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Affected Programs: BadgerCare Plus, Medicaid, SeniorCare, Wisconsin Chronic Disease Program
To: All Providers, HMOs and Other Managed Care Programs

Medicare Crossover Claims for ForwardHealth Providers

As a result of the implementation of ForwardHealth interChange in November 2008, ForwardHealth is making changes to the way Medicare crossover claims are processed. This *ForwardHealth Update* provides information on the changes and introduces Medicare crossover claims to Wisconsin Chronic Disease Program providers.

ForwardHealth interChange

In November 2008, the Department of Health Services (DHS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

As a result of the implementation of ForwardHealth interChange, ForwardHealth is making changes to the way crossover claims are processed. This *Update* informs Medicaid, BadgerCare Plus, and SeniorCare providers of these changes and introduces crossover claims to Wisconsin Chronic Disease Program (WCDP) providers.

Definition of a Dual Eligible and Medicare Crossover Claim

Dual eligibles are members who are eligible for coverage from Medicare (either Medicare Part A, Part B or both) and Wisconsin Medicaid or BadgerCare Plus. A Medicare crossover claim is a Medicare-allowed claim for a dual eligible, Qualified Medicare Beneficiary-Only (QMB-Only) member or a member eligible for Medicare and WCDP, sent to ForwardHealth for payment of coinsurance, copayment, and deductible. A QMB-Only member is a member of a limited benefit category of Medicaid. They are eligible for coverage from Medicare and limited coverage from Wisconsin Medicaid.

Submit Medicare claims first, as appropriate, to one of the following:

- Medicare Part A fiscal intermediary.
- Medicare Part B carrier.
- Medicare durable medical equipment regional carrier (DMERC).
- Medicare Advantage Plan.
- Railroad Retirement Board carrier (also known as the Railroad Medicare carrier).

Types of Crossover Claims

There are two types of crossover claims based on who submits them to ForwardHealth:

- Automatic crossover claims.
- Provider-submitted crossover claims.

Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to ForwardHealth by the Coordination of Benefits Contractor (COBC).

Claims will continue to be forwarded to ForwardHealth if the following occur:

- Medicare has identified that the services were provided to a dual eligible, a QMB-Only member, or a member enrolled in Medicare.
- The claim is for a member who is not enrolled in a Medicare Advantage Plan.

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is any Medicare-allowed claim that providers submit directly to ForwardHealth. Providers should submit a provider-submitted crossover claim in the following situations:

- The automatic crossover claim does not appear on the ForwardHealth Remittance Advice (RA) within 30 days of the Medicare processing date.
- ForwardHealth denied the automatic crossover claim and additional information may allow payment.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
- The claim is for a member who was not eligible for ForwardHealth at the time the service was submitted to Medicare for payment, but the member was retroactively determined eligible for a ForwardHealth program.
- The claim is for a member who is enrolled in a Medicare Advantage Plan.

Providers may initiate a provider-submitted claim in one of the following ways:

- Direct Data Entry (DDE) through the ForwardHealth Provider Portal
- 837 Health Care Claim: Institutional transaction, as applicable.
- 837 Health Care Claim: Professional (837P) transaction, as applicable.
- Provider Electronic Solution (PES) software.
- Paper claim form.

When submitting crossover claims directly to ForwardHealth, the following additional data may be required on the claim to identify the billing and rendering provider:

- The National Provider Identifier (NPI) that ForwardHealth has on file for the provider.
- Taxonomy code that is required by ForwardHealth.
- The ZIP+4 code that corresponds to the practice location address on file with ForwardHealth.

Refer to the August 2008 *Update* (2008-148), titled "National Provider Identifier Requirements with Implementation of ForwardHealth interChange," for more information.

Automatic Medicare Crossover Claims and National Provider Identifiers

Secondary NPI

Medicare requires that certain subparts of an organization obtain separate NPIs and use the NPI for billing Medicare (e.g., hospital psychiatric unit). If an organization has identified subparts for the purpose of submitting claims to Medicare, and the NPIs appear on automatic crossover claims to ForwardHealth, ForwardHealth considers the NPIs submitted to Medicare to be secondary NPIs. ForwardHealth will process automatic crossover claims using secondary NPIs in cases where the provider has reported a secondary NPI to ForwardHealth. Along with the NPI, providers

should also indicate the taxonomy and ZIP+4 code information.

Professional Crossover Claims

Professional crossover claims received by ForwardHealth from Medicare may not have the taxonomy code of the billing provider indicated on the transaction. Medicare will not accept the 837P transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop (2000A) and in the Rendering Provider Loop (2310B) if the billing and rendering providers are different. For example, a transaction with a physician group indicated as the billing provider and the individual physician indicated as the rendering provider.

Providers should resubmit professional crossover claims to ForwardHealth when the taxonomy code is required to identify the billing provider and it is not indicated on the crossover claim received from Medicare. ForwardHealth will accept the 837P transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop (2000A) and in the Rendering Provider Loop (2310B) and the billing and rendering providers are different.

Taxonomy Code Designated by ForwardHealth

The taxonomy code indicated on automatic crossover claims received from Medicare may be different than the taxonomy designated by ForwardHealth. Providers should resubmit the claim to ForwardHealth when the taxonomy code designated by ForwardHealth is required to identify the provider and is not indicated on the crossover claim received from Medicare.

Refer to *Update* 2008-148 for more information.

Reporting Medicare Crossover Claims on the Remittance Advice

ForwardHealth must be able to identify the billing provider in order to report paid or denied Medicare crossover claims information on the RA. Claims with an NPI that fails to appear on the provider's RA are an indication that there is a problem with the matching and identification of the billing provider and the claims were denied.

ForwardHealth is not able to identify the billing provider on automatic crossover claims submitted by health care providers in the following situations:

- The billing provider's NPI has not been reported to ForwardHealth.
- The taxonomy code designated by ForwardHealth is required to identify the billing provider and is not indicated on the automatic crossover claim
- The billing provider's practice location ZIP+4 code on file with ForwardHealth is required to identify the provider and is not indicated on the automatic crossover claim.

If automatic crossover claims do not appear on the RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth using the NPI that was reported to ForwardHealth as the primary NPI. Additionally, the taxonomy code designated by ForwardHealth and the ZIP+4 code of the practice location on file with ForwardHealth are required when an additional date is needed to identify the provider.

Professional Crossover Claims

Rendering Provider

With the implementation of ForwardHealth interChange, providers are required to indicate the rendering provider on electronic and paper crossover claims when ForwardHealth service-specific policy requires a rendering provider.

Electronic Crossover Claims

Providers submitting crossover claims electronically must indicate all Medicare coinsurance, copayment, and psychiatric reduction amounts at the detail level. If the Medicare coinsurance, copayment, and psychiatric reduction amounts are indicated at the header level, the claim will be denied. Providers may indicate deductibles in either the header or detail level.

When submitting electronic Medicare crossover claims, providers should *not* submit paper Explanation of Medicare Benefits (EOMB) or Medicare RAs as an attachment. Providers should, however, be sure to complete Medicare CAS segments when submitting 837 transactions.

Paper Crossover Claims Require Provider Signature

All paper provider-submitted crossover claims submitted on the 1500 Health Insurance Claim Form and processed after interChange implementation will require a provider signature and date in Element 31. The words "signature on file" will no longer be acceptable. Provider-submitted crossover claims without a signature or date will be denied or be subject to recoupment. The provider signature requirement for paper crossover claims is the same requirement for all other paper 1500 Health Insurance Claims.

Medicare Advantage Plan

Paper Crossover Claims

Providers are required to indicate "MMC" in the upper right corner of provider-submitted crossover claims for services provided to members enrolled in a Medicare Advantage Plan. The claim must be submitted with a copy of the Medicare EOMB. This is necessary in order for ForwardHealth to distinguish whether the claim has been processed as commercial managed care or Medicare managed care.

Reimbursement Limits

In the current system, the copayment for Medicare Advantage Plan crossover claims was paid as billed. With the implementation of ForwardHealth interChange, Medicaid reimbursement limits on Medicare Part B services will now be applied to all Medicare Advantage Plan copayment amounts in accordance with federal law. This may reduce reimbursement amounts in some cases.

Pricing for Outpatient Hospital Crossover Claims

With the implementation of interChange, ForwardHealth will have a new way of pricing outpatient hospital crossover claims for BadgerCare Plus, Medicaid, and WCDP providers that will be more in line with how Medicare processes claims.

After implementation, pricing will no longer be based on the claim summary information. Detail-level information will be used to calculate pricing for all outpatient hospital crossover claims and adjustments. Details that Medicare paid in full or that Medicare denied in full will not be considered when pricing outpatient hospital crossover claims. Medicare deductibles continue to be paid in full.

Providers may use the following steps to determine how reimbursement was calculated:

1. Sum all of the detail Medicare paid amounts to establish the Claim Medicare paid amount.
2. Sum all of the detail Medicare coinsurance or copay amounts to establish the Claim Medicare coinsurance or copay amount.
3. Multiply the number of dates of service by the provider's rate-per-visit. For example, $100 (rate-per-visit) x 3 (dates of service) = $300. This is the Medicaid gross allowed amount.
4. Compare the Medicaid gross allowed amount calculated in step 3 to the Claim Medicare paid amount calculated in step 1. If the Medicaid gross allowed amount is less than or equal to the Medicare paid amount, ForwardHealth will make no further

payment to the provider for the claim. If the Medicaid gross allowed amount is greater than the Medicare paid amount, the difference establishes the Medicaid net allowed amount.

5. Compare the Medicaid net allowed amount calculated in step 4 and the Medicare coinsurance or copay amount calculated in step 2. ForwardHealth reimburses the lower of the two amounts.

Submitting Adjustments for Inpatient Hospital and Nursing Home Crossover Claims

Revenue code/charges will no longer be combined under revenue code 0018 or 0160 on institutional crossover claims. Revenue codes 0018 and 0160 are used internally in the in the current system in place of the revenue codes billed to Medicare because the number of details on the claim could exceed the maximum allowed by Wisconsin Medicaid. This will not be necessary with the implementation of ForwardHealth interChange as the system will be able process claims with the maximum number of allowed details (i.e., 50 details on a paper claim, 999 details on an 837 electronic claim).

ForwardHealth's paper RA and the 835 Health Care Claim Payment/Advice will show the revenue code/charge for each detail as processed by Medicare. Therefore, providers who want to adjust a crossover claim that processed under revenue codes 0018 or 0160 must submit an Adjustment/Reconsideration Request form, F-13046 (10/08), along with the Medicare EOMB showing all revenue codes and amounts from the original Medicare claim.

Medicare Crossover Claims for Wisconsin Chronic Disease Program members

With the implementation of ForwardHealth interChange, all requirements and procedures for Medicare crossover claims apply to WCDP members who are also covered by Medicare.

Information Regarding Managed Care

This *Update* contains only our fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *dhs.wisconsin.gov/forwardhealth/*.

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