Crossover Claims

To access the PDF version of this presentation, please visit our website: www.mmis.georgia.gov -> Provider Information -> Provider Notices – "Presentation – Crossover Claims"

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Agenda

- Objectives
- Terminology
- General Billing Information
- Web Portal Billing Information
- Interactive Voice Response System (IVRS)
- Session Review
- Closing, Questions and Answers

Objectives

The information presented will enable providers to:

- Identify general billing information.
- Submit Crossover claims on the GAMMIS Web Portal.
- Review and resolve common crossover concerns relating to claim denial.
- Identify and perform functions using the Web Portal.

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 the Medicare payment.

Co-payments: The amount required by Medicare Parts C or D when services are rendered, or drugs are purchased. Medicaid will pay eligible cost share amounts up to the Medicaid maximum allowable amount for the service. Policies and Procedures for Medicaid PeachCare for Kids® Part 1 Manual Division state that payments for Medicare coinsurance and deductible obligations are limited to the Medicaid maximum allowable payment.

Deductible: The dollar amount Medicare members must pay for Part A or Part B services prior to receiving Medicare benefits.

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.

- **Medicare Part A** - Covers inpatient hospital services

- **Medicare Part B** - Covers professional, outpatient hospital, and vendor services.

- **Medicare Part C** - A managed care version of Medicare, also called a Medicare Advantage Plan, offered through private insurance companies. These claims do not crossover from Medicare to Medicaid.

- **Medicare Part D** - Covers prescription drugs.

General Billing Information

- Crossover claims must be received by the Department of Community Health within 12 months of the month of service.

- Medicaid providers must accept Medicare assignment to submit claims to Medicaid for consideration of payment.

- If Medicare denies the claim, providers have 90 days from the Medicare denial date to submit the Medicaid Primary claim with a copy of the Medicare EOB showing the denial attached. Since GA Medicaid is Primary, all Medicaid billing requirements must be followed.

- Medicare crossover claims with a negative Medicare paid amount will not be reimbursed by GA Medicaid.

- Submit the crossover claim to GA Medicaid in the same manner it was billed to Medicare. Do not change anything (i.e. codes, modifiers) from the Medicare claim.

Web Portal Billing Information

Professional Billing Information

- Enter the required information and as much optional information as possible (all items denoted with an asterisk (*) are required fields).
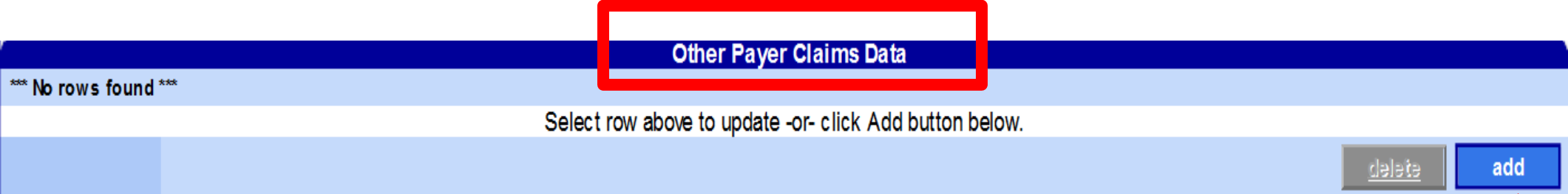
Diagnosis

Allows entry of up to ten diagnoses

1. Click **add** to activate the diagnosis section for each additional diagnosis to be entered.
2. Enter the sequence (diagnosis code pointer) number.
3. Enter the diagnosis [to find a diagnosis code, use the (Search) feature].

Other Payer Claims Data

Click **add** to indicate this is a crossover/ secondary claim and enter all information required.

Other Payer Claims Data

- **Other Insured Identifier is the member identification number for the other insurer.**
- **All areas indicated with an asterisk (*) are required fields.**

Other Payer Claims Data

- Claim Filing indicates how the other payer information is related (e.g., Medicare, Commercial, Blue Cross Blue Shield).
- **Medicare Part B also includes the Advantage Plans**.

Other Payer Adjustment Information

-Other Payer Adjustment Information-   The data below is for the row selected above.

*** No rows found ***

Select row above to update -or- click Add button below.

Claim Adjustment Group Code [V]   Adjustment Reason Code [   ] [Search]

Adjustment Amount [   ]   Adjustment Quantity [   ]

[delete] [add]

Other Payer Adjustment Information Summary

Payer ID	Insurance Company Name	Claim Adjustment Group Code	Adjustment Reason Code	Adjustment Amount	Adjustment Quantity
				$0.00	0.00

Detail

**Bypass this Other Payer Adjustment Information panel.

Detail Panel

Professional Claim Detail Panel

1. Click **add** to add up to 50 lines.
2. Click **copy** to duplicate information.
3. Click **delete** to delete details entered.

Detail Panel 1, 2, 3

Detail		

A Item 3   Emergency
From DOS   EPSDT/Fam Plan
To DOS   PA/Precert Number
POS   Mammogram Certification Number
Procedure   DME Serial Number
Procedure Description   Ordering Provider ID
Modifiers ...   Ordering Provider Name
Diagnosis Pointers   NDC
Units 0.00   Drug Name
Charges $0.00   Drug Unit Count
Rendering Provider ID   Drug Unit of Measure
Referring Provider ID   Status
Referring Provider Name   Allowed Amount $0.00
Primary Care Provider ID   CoPay Amount $0.00
Primary Care Provider Name   Paid Amount $0.00

A Item 2   Emergency
From DOS   EPSDT/Fam Plan
To DOS   PA/Precert Number
POS   Mammogram Certification Number
Procedure   DME Serial Number
Procedure Description   Ordering Provider ID
Modifiers ...   Ordering Provider Name
Diagnosis Pointers   NDC
Units 0.00   Drug Name
Charges $0.00   Drug Unit Count
Rendering Provider ID   Drug Unit of Measure
Referring Provider ID   Status
Referring Provider Name   Allowed Amount $0.00
Primary Care Provider ID   CoPay Amount $0.00
Primary Care Provider Name   Paid Amount $0.00

A Item 1   Emergency
From DOS   EPSDT/Fam Plan
To DOS   PA/Precert Number
POS   Mammogram Certification Number
Procedure   DME Serial Number
Procedure Description   Ordering Provider ID
Modifiers ...   Ordering Provider Name
Diagnosis Pointers   NDC
Units 0.00   Drug Name
Charges $0.00   Drug Unit Count
Rendering Provider ID   Drug Unit of Measure
Referring Provider ID   Status
Referring Provider Name   Allowed Amount $0.00
Primary Care Provider ID   CoPay Amount $0.00
Primary Care Provider Name   Paid Amount $0.00

Detail Other Payer Information

Enter information on the Other Payer Information panel. This panel allows you to tell us:

- Paid date for each active line.
- What has been paid.
- What is due to be paid.
- Any adjustments indicated from the primary carrier.

Detail Other Payer Information

(continued)

All fields must be completed with the payment information from the primary payer:
- Paid Amount - the amount paid for the specific detail line from the primary payer.
- Paid Date - EOMB payment date for this claim.
- Payer ID - the primary payer ID (found at www.mmis.georgia.gov Provider Information, Reports, and Carrier master list).

Please make sure that the information entered for the primary carrier is for the specific detail line you entered – i.e. enter payment for Detail Item 1 under Detail Item 1 of Detail Other Payer Information section.

Detail Other Payer Adjustment Information

This panel allows the provider to indicate what payment is expected from Medicaid.

• Claim Adjustment Group: Patient Responsibility, Contractual Obligation
• Adjustment Reason Code:
   o Co-Insurance is indicated by a number 2.
   o Deductible is indicated by a number 1.

Detail Other Payer Adjustment Information

(continued)

This area allows you to tell us what payment is being requested and for what reason.
- **Adjustment Reason codes (1) deductible and (2) co-insurance are automatically populated.**

Detail Other Payer Adjustment Information

(continued)

- Claim Adjustment Group Code: Drop down arrow give the option to select the reason for adjustment.
- Adjustment Reason Code: Offers a search option for code description.

Additional Detail Other Payer Adjustment

To enter adjustment for additional detail lines:

➢ Select/Highlight the detail line from the Detail panel.
➢ Return to Detail Other Payer Information Panel.
➢ Select **add** to activate the panel for next detail line.

Detail Summary Information

Detail Other Payer Information Summary			
Detail Item	Payer ID	Paid Amount	Paid Date
1	12345	$45.00	04/02/2015
2	12345	$300.00	04/02/2015

Detail Other Payer Adjustment Information Summary					
Detail Item	Payer ID	Claim Adjustment Group Code	Adjustment Reason Code	Adjustment Amount	Adjustment Quantity
1	12345	Patient Responsibility	2	$10.00	0.00
1	12345	Patient Responsibility	1	$25.00	0.00
2	12345	Patient Responsibility	2	$0.00	0.00
2	12345	Patient Responsibility	1	$150.00	0.00

- Detail Other Payer Information Summary indicates what was paid by the primary carrier.
- Detail Other Payer Adjustment information summary indicates what adjustments were made and what payments are being submitted for reimbursementon this claim.

Submitting or Uploading Hard Copy Attachments

Hard Copy Attachments

1. Click **add** to activate the Hard Copy Attachment panel.

- **Control Number**: a number or reference for your company.

- **Transmission**: how the document will be sent (upload only).

- **Report Type**: the type of document being sent.

Hard Copy Attachments
Section B

HIPAA Attachment Codes

CT - Member Eligibility Certification
OZ - Miscellaneous Other
EB - Medicare EOMB
EB - Third party Liability (TPL)
EB - Remittance Advice (RA)

These are the codes that pertain to secondary claims. Other acceptable codes can be found on the dropdown list.

Hard Copy Attachments

Hard-Copy Attachments		
Control Number Transmission Report Type		
A		
Type data below for new record.		
Control Number 987654		
Transmission* EL - Electronic Upload		
Report Type* EB - EOB (Coordination of Benefits or Medicare Secondary Payor)		
Claim Status Information		
Claim Status Not Submitted yet		

top of page ←   top of page

Provider Billing Manuals

You are now ready to submit your claim.
- Click **top of page**.
- Click **submit**.

→ submit   cancel

Hard Copy Attachments

(continued)

If the claim suspends, the Hard Copy Attachments panel will display an upload button. Click upload

Hard Copy Attachments

(continued)

➢ Highlight the row the attachment appears.

➢ Click **Upload Attachment**.

➢ The attachment is loaded successfully and associated to the suspended ICN.

Hard Copy Attachments

(continued)

The MMIS will display the message:
"**Attachment Successfully Attached**"

Timely Filing
And
Claims Adjustments

Timely Filing Rules

For crossover claims, timely filing is 12 months from the month the service (MOS) was rendered by the provider.

- Claim adjustment – Within three months of the month of payment
- Claim resubmission – Within three months of the month the denial occurred

Claims Adjustment

Medicare and Medicare Advantage plans claims

➢ If Medicare adjusts the claim, providers have 90 days from the Medicare adjustment date to update the GA Medicaid claim.

➢ If Medicare does an adjustment to a previously paid claim, use the DMA-501 form along with the adjusted EOMB.

Note: Be sure to check the appropriate box in Field 4 for the reason for the adjustment. In this situation it would be C.

DMA-501 Adjustment Request Form

ADJUSTMENT REQUEST FORM

Adjustment Requests must be received within three months from the month of Medicaid payment.

1. Internal Control Number (ICN) of the **paid** claim to be adjusted as shown on the Remittance Advice	3. Provider Name/Address
Member Medicaid Information 2. Medicaid Number Member Name (Last, First, Initial)	Provider Number: Phone Number ( ) Contact Person

4. Reason for adjustment (check one box)

- [ ] A. Member Medicaid ID linking issue
- [ ] B. Payee Change
- [ ] C. Provider receives payment from a third party such as Medicare after Medicaid has made a payment and the adjustment/claim is untimely. (attach all EOMBs that apply to this adjustment)
- D. Patient Liability update - provider receives an updated Summary Notification Letter indicating the member's patient liability amount changed after the 90 day adjustment window and the claim is untimely.

5. Please list the information to be corrected in Blocks 5A-5D. If the information to be corrected does not have a line number enter z e r o in the line number field. COB applied should always be line #0.

5A Line to be Corrected	5B Information to be Changed	5C From (Current) Information	5D To (Corrected)

6. Explanation for Adjustment

7. FOR DCH USE ONLY

CCN_____FS Line Amount $ _____

Provider Signature_____Date _____

Frequently Asked Questions:

Q: What is a crossover claim?

❖ **A:** A claim for services rendered to a member eligible for benefits under both Medicaid and Medicare programs. Medicare benefits must be processed prior to Medicaid benefits.

Q: What is timely filing on a crossover claim?

❖ **A**: Claims in this category must be received within 12 months from the month of service. A provider must wait at least 45 days from the date of payment by Medicare and not automatically sent by the Medicare Carrier or Intermediary to submit a Medicare crossover claim.

Q: All of my crossover claims are being denied?

❖ **A:** Please check the denial code and make sure all required information is being provided on the claim. You should get a PAID claim even if Medicaid is making no payment because Medicare paid more than Medicaid allowed.

Frequently Asked Questions:
(continued)

Q: Does Medicaid make any payment after Medicare?
- ❖ **A:** Medicaid pays up to the Medicaid approved amount and the Medicare yearly deductible for covered services.

Q: Does Medicare automatically crossover to Medicaid?
- ❖ **A:** If Medicare has the covered member's Medicaid information a claim should automatically crossover. Medicare Advantage Plans do not automatically crossover. They will have to be entered manually on the GAMMIS Web Portal.

Q: Do Medicare Advantage Plans automatically crossover?
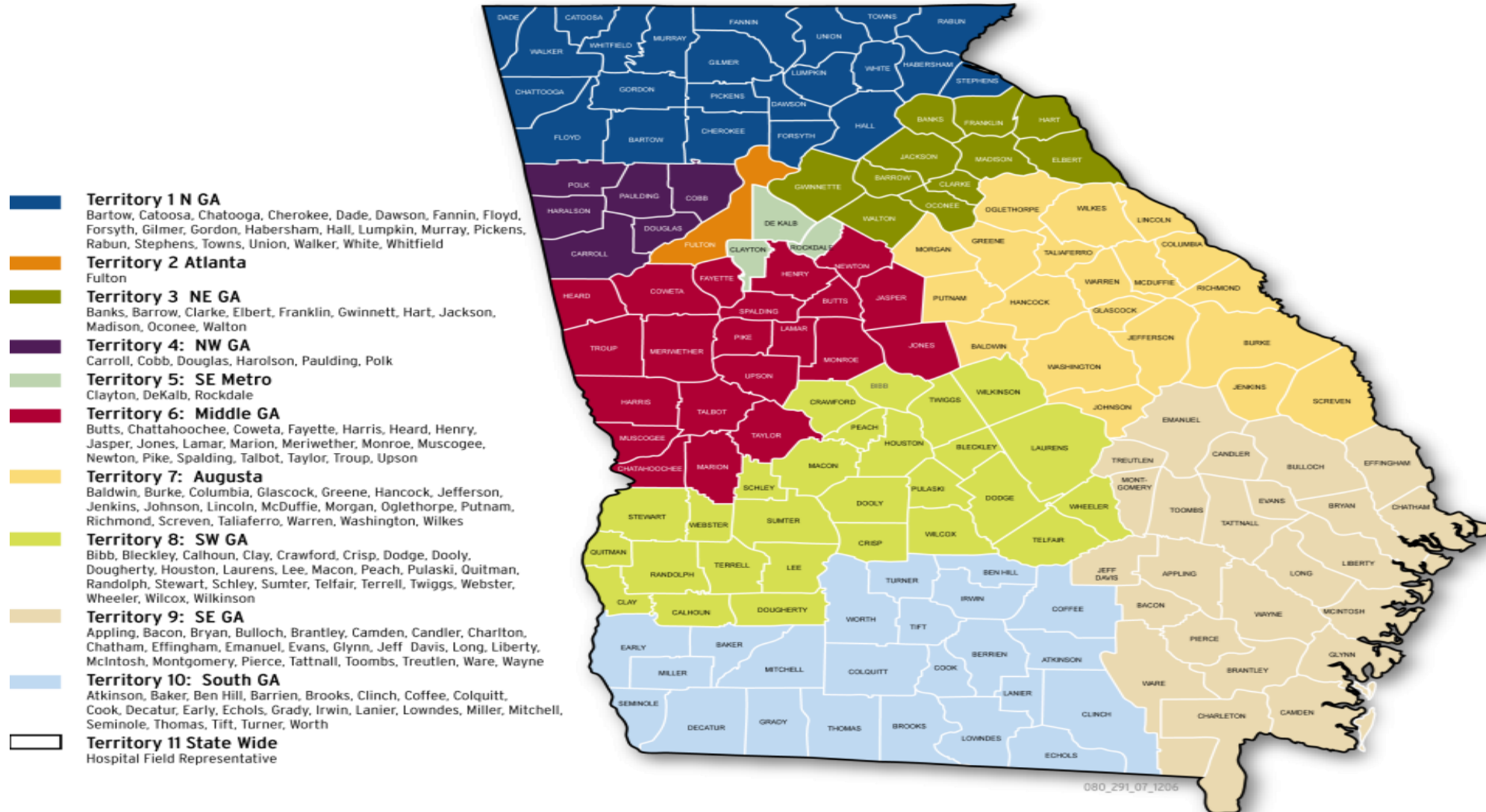- ❖ **A:** No. They will have to be entered manually on the GAMMIS Web Portal.

Q: How do I manually enter a crossover claim?
- ❖ **A:** There is a crossover claim manual on the GAMMIS Web Portal under Provider Information – Web Portal Training that has step-by-step instructions. You can also request an on-site visit from your Provider Relations Representative.

Georgia Field Territories

Territory 1 N GA
Bartow, Catoosa, Chatooga, Cherokee, Dade, Dawson, Fannin, Floyd, Forsyth, Gilmer, Gordon, Habersham, Hall, Lumpkin, Murray, Pickens, Rabun, Stephens, Towns, Union, Walker, White, Whitfield

Territory 2 Atlanta
Fulton

Territory 3 NE GA
Banks, Barrow, Clarke, Elbert, Franklin, Gwinnett, Hart, Jackson, Madison, Oconee, Walton

Territory 4: NW GA
Carroll, Cobb, Douglas, Harolson, Paulding, Polk

Territory 5: SE Metro
Clayton, DeKalb, Rockdale

Territory 6: Middle GA
Butts, Chattahoochee, Coweta, Fayette, Harris, Heard, Henry, Jasper, Jones, Lamar, Marion, Meriwether, Monroe, Muscogee, Newton, Pike, Spalding, Talbot, Taylor, Troup, Upson

Territory 7: Augusta
Baldwin, Burke, Columbia, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, McDuffie, Morgan, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

Territory 8: SW GA
Bibb, Bleckley, Calhoun, Clay, Crawford, Crisp, Dodge, Dooly, Dougherty, Houston, Laurens, Lee, Macon, Peach, Pulaski, Quitman, Randolph, Stewart, Schley, Sumter, Telfair, Terrell, Twiggs, Webster, Wheeler, Wilcox, Wilkinson

Territory 9: SE GA
Appling, Bacon, Bryan, Bulloch, Brantley, Camden, Candler, Charlton, Chatham, Effingham, Emanuel, Evans, Glynn, Jeff Davis, Long, Liberty, McIntosh, Montgomery, Pierce, Tattnall, Toombs, Treutlen, Ware, Wayne

Territory 10: South GA
Atkinson, Baker, Ben Hill, Barrien, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Early, Echols, Grady, Irwin, Lanier, Lowndes, Miller, Mitchell, Seminole, Thomas, Tift, Turner, Worth

Territory 11 State Wide
Hospital Field Representative

Provider Relations Field Services Representatives

Territory	Region	Rep
1	North Georgia	Deandre Murray
2	Fulton	Adrian Hogan
3	NE Georgia	Carolyn Thomas
4	NW Georgia	Danny Williams
5	SE Metro	Ebony Hill
6	Middle Georgia	Shawnteel Bradshaw
7	Augusta	Jessica Bowen
8	SW Georgia	Jill McCrary
9	SE Georgia	Kendall Telfair
10	South Georgia	Anitrus Johnson
North	Hospital Rep	Sherida Banks
South	Hospital Rep	Janey Griffin

Contact My Provider Rep Directly

Login to the MMIS system with your username and password

Contact My Provider Rep Directly

(continued)

Select the Web Portal Option

Contact My Provider Rep Directly

(continued)

Select Contact Information, Contact Us

Contact My Provider Rep Directly

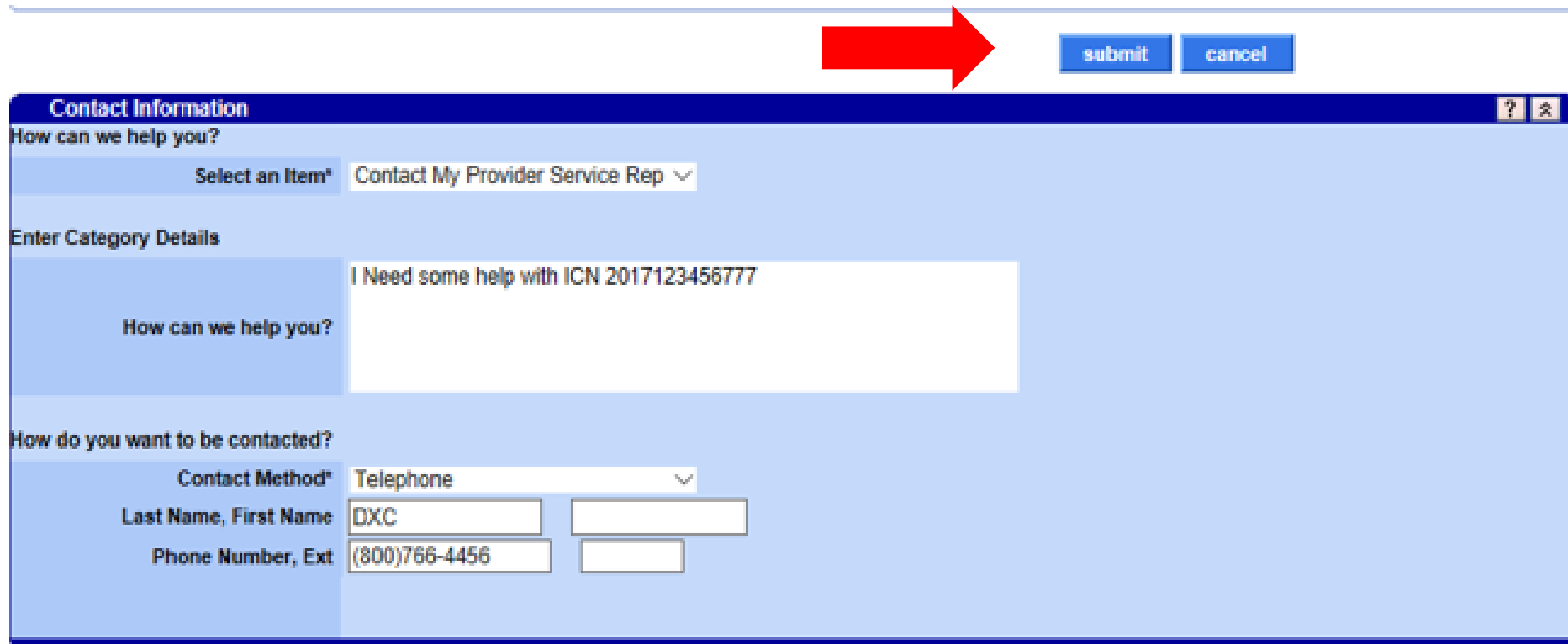*(continued)*

Select an Item

Contact My Provider Rep Directly

(continued)

Contact My Provider Rep Directly

(continued)

Please provide all details pertaining to your issue, including ICN, member ID, etc.

Contact My Provider Rep Directly

(continued)

The following messages were generated:

Your request has been processed. Your tracking number is **20763193.**

Providers may call the Provider Contact Center at (770) 325-9600 or toll-free at (800) 766-4456. Members may call the Member Contact Center at (770) 325-2331 or toll-free at (866) 211-0950.

Contact Information

How can we help you?

Select an Item* : Contact My Provider Service Rep

Enter Category Details

How can we help you? : test

How do you want to be contacted?

Contact Method* : Telephone

Last Name, First Name : HP | test

Phone Number, Ext : (800)766-4456 |

Provider Services Contact Center

PSCC assists providers with inquiries regarding claims status, eligibility coverage, prior authorization, remittance advice, demographic changes, and other Medicaid questions. PSCC is available:

- 1-800-766-4456
- Monday through Friday (excluding state holidays)
- 7 a.m. to 7 p.m. Eastern Standard Time
- Providers can also use the "Contact Us" link on GAMMIS

Contacting Gainwell Technologies

- Interactive Voice Response System (IVRS)

- Provider Services Contact Center (PSCC)

- Georgia Medicaid Management Information System (GAMMIS)

- Provider Relations Representatives

IVRS Overview

The Interactive Voice Response System (IVRS) allows users to call and conduct inquiries or transactions on the Georgia Medicaid Management Information System (GAMMIS) using a touch-tone telephone.

800-766-4456	
Option 1	Member Eligibility
Option 2	Claims Status
Option 3	Payment Information
Option 4	Provider Enrollment
Option 5	Prior Authorization
Option 6	GAMMIS website password reset, Pharmacy Benefits, the Nurse Aide Registry or Nurse Aide Training program, PeachCare for Kids® EDI submission or electronic claim submission, or a system overview

Session Review

You should now be able to:

- Identify general billing information and policy changes
- Explain how to submit crossover claims
- Resolve common crossover concerns relating to claim denials
- Perform functions using the IVRS and Web Portal

Closing

Questions and Answers