

Medicare-Medicaid Crossover Claims FAQ

Table of Contents

1. Benefits of Crossover Claims	1
2. General Information	1
3. Medicare Part B Professional Claims and DMERC Claims.....	2
4. Professional Miscellaneous.....	3
5. Hospital/Nursing Facility Crossover Claims	3
6. Transmitting Crossover Claims (Professional & Institutional)	5
7. Verifying/Adjusting Transmitted Claims (Professional & Institutional)	6

Refer to the Coordination of Benefits Chapter of the Medicaid Provider Manual for detailed information on the crossover process.

1. Benefits of Crossover Claims

Q: What are the benefits of crossover?

A: Providers will benefit from crossover in the following ways:

- Only one claim will need to be generated instead of two, saving administrative costs
- No Medicare explanation of benefits (EOBs) need to be sent to Medicaid
- Providers will experience expedited payment due to electronic submission
- Medicare payment information will be accurate

2. General Information

Q: How timely is the Michigan Medicaid eligibility data given to Coordination of Benefits Contractor (COBC)?

A: Medicaid submits an eligibility file monthly to the COBC.

- Q: Is it necessary to include Medicaid patient specific information on Medicare claims or will the crossover happen regardless?**
- A:** Secondary payer information must be included on the Medicare primary claim (including the Medicaid beneficiary ID) in order for the claim to crossover.
- Q: Is there unique or identifiable data within CHAMPS that will reflect claims that were auto crossed by Medicare?**
- A:** The first two characters of the TCN will be 32.
- Q: Will the crossover claims be subject to primary Medicaid claims editing?**
- A:** Yes.

3. Medicare Part B Professional Claims and DMERC Claims

- Q: Which Medicare Part B claims crossover to Michigan Medicaid?**
- A:** Michigan Medicaid receives :
- Medicare Part B professional claims, and
 - DMERC claims from the COBC.
- Q: Are there any claims excluded from the crossover process between the COBC and Medicaid?**
- A:** The following claims are EXCLUDED from the crossover:
- Totally denied Medicare claims
 - Claims denied as duplicates or for missing information
 - Adjustment claims (referred to as “replacement or void/cancel claims”)
 - Claims reimbursed at 100 percent by Medicare
 - Claims for dates of services outside the beneficiary’s Medicaid eligibility begin and end dates
 - Federally Qualified Health Centers (FQHC) professional services.
 - Claims if other insurance exists for beneficiary
- Q: Do non-physician practitioner (e.g., physician assistant, nurse practitioner, nurse mid- wife, psychologist, social worker, etc.) claims crossover to Michigan Medicaid?**
- A:** **Yes.** The claims are transmitted to Medicaid, but Medicaid can only process the claims if the practitioner is directly enrolled in Michigan Medicaid. Currently Michigan Medicaid fee-for-service does not directly enroll psychologists or social workers.

Q: Does a CMS 1500 paper claim sent to Medicare Part B or DMERC carrier crossover?

A: No. If a paper claim is submitted to Medicare Part B or the DMERC carrier, a claim must be submitted directly to Michigan Medicaid after receiving the remittance advice from the Medicare carrier.

Q: Does a claim for a beneficiary who has Medicare, other insurance, and Medicaid crossover to all payers?

A: No. Claims that include a secondary payer other than Michigan Medicaid may be crossed over to the secondary payer, but not to Michigan Medicaid. Once a remittance advice or EOB is received from the secondary payer, the claim can be submitted directly to Michigan Medicaid, with the updated Medicare and other insurer payment and/or adjudication information.

Q: Do claims where Medicare is the secondary payer and Michigan Medicaid is the tertiary payer crossover?

A: Yes. If Michigan Medicaid is identified as the only other payer following Medicare, the Part B professional and DMERC claims should be crossed over from the COBC.

4. Professional Miscellaneous

Q: Should the UA and UD modifiers be billed to Medicare for emergency room E&M services?

A: Yes. Medicare will accept the UA & UD modifiers for the emergency room E&M services and the claim should not reject.

5. Hospital/Nursing Facility Crossover Claims

Q: Which Medicare Part A (Institutional) claims crossover to Medicaid?

A: Hospital, nursing facilities (including county medical care facilities, hospital long-term care units, hospital swing beds, ventilator-dependent care units and outpatient county medical care facilities).

Nursing facility providers can refer to MSA Bulletin 11-32 for more information

Q: Are there any claims excluded from the crossover process between the Coordination of Benefits Contractor and Medicaid?

A: The following claims are EXCLUDED (not sent to Michigan Medicaid from the COBC):

- Original Medicare claims paid in full without deductible or co-insurance remaining
- Claims with private and commercial insurance
- Adjustment claims fully paid without deductible or co-insurance
- Original Medicare claims paid at greater than 100% of submitted charges without deductible or co-insurance remaining
- 100% denied original claims
- 100% denied adjustment claims, with no additional beneficiary liability
- 100% denied original claims, with additional beneficiary liability
- 100% denied adjustment claims, with additional beneficiary liability
- Adjustment claims
- Mass adjustment claims - other (monetary or non-monetary)
- Medicare secondary payer cost-avoided (fully denied) claims
- Nursing facility claims reporting Revenue Code 0160 (Medicaid Reimbursement for a Nursing Facility Bed Following a Qualifying Medicare Hospital Stay).
- Rural Health Clinic claims (MDCH is planning to phase them in at a future date)
- Freestanding Dialysis Clinic claims
- Federally Qualified Health Center claims (MDCH is planning to phase them in at a future date)
- Home Health claims
- Private Duty Nursing claims
- Special Facility: Hospice Non-Hospital
- Special Facility: Hospice Hospital

Q: Are hospitals and nursing facilities required to record Medicaid beneficiary deductible/patient-pay amounts on their claims?

A: Yes.

Q: Are there any special nursing facility billing instructions or reminders?

A: Yes:

- Nursing facilities must continue to complete their claims as they have been doing for Medicare.
- Nursing facilities must report the beneficiary's patient-pay, any offset to the patient-pay amount, and voluntary payments on the claim submitted to Medicare.

- When reporting ancillary services, the facility must indicate the service date on the line level of the claim. Ancillary services are listed in the Medicaid Provider Manual, Billing & Reimbursement for Institutional Providers Chapter, Sections 7.11 – 7.14 (for example, Revenue Code 0410 – Oxygen). The manual is posted online at: www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual.
- .Medicaid-enrolled ventilator-dependent care units have a distinct National Provider Identifier (NPI) number for Medicaid billing. That number is separate from their “regular” facility NPI number. The facility would use their “regular” NPI number to bill days 1 to 100 to Medicare. Starting on day 101, the facility would bill Medicaid directly using its ventilator-dependent care unit’s distinct NPI number.

6. Transmitting Crossover Claims (Professional & Institutional)

Q. What is reflected on the Medicaid remittance advice (RA) if the claim being adjudicated was submitted by a billing agent or if it was sent as a part of Medicare crossover?

A. If the claim being adjudicated is a crossover claim, the Medicaid 835 will have a "006B" in Loop 2100 NM109 [Service Provider Name] (e.g. 101111111**006B**). On the Medicaid paper RA, the value of "006B" will be listed in the column to the right of the TCN number.

Q: What is the most important requirement for Michigan Medicaid to successfully process a crossover claim?

A: For all billing, rendering, and attending the following must be: reported:

Billing NPI:	Loop 2010AA	NM108 segment:	enter XX
		NM109 segment:	enter NPI
Attending NPI:	Loop 2310A	NM108 segment:	enter XX
		NM109 segment:	enter NPI
Rendering NPI:	Loop 2310B	NM108 segment:	enter XX
		NM109 segment:	enter NPI

This information will be passed on to Michigan Medicaid and will be the basis of identifying the provider for purposes of Michigan Medicaid claims processing. **If the NPI is not included on the claim sent to Medicare, Michigan Medicaid will not be able to process the claim.**

Q: What if claims are denied or rejected by Medicare Part A or B or DMERC carrier?

A: Providers must resolve rejected and denied claims directly with the Medicare Part A or B or DMERC carrier. If the service is an excluded benefit for Medicare that Medicaid will cover, then the excluded Medicare service can be billed directly to Michigan Medicaid.

Q: If a clearinghouse is used, how is the NPI transmitted to Medicare?

A: The provider must work with their clearinghouse or vendor to determine this.

7. Verifying/Adjusting Transmitted Claims (Professional & Institutional)

Q: Will the Medicare Remittance Advice (RA) indicate that the COBC crossed over the claim?

A: Yes. For Medicare crossover claims, the Medicare RA will include Remark Code MA07 (“The claim information has also been forwarded to Medicaid for review”).

Q: How is Michigan Medicaid’s payment decision known?

A: Crossover claims follow the same rules and regulations for claim adjudication as any other type of claim.

Q: What happens if the Medicare RA indicates that a claim was crossed over but a response or payment from Michigan Medicaid is missing?

A: Once payment is received from Medicare and Remark Code MA07 (“The claim information has also been forwarded to Medicaid for review”) appears on the Medicare RA, providers should expect to see the claim appear on the Medicaid RA within 30 days. Providers may check the status of their claims online through the Community Health Automated Medicaid Processing System (CHAMPS). If the claim does not appear in CHAMPS or on a Medicaid RA within 30 days, a claim should be submitted directly to MDCH showing all of the Medicare payment information.

Q: What if a crossover claim is rejected or denied by Michigan Medicaid?

A: If it appears the claim has been inappropriately rejected or denied by Michigan Medicaid, the provider should contact the MDCH Provider Support line at 1-800-292-2550 or e-mail ProviderSupport@michigan.gov for guidance on how to proceed.

Q: How does a previously crossed over claim that needs to be adjusted (replacement or void/cancel) get submitted to Medicare and Michigan Medicaid?

A: The adjustment (replacement or void/cancel) must be submitted to Medicare first. Adjustments (replacements or void/cancels) are excluded from the crossover process. When the RA arrives from Medicare, submit the claim adjustment (replacement or void/cancel) directly to Michigan Medicaid with the updated Medicare payment and/or adjudication information.

Q: Can a 276 Status Request be submitted for a crossover claim?

A: Yes.