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Changes to Medicare Crossover Claims Processing and Reimbursement Effective January 1, 2012

Information posted December 1, 2011

Effective for dates of service on or after January 1, 2012, the following claims submission and processing guidelines will change for Medicare crossover claims:

- Coinsurance and deductible reimbursement will change for professional and outpatient facility crossover claims in accordance with cost containment reductions included in H.B. 1, 82nd Legislature, Regular Session, 2011.
- If a TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form (i.e., MRAN template) is included with a paper crossover submission, the Medicare Remittance Advice (RA) or Remittance Notice (RN), other approved notice that is issued by Medicare, or the MAP explanation of benefits (EOB) must also be submitted to TMHP.
- The performing provider information will be required for electronic and paper submissions billed by group providers.
- The TMHP Standardized Medicare and MAP Remittance Advice Notice Forms (i.e., MRAN template) for paper crossover submissions will be updated to include additional required fields.

Coinsurance and Deductible Reimbursement for Professional and Outpatient Facility Crossover Claims

Effective for dates of service on or after January 1, 2012, coinsurance and deductible reimbursement for Medicare Part B and Part C (noncontracted MAPs only) professional and outpatient facility crossover claims will change for Texas Medicaid in accordance with cost containment reductions included in H.B. 1, 82nd Legislature, Regular Session, 2011.

The mandated changes align the Texas Medicaid payment policy for Medicare Part B and Part C (noncontracted MAPs only) with the Texas Medicaid payment policy for Medicare Part A.

For Part B and Part C (noncontracted MAPs only) professional and outpatient facility crossover claims, Texas Medicaid will reimburse the lesser of the following:

- The coinsurance and deductible payment
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service

If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid will not make a payment for coinsurance and deductible.

Important: *The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.*

Refer to: The 2011 *Texas Medicaid Provider Procedures Manual, Vol. 1, General Information,* subsection 1.4.9, "Billing Clients."

For crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers, Texas Medicaid will continue to pay the Medicare coinsurance and deductible less 5 percent.

The Texas Health and Human Services Commission (HHSC) makes a per-client-per-month payment to MAPs that contract with HHSC. The payment to the MAP includes all costs associated with the Medicare coinsurance and deductible for a client who is dually eligible for Medicare and Medicaid. TMHP does not reimburse the coinsurance or deductible amounts for these claims. These costs must be billed to the MAP and must not be billed to TMHP or the Medicaid client.

Performing Provider Requirement for Group Providers That Submit Professional Crossover Claims

Effective January 1, 2012, if the billing provider is a group, the performing provider information must be submitted on all professional crossover claims as follows:

- *Paper claim submissions.* The performing provider National Provider Identifier (NPI) and Texas Provider Identifier (TPI) must be submitted on each detail line item. A detail line item will be denied if the performing provider NPI or TPI is omitted, if the performing provider NPI is not associated with the TPI according to the performing provider's enrollment information, or if the performing provider is not a member of the billing group provider.
- *Electronic claim submissions.* Claims will be processed using the performing provider NPI submitted on the Medicare claim. If the performing provider NPI is invalid or not a member of the billing group provider, the claim will be denied. Denied claims may be appealed on paper with the appropriate performing provider information.

If the appropriate performing provider information is not on the claim, the claim will be denied.

Important: *The performing provider identified on the paper or electronic claim must be a member of the billing group provider. If the performing provider is not a member of the billing group provider, the detail line item will be denied.*

Individual billing providers (i.e., billing providers that are not groups) are not required to submit a performing provider TPI.

TMHP Standardized Medicare and MAP Remittance Advice Notice Forms for Paper Submissions

Effective for dates of service on or after January 1, 2012, providers that submit the TMHP MRAN template will also be required to submit the paper MRAN from Medicare or a Medicare intermediary, or the computer generated MRAN from the CMS-approved software applications, which are *MREP* for professional services and *PC-Print* for institutional services.

Providers that currently submit only the Medicare notice for paper crossover claims must include the appropriate TMHP MRAN template if the Medicare notice does not contain all of the required information.

The TMHP MRAN templates will be updated to accommodate the claims processing and reimbursement changes for professional and outpatient facility crossover claims:

- Crossover Professional Claim Type 30
- Crossover Outpatient Facility Claim Type 31
- Crossover Inpatient Hospital Claim Type 50

The revised MRAN templates will be available on this website by December 31, 2011.

The following changes will be applied to these forms:

- The Medicare ICN and the MAP ICN (if applicable) will be required fields. Claims will be denied if the ICNs are omitted.
- For the TMHP claim type 30 MRAN template, the performing provider TPI and NPI will be required fields. Claims will be denied if required performing provider information is omitted or invalid.

  Note: *Individual billing providers (i.e., billing providers who are not groups) are not required to fill out the performing provider fields on the TMHP* claim type 30 MRAN template*.*
- For the TMHP claim type 31 MRAN template, the detail line items will be required fields. Claims without coinsurance and/or deductible on the details may not be reimbursed appropriately.

By submitting an MRAN template to TMHP, the provider attests that the information included in the form matches the Medicare RA or RN that was received either from Medicare or the MAP. If the information on the crossover claim type form does not exactly match the information on the RA or RN, the claim may be denied.

Reminder: TMHP MRAN templates, paper MRANs from Medicare or a Medicare intermediary, or computer generated MRANs from the CMS-approved software applications (MREP for professional services or PC-Print for institutional services) must be received by TMHP within 95 days of the Medicare date of disposition in order to be considered for processing. Providers may also submit Medicare adjusted claims by submitting the adjusted computer-generated MRANs from the CMS-approved software applications (*MREP* for professional services and *PC-Print* for institutional services), or paper adjusted MRANs that were received from Medicare or a Medicare intermediary.

For more information, call the TMHP Contact Center at 1-800-925-9126.