Medicare/Medi-Cal Crossover Claims Overview

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Some Medi-Cal recipients are eligible for services under the federal Medicare program. For most services rendered, Medicare requires a deductible and/or coinsurance that, in some instances, is paid by Medi-Cal. A claim billed to Medi-Cal for Medicare deductible and coinsurance is called a crossover claim. This type of claim has been approved or paid by Medicare. This section contains eligibility information and general guidelines about Medicare/Medi-Cal crossover claims. Refer to Medicare/Medi-Cal crossover claims sections in the appropriate Part 2 manual for claim form billing instructions and examples.

HIC/MBI Notice

Beginning April 1, 2018, the Health Insurance Claim (HIC) number traditionally appearing on Medicare cards is being replaced by a non-Social Security Number based Medicare Beneficiary Identifier (MBI) number. Updated Medicare cards with MBIs will be phased into use through December 31, 2019. Therefore, the term HIC will be phased out of the Medi-Cal provider manuals, as appropriate. Removal of references to HIC does not preclude providers from processing transactions using HIC numbers. Providers can continue to process both HIC and MBI numbers, as appropriate, from April 1, 2018 through December 31, 2019. Providers should refer to the CMS website for detailed information.

Legal Constraints

Medi-Cal Reimbursement

California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services. (Refer to *Welfare and Institutions Code*, Section 14109.5.)

Expectations for Qualified Medicare Beneficiaries' (QMBs) Before August 1, 1999

The following exceptions apply to Qualified Medicare Beneficiaries (QMBs), for claims with dates of service before August 1, 1999. See "Crossover Programs" on a following page for additional information on the QMB program.

Exception 1
For Part A inpatient crossover claims for recipients with aid code(s) 10, 20, 60 and/or 80 ("pure QMB" and "QMB plus" recipients), Medi-Cal reimburses the amount of the Medicare deductible and coinsurance (cost-sharing). This reimbursement is allowed pursuant to a federal court order in Beverly Community Hospital v. Belshe, effective December 11, 1995.

For QMBs identified as “QMB only” recipients, Medi-Cal will render retroactive reimbursement for acute care hospital inpatient crossover claims for dates of service on or after May 1, 1994 *(State Plan Amendment 94-008*). QMB only recipients are identified by Medi-Cal with aid code 80 only. Retroactive reimbursement for QMB only recipients must be offset by subtracting any previously allowed Medicare “Bad Debt Allowance.”

Exception 2
For recipients with aid code 80 only (QMB only), Medi-Cal reimburses the full Medicare Part B deductible and coinsurance.

Part B Premiums

California has a buy-in agreement with the federal government whereby the Department of Health Care Services (DHCS) pays the Medicare Part B premiums on behalf of all individuals eligible for Medi-Cal. These individuals are therefore protected by federal Medicaid rules that preclude providers from charging recipients any sums in addition to payments made to the provider.

Deductibles and Coinsurance

Providers who accept persons eligible for both Medicare and Medi-Cal as recipients cannot bill them for the Medicare deductible and coinsurance amounts. These amounts can be billed only to Medi-Cal. (Refer to *Welfare and Institutions Code* [W&I Code], Section 14019.4.) However, providers should bill recipients for any Medi-Cal Share of Cost (SOC).

Note: Providers are strongly advised to wait until they receive the Medicare payment before collecting SOC to avoid collecting amounts greater than the Medicare deductible and/or coinsurance.

Payments Received From Medi-Cal Recipients

Any payments received from a Medi-Cal recipient, with the exception of SOC payments, must be refunded upon receipt of Medi-Cal’s *Remittance Advice Details* (RAD) for that service. (Refer to *Welfare and Institutions Code*, Section 14019.3.)

Health Maintenance Organization (HMO)/Medicare Advantage Plans

Plan Overview

Medi-Cal recipients who receive benefits from a Medicare-contracted Health Maintenance Organization (HMO) or Medicare Advantage plan are identified with Other Health Coverage (OHC) code "F."

Note: Medi-Cal recipients who also have Medicare HMO/Medicare Advantage plan coverage must seek medical treatment through the plan. Neither the plan nor Medi-Cal pays for services rendered by non-plan providers.

Exception: Plans often cover required emergency care until the patient's condition permits transfer to the plan's facilities. Providers should contact the plan for emergency treatment authorization and billing instructions.

To bill Medi-Cal for services not included in the plan, providers submit a hard copy claim to Medi-Cal accompanied by a plan denial letter or *Explanation of Benefits* (EOB) documenting that the plan does not cover the service. These claims are not Medicare/Medi-Cal crossover claims. Refer to the *Other Health Coverage* (OHC) section in the Part 2 manual for billing instructions.

Medicare Part C Recipients

Medicare providers of services to dual-eligible VillageHealth Medicare Part C recipients should refer to the *Other Health Coverage* (OHC) section for instructions for requirements for billing coinsurance and/or deductible claims.

End Stage Renal Disease Pilot Project

Providers may refer to "End Stage Renal Disease Pilot Project: VillageHealth" in the *MCP: Special Projects* section in this manual for information about a pilot project (begun January 1, 2006, and extended through December 31, ‹‹2022››) that was developed to provide care for recipients with End Stage Renal Disease (ESRD) who otherwise would be precluded from Medicare HMO/Medicare Advantage plan enrollment. For this pilot project, specialty health plans perform the function of Medicare.

Medicare Summary Of Services

Medicare Covered Services

Medicare divides its services into Part A and Part B. Part A covers institutional services and Part B covers non-institutional services. Recipients may be covered for Part A only, Part B only or both.

Claims Processing

Medicare uses the following contractors in this region to process claims:

- Part A – Noridian Administrative Services, Jurisdiction E
- Part B – Noridian Administrative Services, Jurisdiction E and (Durable Medical Equipment Medicare Administrative Contractor [DME MAC]), Jurisdiction D

Medicare providers bill Medicare in one of the following ways:

- Part A services billed to Part A contractors
- Part B services billed to Part A contractors
- Part B services billed to Part B contractors

Medicare Part A Services

Part A coverage includes:

- Home health services
- Home intravenous drugs
- Hospice care
- Inpatient hospital care
- Psychiatric hospital care
- Respite care
- Skilled nursing facility care

Part A services are reflected on a Medicare *Remittance Advice* (RA).

Medicare Part B Services

Part B coverage includes:

- Blood supplies
- Diabetic supplies
- Home health services *(see note below)*
- Immunosuppressive drugs for one year after transplant surgery
- Inpatient and outpatient medical services and supplies
- Other medical and health services, such as:
  - Chemotherapy
  - Diagnostic radiology
  - Emergency Medical Transportation
  - Home dialysis equipment
  - Oral surgery
  - Outpatient physical and occupational therapy
  - Pathology and laboratory services
  - Psychology (50 percent payable)
  - Radiation treatments
  - Renal dialysis
  - Speech pathology
  - Vision care
- Outpatient hospital treatments
- Physician services

Part B services billed to Part B contractors are reflected on the *Medicare Remittance Notice* (MRN). Part B services billed to Part A contractors are reflected on the Medicare RA.

Note: If a recipient has both Medicare Part A and Part B coverage, Part A will pay for the home health services. However, Part B will pay for home health services if a recipient does not have Part A coverage.

Types of Medicare Eligibility

The Medi-Cal eligibility verification system indicates a recipient's Medicare coverage when a provider submits a Medi-Cal eligibility inquiry. One of the following messages will be returned if a recipient is eligible for Medicare:

- Part A Medicare coverage with Medicare ID #____. Bill Medicare covered services to Medicare before Medi-Cal.
- Part B Medicare coverage with Medicare ID #_____. Bill Medicare covered services to Medicare before Medi-Cal.
- Part A and B Medicare coverage with Medicare ID #____. Bill Medicare covered services to Medicare before Medi-Cal.

Billing Guidelines

General Crossover Information

General information about Medicare/Medi-Cal crossover claims appear on the following pages. Refer to the Medicare/Medi-Cal crossover claims sections in the appropriate Part 2 manual for billing instructions. The following guidelines apply to crossover claims.

‹‹Providers seeking Medi-Cal Rx crossover information should refer to the Medi-Cal Rx website (*https://medi-calrx.dhcs.ca.gov/*).

The following guidelines apply only to Medi-Cal crossover claims.››

Part A Coverage Only

If a recipient has Medicare Part A coverage only, and a provider is billing for Part A covered services, the provider must bill Medicare prior to billing Medi-Cal. However, if billing for Part B covered services only, do not bill Medicare prior to billing Medi-Cal. Refer to the Medicare/Medi-Cal crossover claims sections in the appropriate Part 2 manual for Medi-Cal claim form billing instructions.

Part B Coverage Only

If a recipient has Medicare Part B coverage only, and a provider is billing for Part B covered services, the provider must bill Medicare prior to billing Medi-Cal. However, if billing for Part A covered services only, do not bill Medicare prior to billing Medi-Cal. Refer to the Medicare/ Medi-Cal crossover claims sections in the appropriate Part 2 manual for Medi-Cal claim form billing instructions.

Part A and Part B Coverage

If a recipient has Medicare Part A and Part B coverage, and a provider is billing for Part A and Part B covered services, the provider must bill Medicare prior to billing Medi-Cal.

Medicare and Medi-Cal Dual Eligibility

Claims for recipients eligible for both Medicare and Medi-Cal must be submitted to Medicare prior to billing Medi-Cal, except for services that Medicare does not cover. Medi-Cal may reimburse providers for Medicare non-covered, exhausted or denied services when billed on a straight Medi-Cal claim with the appropriate Medicare denial attached.

Medical Supplies

Most medical supplies are not covered by Medicare and can be billed directly to Medi-Cal. However, the medical supplies listed in the *Medical Supplies: Medicare-Covered Services* section of the appropriate Part 2 manual are covered by Medicare and must be billed to Medicare prior to billing Medi-Cal.

Share of Cost (SOC)

Providers should bill recipients for Medi-Cal Share of Cost (SOC) when applicable. Providers are strongly advised to wait until they receive the Medicare payment before collecting SOC to avoid collecting amounts greater than the Medicare deductible and/or coinsurance. Refer to the *Share of Cost (SOC)* section in this manual for additional information.

Electronic Billing

Crossover claims cannot be submitted to Medi-Cal through the Point of Service (POS) network but can be submitted through the Computer Media Claims (CMC) process. Refer to the *CMC Submission*s and *Billing Instructions* section of the *Medi-Cal Computer Media Claims* (CMC) *Billing and Technical Manual* for additional information.

Prior Authorization

Crossover claims do not require a *Treatment Authorization Request* (TAR).

Automatic Crossover Claims

Medicare uses a consolidated Coordination of Benefits Contractor (COBC) to automatically cross over to Medi-Cal claims billed to any Medicare contractor for Medicare/Medi-Cal eligible recipients.

Note: Providers do not need to rebill to Medi-Cal on paper or electronically claims that automatically cross over.

Eligibility Information

The Medicare COBC uses eligibility information provided by DHCS to identify Medi-Cal crossover claims. Therefore, it is not necessary to include Medi-Cal information on claims submitted to Medicare.

Inpatient Services and Long Term Care Providers

For additional information about automatically submitted crossover claims, refer to the Medicare/Medi-Cal crossover claims section in the appropriate Part 2 manual.

"Zero Pay" Crossovers

If a Part B claim is submitted to a Medicare Part B contractor and payment is made by Medicare, the claim may automatically cross over to Medi-Cal (refer to "Automatic Crossover Claims" in this section). If the automatic crossover claim does not appear on the Medi-Cal RAD within three weeks from the *Medicare Remittance Notice* (MRN) date, it may be a "zero pay" claim that results when Medicare has already paid more than the Medi-Cal maximum allowance. Providers may determine zero pay status by calling the *Provider Telecommunications Network (PTN)* at 1-800-786-4346. See the "Claim Crossed Over from Medicare, not Payable" entry in the Provider Telecommunications Network (PTN) section of this manual for the message that the PTN returns in zero pay situations. Part B claims submitted to a Medicare Part A contractor and subsequently received and paid zero by Medi-Cal will appear on the RAD.

If an automatic crossover claim results in no Medi-Cal payment (zero pay) but the provider needs the claim to appear on the RAD, the provider must rebill to Medi-Cal on paper or electronically. Providers must also rebill if the claim cannot be located.

If the provider believes payment should have been received for an automatic crossover, but none was received, it is possible that the claim did not cross over. In this instance the provider may rebill to ensure the claim is submitted and will appear on the RAD.

Claims Requiring Direct Medi-Cal Billing

The following claims must be billed directly to Medi-Cal:

- Claims for recipients with Other Health Coverage (OHC); particular Health Care Plans, or Managed Care coverage (not crossover claims); or Share of Cost (SOC)
- Unassigned claims
- Medicare denied claims (not crossover claims)
- Claims billed to Medicare with a National Provider Identifier (NPI) number that is not registered with Medi-Cal
- Claims with an invalid recipient Medicare ID number
- Claims exceeding the detail line limits that must be split-billed
- Claims that result in no Medi-Cal payment (zero pay) and must appear on a *Remittance Advice Details* (RAD) for claim follow-up or resubmission

Note: "Zero pay" appears on RADs for institutional providers, and not for all other providers. A hard copy or CMC Medicare crossover claim is required to register on the RAD.

- Claims that Medicare indicates were automatically crossed over to Medi-Cal but do not appear on a RAD within two to three weeks from the Medicare remittance date, or that cannot be located in the system. (Providers may call the Provider Telecommunications Network [PTN] at 1-800-786-4346 for claim status information.)

Note: The ability for the PTN to retrieve this information ends about 12 weeks from the Medicare remittance date.

- Claims that Medicare originally indicated were automatically crossed over to Medi-Cal electronically, but then later notified the provider the claims were rejected by Medi-Cal.
- Claims for contracted medical supply items. When billing Medicare for Medi-Cal medical supply crossover claims, providers <u>should not</u> include the Universal Product Number (UPN), qualifier, unit of measurement qualifier and UPN units. Crossover claims for Medi-Cal medical supply items that require hard copy crossover claims to be submitted to Medi-Cal must contain the UPN and appropriate qualifier listed in the shaded area of Box 24A (*Date of Service*). Claims for contracted medical supplies that do not have the appropriate UPN will be denied. The unit of measure qualifier and quantity <u>may</u> be listed in the shaded area of Box 24D (*Procedure Code*); however, hard copy crossover claims without this information will not be denied.

CROSSOVER PROGRAMS

Qualified Medicare Beneficiary (QMB) Program

The Qualified Medicare Beneficiary (QMB) program is a Medi-Cal program for certain Medicare recipients who have limited income and resources. Under this program, Medi-Cal pays for Medicare Part A and Part B premiums. Medi-Cal payments for Medicare deductibles and coinsurance (such as, Medicare cost-sharing expenses) are issued within Medi-Cal guidelines.

Aid Code 80

Qualified Medicare Beneficiaries (QMBs) are identified by aid code 80 and are covered only for restricted services. The following message will be returned from the Medi-Cal eligibility verification system when inquiring about eligibility for QMBs:

> "Medi-Cal Eligibility Limited to Medicare Coinsurance, Deductibles. Part A, B Medicare Coverage with Medicare ID #_____. Bill Medicare before Medi-Cal."

Providers must first bill Medicare for Medi-Cal to determine appropriate deductible and coinsurance payments. As with current crossover claims, Medi-Cal pays coinsurance and/or deductibles for both Medicare Part A and Part B services. Determination of Medicare Part B coinsurance and deductible payments for QMB recipients is based on current processing of Medicare crossover claims. Medi-Cal payment, when combined with the Medicare payment, will not exceed the lower of the Medicare or the Medi-Cal maximum allowable. Any residual amounts may not be collected from QMBs. Claims submitted for services other than the Medicare deductible and coinsurance will be denied.

NATIONAL PROVIDER IDENTIFIER (NPI) UPDATES

Inaccurate or Missing NPI

Most crossover claims are transmitted automatically from Medicare contractors through the Coordination of Benefits Contractor directly to Medi-Cal. Processing of these claims is based on the NPI billed to Medicare and registered with Medi-Cal. Providers who have more than one NPI should ensure that each number is registered and reflected accurately on the Medi-Cal Provider Master File.

An inaccurate or missing NPI on the Provider Master File is the most common reason for an automatic Medicare crossover claim to be rejected.

Providers are responsible for notifying DHCS Provider Enrollment Services, in writing, of any changes to be made to their provider files.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.