy of the RA/EOMB and complete another Part B sticker for Robert Smith and affix it to another copy of the RA/EOMB.

Sometimes the same Medicaid recipient's name may appear multiple times on the RA/EOMB; each name repeated represents a separate Medicare claim. This is usually the result of the provider having submitted multiple claims to Medicare for this person. In this situation, a separate paper crossover claim *must* be submitted to Medicaid for each Medicare claim. As in the above example, the provider *must* complete a Part B sticker for each Medicare claim and affix it to a copy of the RA/EOMB.

It is *not* acceptable to affix two Part B stickers on one RA/EOMB whether each sticker is for the same or a different recipient.

When there are several claims shown on one RA/EOMB, it is recommended that the provider highlight by circling or using an asterisk to indicate the Medicare claim being submitted to Medicaid.

16.3.B MULTIPLE LINES PER CLAIM

Frequently several lines representing different dates of service appear on an RA/EOMB for one Medicare claim. Only one paper crossover claim needs to be submitted to Medicaid, but it is important that the "From" and "Through" fields on the Part B sticker are inclusive of all dates of service shown for that claim. This is applicable even if the service for the "From" or "Through" date was denied. A separate claim *must* be billed for denied services. (Reference Section 16.5.)

For example, if the RA/EOMB indicates dates of service 05/02/95, 04/30/95, 05/14/95, and 05/23/95 for one claim, the provider *must* enter 04/30/95 in the "From" field and 05/23/95 in the "Through" field.

16.3.C MULTIPLE PAGES OF AN RA/EOMB

Sometimes Medicare needs to continue the claim information on a second page of the RA/EOMB. The provider needs to submit only one paper crossover claim to Medicaid showing inclusive dates of services as explained above, but the second page of the RA/EOMB *must* be stapled to the first page with the Part B sticker affixed to one of the pages.

16.4 INSTRUCTIONS FOR COMPLETING THE PART B STICKER

Complete the Medicare Part B/Medicaid-Title XIX sticker as follows and attach it to the RA/EOMB so it does *not* cover the recipient's identifying information or claim payment information.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Provider Name	Enter the provider's name as shown on the provider label.
2. Provider Medicaid Number	Enter the provider's nine-digit Medicaid number.
3. Recipient Name	Enter the recipient's name exactly as shown on the ID card.
4. Recipient Medicaid Number	Enter the recipient's eight-digit identification number as shown on the ID card.
5. Other Insurance Payment	Enter the amount paid by any other insurance. Do *not* show the Medicare payment here.
6. Name Other Insurance Company	If an insurance amount is shown on line 5, enter name of insurance company.
7. Patient Account Number	For the provider's own information, a number may be entered here.
8. Beneficiary HIC Number	Enter the patient's HIC Number as shown on the Medicare card.

9. & 10.	Service Date: From and Through	Enter the date of service. If multiple dates of service are shown on the Medicare RA/EOMB for a single claim, enter the first chronological date of service in "From" field and the last chronological date of service in "Through" field.
11.	Billed	Enter the total billed dollar amount for the claim. Use the amount shown on the Medicare RA/EOMB.
12.	Allowed	Enter the total Medicare allowed amount for the claim. Use the dollar amount shown on the RA/EOMB.
13.	Paid	Enter the total dollar amount paid for the claim by Medicare.
14.	Paid Date	Enter the date shown at the top of the RA/EOMB.
*15.	Deductible	If any deductible was applied on this claim, enter the amount due in this field.
*16.	Coinsurance	Enter the total amount of coinsurance due on this claim.
17.	Blood Deductible	If there is blood deductible due, enter that dollar amount.

* Do *not* enter deductible and coinsurance amounts in the same field. They *must* each be listed in their own field.

16.5 BILLING OF SERVICES NOT COVERED BY MEDICARE

Not all services covered under the Medicaid Program are covered by Medicare. (Examples are: prescription drugs, eyeglasses, most dental services, hearing aids, adult day health care, personal care or most eye exams performed by an optometrist.) In addition, some benefits that are provided under Medicare coverage may be subject to certain limitations. The provider will receive a Medicare Remittance Advice that indicates if a service has been denied by Medicare. The provider may submit a claim to Medicaid, using the proper claim form for consideration of reimbursement.

To bill Medicaid for a service that has been denied by Medicare, the provider may file a paper claim and attach a copy of the Medicare Remittance Advice that indicates the Medicare denial for the service billed to Medicaid. Highlight the Medicare denial of the service on the Medicare Remittance Advice by circling or using an asterisk.

File the paper claim using the instructions found in Section 15. If Medicare denies any service on the claim, the denied services only should be listed on the Medicaid claim.

16.6 HOW TO REORDER PART B STICKERS

To order Medicare Part B crossover stickers, use the Forms Request or call the Program Relations Unit at (573) 751-2896.

END OF SECTION

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