Claims Crossovers Account Training Tutorial

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Navigation Menu

Go directly to a topic using the links below:

- Medicare/Medicaid Differences/ Scope of Coverage for Medicare
- How to File a Crossover Using the secure Web Portal
- Where to send Paper Crossover Claims
- How to Access Billing Manuals & Crossover Resources

Claims Crossovers eLearning Tutorial

The purpose of the Crossovers eLearning Tutorial is to explain the general procedures for billing crossovers in the Georgia Medicaid Program.

What's covered in the Claims Crossovers eLearning Tutorial?

- Understanding the differences between Medicaid and Medicare and Scope of Coverage
- Steps to complete a crossover properly using the secure Web Portal
- Where to send paper crossover claims
- How to access Web Portal Billing Manuals and Crossover Resources

Terminology

- Crossover: A claim billed to Georgia Medicaid for the Medicare deductible and/or coinsurance is called a crossover claim.
- Coinsurance: The remaining balance of the Medicare Allowed Amount after a Medicare payment.
- Co-payments: The amount required by Medicare Parts C or D when services are rendered or drugs are purchased. Providers may choose to waive these co-payments or may deny service if a member cannot pay this amount. Georgia Medicaid does not pay for co-payments.
- Deductible: The dollar amount Medicare members must pay for Part A or Part B services prior to receiving Medicare benefits.

Medicare and Medicaid Differences

»**Medicaid** is a state and federal partnership that provides comprehensive health insurance benefits to low-income children, pregnant women and people with disabilities.

»**Medicare** is a federal health insurance program for all Americans over age 65, some disabled people under age 65, and anyone with end-stage renal disease. There are over 40 million Americans on Medicare (or 98% of Americans over age 65).

Scope of Coverage for Medicare

Medicare divides its services into specific classifications: Part A, Part B, Part C and Part D. Members may be covered for Part A only, Part B only or both.

1. Medicare Part A - Covers inpatient hospital services
2. Medicare Part B - Covers professional, outpatient hospital, and vendor services
3. Medicare Part C - A Managed Care version of Medicare, also called a Medicare Advantage Plan, offered through private insurance companies
4. Medicare Part D - Covers prescription drugs

Medicare Savings Programs

Medicaid provides partial financial assistance with Medicare premiums, deductible, or coinsurance – through the Medicare Savings Program (i.e., Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals) – to certain low income Medicare beneficiaries who are not entitled to the full Medicaid benefit package.

Qualified Medicare Beneficiary (QMB) (Aid category 660)

This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. The Medicaid program pays full Medicare Part B Premiums only. Beneficiaries have no Medicaid benefits other than paying for premiums, coinsurance and deductibles. Medicaid pays Part A premiums (if any) also.

Specified Low-Income Medicare Beneficiaries (SLMB) (AID CATEGORY 661)

This is a Medicaid program for beneficiaries who need help paying for Medicare Part B premiums. The beneficiary must have Medicare part A and limited income and resources and not be otherwise eligible for Medicaid. Medicaid pays the Medicare Part B premium only; these members are not eligible for Medicaid benefits.

Qualified Individual (QI) Program

You must be eligible for Part A to qualify, and you must apply every year for QI benefits. QI applications are granted on a first-come, first-served basis, with priority given to people who got QI benefits the previous year. QI benefits are not available to people who qualify for Medicaid. Medicaid pays the Medicare Part B premium only; these members are not eligible for Medicaid benefits.

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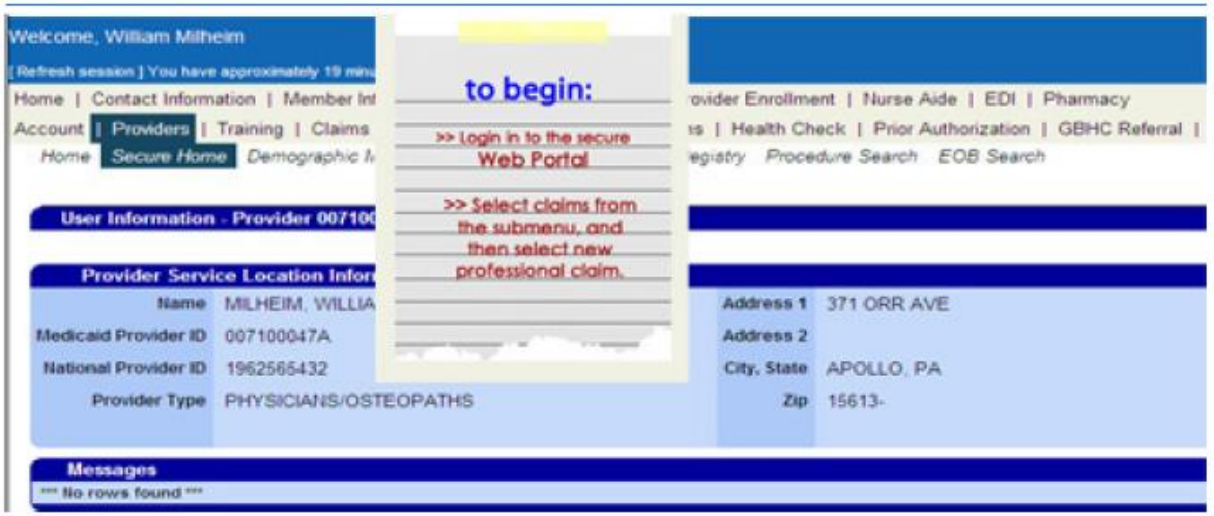
Medicare Advantage plans/Medicare

Part C: This combines parts Part A and Part B and sometimes the Medicare prescription program (Medicare Part D). These plans cover the same benefit as the original Medicare plans; however, they are administered by private health insurance payers. Some of these plans offer additional services beyond what the original Medicare plans offer. These claims do not automatically cross-over to Medicaid; the provider must submit the claim to Medicaid along with the Explanation of Benefits or EOB from the Medicare Advantage Plan. Providers should write "06 Attachment" on the top right corner of Medicare Advantage EOB.

The next section of the eLearning tutorial covers using the secure Web Portal to file a crossover claim.

To get started, login to the secure Web Portal of the Georgia Medicaid web site - www.mmis.georgia.gov. The secure Web Portal is the preferred method for filing claims with the Georgia Medicaid Management Information System (GAMMIS).



This tutorial provides instructions for completing a CMS-1500 claim along with specific instructions for completing a Medicare crossover claim. The examples are for illustration purposes only.

How to File a Crossover Using the secure Web Portal

This section contains billing information, billing tips and Medicare documentation requirements for Georgia crossover claims submitted on a CMS-1500 claim using the secure Web Portal.

NEW Effective July 1, 2011, the maximum period for submission of Medicare Crossover Claims to Medicaid has been reduced to not more than 12 months. This change is necessary due to Centers for Medicare and Medicaid Services (CMS) changes to timely filing limits for submitting claims for Medicare-FFS reimbursement.

Login to the secure the Web Portal, and select **Claims** from the main menu drop-down.

Next, click on the type of claim that you are filing - **New Dental, New Institutional, or New Professional Claims.**

The New Professional Claim Billing Panels include:

1. Professional Claim Information*
2. Diagnosis
3. Other Payer Claims Data*
4. Other Payer Adjustment Information*
5. Detail
6. Detail Other Payer Information*
7. Detail Other Payer Adjustment*
8. Hard-Copy Attachments*

*Fields and panels important for Medicare crossovers.

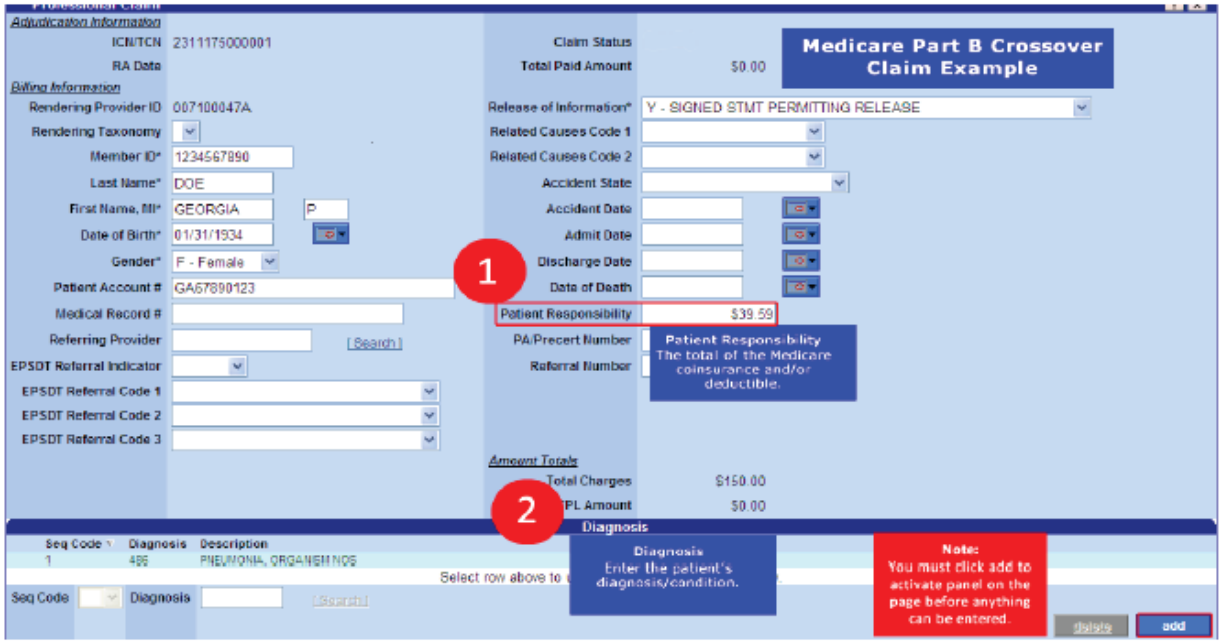
A NOTE ABOUT CLAIM PANELS:

Each field which contains an asterisk (*) represents a required field.

Clicking **add** on a panel will activate the panel for entry. Users only need to click add again if a second record needs to be entered against the claim, otherwise, continue to the next panel.

The claim is not considered complete until all required fields have been completed with the appropriate data.

Steps 1 and 2 – Enter information on the Professional Claim and Enter Diagnosis Information

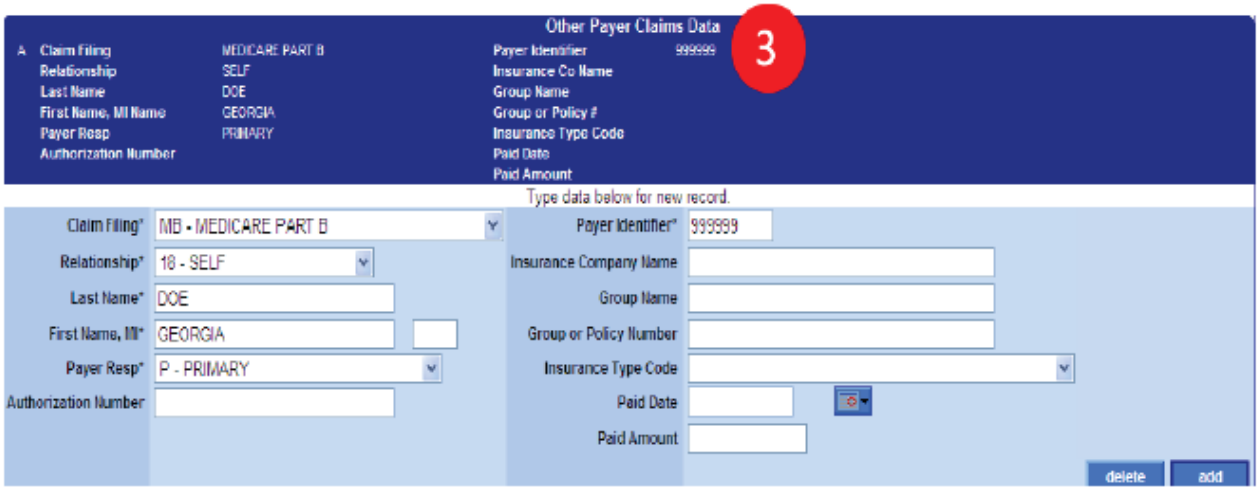


Enter information on the **Professional Claim** panel - complete the billing information and make sure to complete the **Patient Responsibility** field. This should reflect the total amount of the member's Medicare coinsurance and/or deductible.

Enter information on the **Diagnosis** panel - Enter the patient's diagnosis/condition information.

You must click add to activate the panel before anything can be entered or selected.

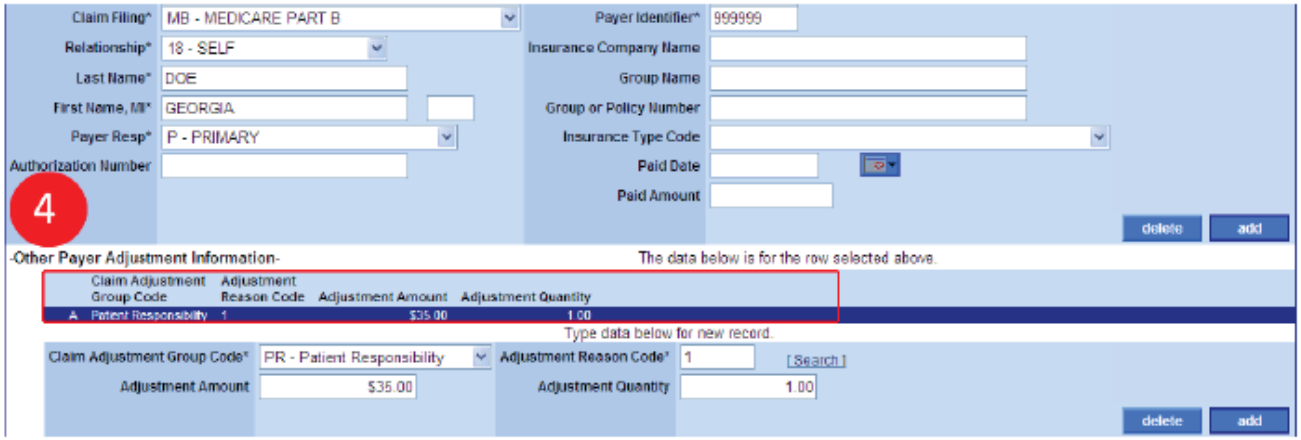
Step 3 – Other Payer Claims Data panel



Entering information on the **Other Payer Claims** panel - This panel allows users to enter insurance information outside of Medicaid, such as Third Party Liability (TPL) or Medicare insurance. This is indicated by selecting the appropriate Claim Filing indicator from the drop-down box, such as Medicare Part A, Medicare Part B, etc., and completing the remaining applicable fields.

You must click add to activate the panel before anything can be entered or selected.

Step 4 - Other Payer Adjustment Information

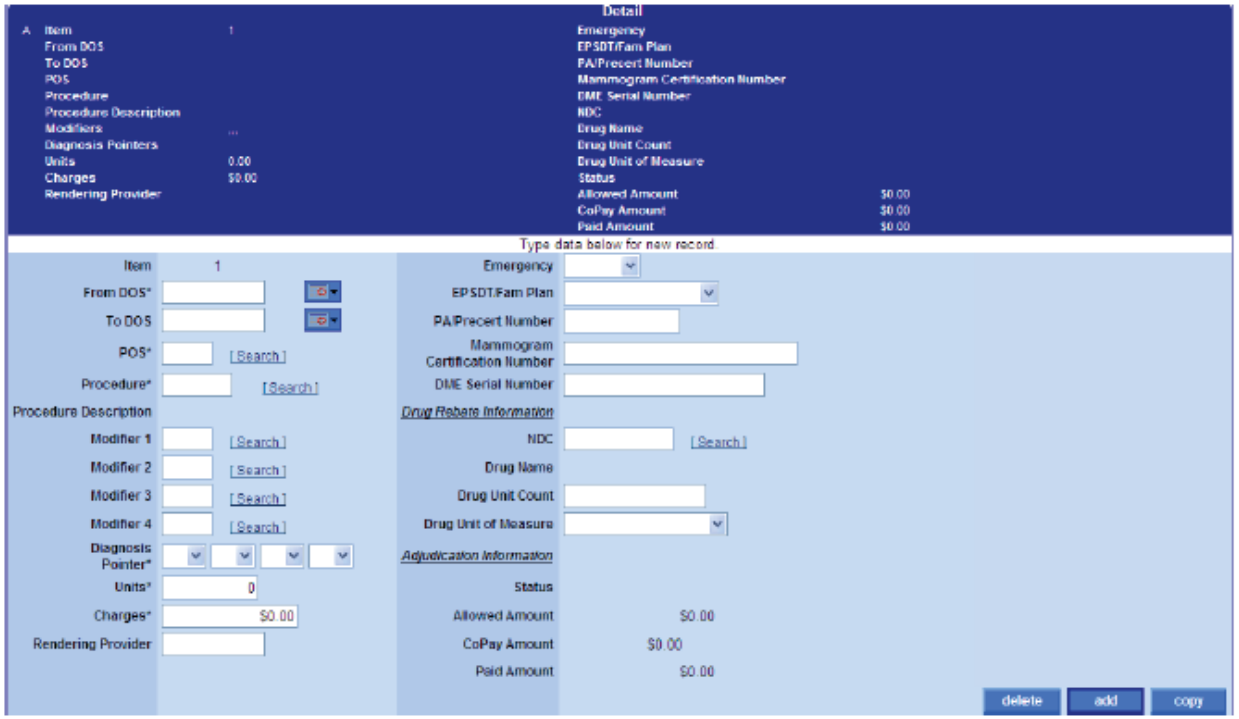


Enter information on the **Other Payer Adjustment Information** panel. This panel allows for the entry of TPL and/or Medicare coinsurance, deductibles, etc to be entered at a header level. When the *Payer ID* selected is **Medicare Part A for an inpatient type of bill**, select the row(s) that appear to enter the appropriate Medicare Coinsurance or Deductible amounts if applicable.

NOTE: The adjustment reason code is a HIPAA required field and is used to identify the reason why the other insurance did not make payment in full.
Click on [Search] for a list of adjustment reason codes.

You must click add to activate the panel before anything can be entered or selected.

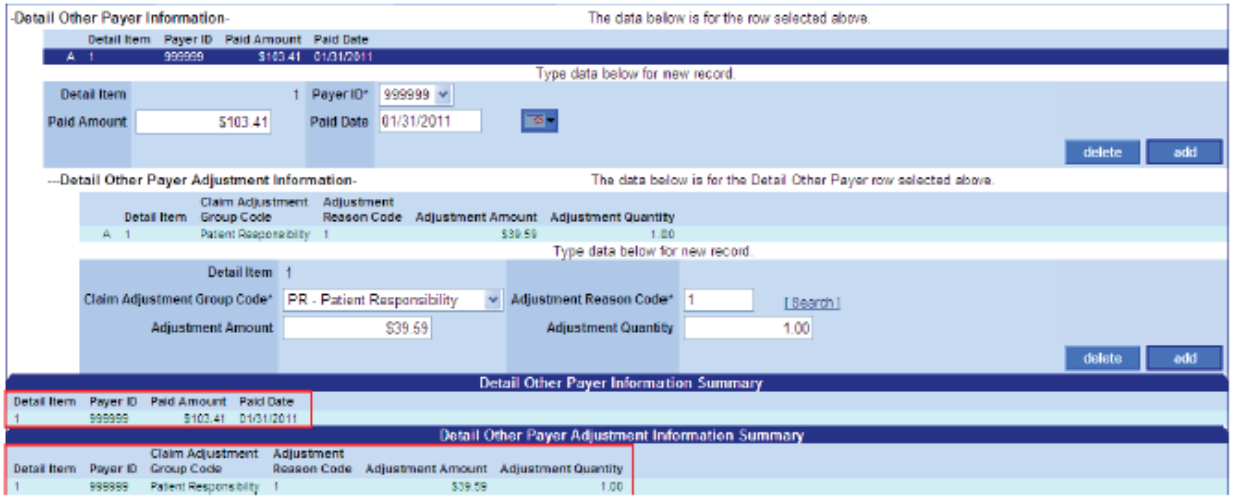
Step 5 – Detail



On the **Detail** panel, enter information about the service (s) being billed.

You must click add to activate the panel before anything can be entered or selected.

Steps 6 and 6a – Detail Other Payer Claims and Detail Other Payer Adjustment panels



Step 6 - Detail Other Payer Information

For each **Detail** item added, providers will complete the **Detail Other Payer Information** panel to indicate TPL and/or Medicare information where applicable. To do so, after clicking add to activate the panel, choose the **Payer ID*** from the drop-down list. *This relates to the Payer Identifier entered on the **Other Payer Claims Data** panel.

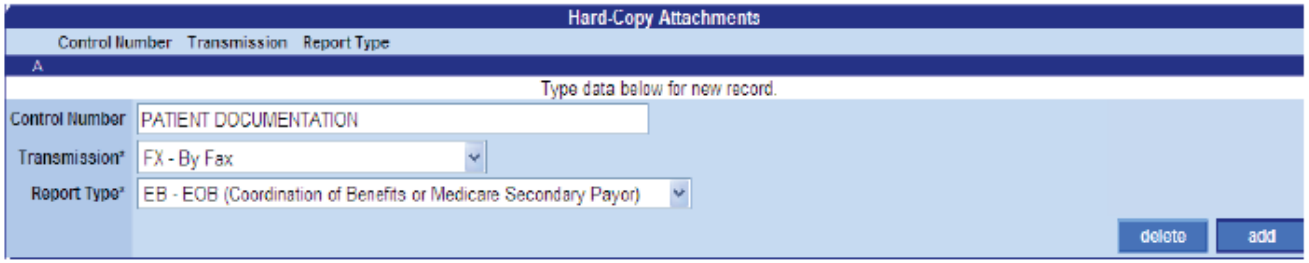
Step 6a- Detail Other Payer Adjustment Information

When the *Payer ID* selected is **Medicare Part B for an outpatient type of bill or professional claim**, select the row(s) that appear on the **Detail Other Payer Adjustment Information** panel to enter the appropriate Medicare Coinsurance or Deductible amounts if applicable.

NOTE: The adjustment reason code is a HIPAA required field and is used to identify the reason why the other insurance did not make payment in full. Click on [Search] for a list of adjustment reason codes.

You must click add to activate the panel before anything can be entered or selected.

Step 7 – Hard-Copy Attachment panel



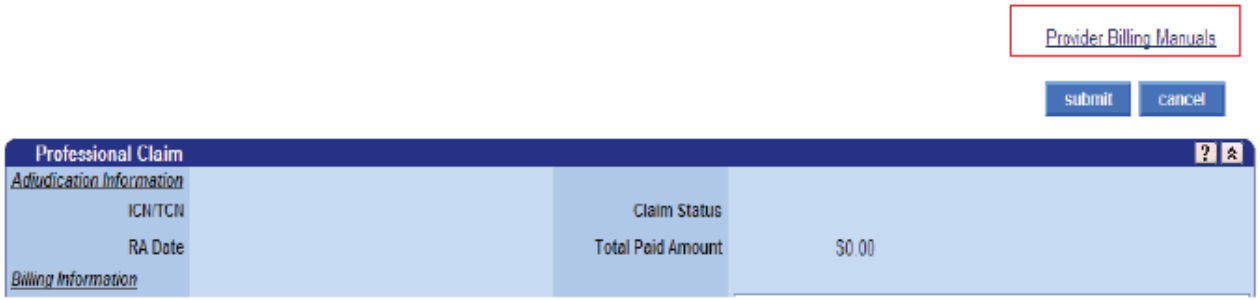
NOTE: The upload capability will be made available when the transmission type is Electronic or File Transfer.

The HP Fax number for attachments is 1-866-483-1044.

Use the Hard-Copy Attachments panel (prior to submitting claim), to attach the Explanation of Medicare Benefits (EOMB) or COB Explanation of Benefits (EOB).

You must click add to activate the panel before anything can be entered or selected.

Step 8 – Submit the New Professional Claim



After completing all of the panels, scroll back to the top of the page and click submit. The claim will be submitted and an ICN (internal control number) will be assigned (if no other web panel edits appear). Please be advised that If you click the **submit** button, and the claim shows in a **Not Submitted** status, the claim may likely contains errors which will displayed at the top of the claim submission panel. Review the errors, by scrolling up to the top of the page to make any necessary corrections. After corrections are made, click the **submit** button again. Links to **Provider Billing Manuals** are located on the top right of the page.

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Medicare/Medicaid Differences/ Scope of Coverage for Medicare

How to File a Crossover Using the secure Web Portal

Where to send Paper Crossover Claim Forms

How to Access Billing Manuals & Crossover Resources

Where to Send Paper Claim Forms (Original and Crossover)

Although paper claims are accepted, providers are encouraged to submit claims electronically through the Georgia Medicaid Web Portal or through PES (Provider Electronic Solution).

CLAIM TYPE	ADDRESS
Original or Resubmitted ADA 2006	ADA Dental Claims P.O. Box 105205 Tucker, Georgia 30085-5205
CMS-1500 Original or Resubmitted	CMS 1500 Claims PO Box 105202 Tucker, GA 30085-5202
CMS-1500 Crossover	CMS-1500 Crossover Claims PO Box 105203 Tucker, GA 30085-5203
Original or Resubmitted UB-04	UB-04 Claims P.O. Box 105204 Tucker, Georgia 30085-5204
UB-04 Crossover	UB-04 Crossover Claims P.O. Box 105203 Tucker, Georgia 30085-5203
Part B Only Inpatient Claims	Medicare Part B Only Inpatient Claims P.O. Box 105208 Tucker, Georgia 30085-5208

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WE HOPE THAT THIS INFORMATION HAS BEEN HELPFUL!

Click here to be taken to the Georgia Medicaid Web Portal

How to Access Billing Manuals & Crossover Resources

Manuals and crossover resources can be accessed from the Georgia Medicaid Web Portal. Go to www.mmis.georgia.gov. Then, from the main menu, select **Provider Information** > **Provider Manuals**.

Then search for:

- Georgia ADA Dental Billing Manual
- Georgia CMS 1500 Billing Manual
- Georgia UB-04 Billing Manual

For specific policy regarding crossovers, search for:

- PART I of the Policies and Procedures for Medicaid/PeachCare for Kids - Chapter 300 (Coordination of Benefits and Third Party Liability); or, The Medicaid Secondary Claims User Guide

IMPORTANT MEDICAID/MEDICARE CROSSOVER INFORMATION:

On 10/18/2010, ACS issued a Provider Notice regarding Medicare Secondary Payment changes.

Please go to www.mmis.georgia.gov and select **Provider Notices** from the **Provider Information** main menu. Then search and select the "Medicare Crossover Claims" publication released on 10/27/2010 to review in detail.