Billing and Reimbursement Guideline: Cross Over Claims for Dual Eligible Members

Guideline Publication Date: December 31, 2013

Key coding, documentation and reimbursement points include:

Cross Over Claims for Dual Eligible Members

Prior to November 1, 2013, claims for individuals with both Medicare and Medicaid coverage (dual eligible) would automatically "crossover" to Medicaid FFS after Medicare is paid as the primary insurance. Effective November 1, 2013, all providers who bill Medicare Part A and B for services, whose claims get sent to Medicaid Fee-For-Service, will have their claims denied payment by Medicaid FFS. This is a **temporary** situation involving crossover claims for dual eligible and a fix is underway and will be resolved by spring 2014. In the meantime, denied claims from Medicaid FFS will say "Recipient is covered under *Rhody Health Options*; please bill Neighborhood Health Plan of RI

For Medicare and Medicaid members/ Neighborhood will reimburse the Medicaid obligation of a Medicare claim, or will reimburse for Medicare covered services once the Medicare benefit has been exhausted, in addition to the services that Medicare denies as non-covered. Neighborhood will be using the "lesser of "logic to process these cross over claims. The claim adjudicates and is paid at the "lessor of" the Neighborhood allowable minus the Medicare payment or the coinsurance and/or deductible.

- If Medicare paid more than the Neighborhood allowed amount per fee schedule, payment is zero.
- If Medicare denies the entire service, Neighborhood will process a claim for covered services at a contracted fee schedule for participating providers. Neighborhood will process a claim for covered services at an out of network rate for non contracted providers.
- If Neighborhood's allowed per fee schedule is greater than Medicare's payment amount, the lessor of logic is applied. Lessor of logic states Neighborhood pays the smallest sum of: *Sum of the difference between Neighborhood's allowed minus Medicare payment amount or Sum of co-insurance and/or deductible for service*

Example One:
Medicare paid $80, Neighborhood Fee Schedule allows $60, payment is zero.

Example Two:

Neighborhood Fee Schedule allows $40.00 and Medicare paid $30.00. Difference is $10.00. Medicare has applied co-insurance and deductible of 25.70.

In this case the sum of the difference is "lesser than" the co-insurance and/or deductible. Neighborhood pays $10.00.

Example Three:

Neighborhood Fee Schedule allows $40.00 and Medicare paid $30.00. Difference is $10.00.

Medicare has applied co-insurance and deductible of $6.40.

In this case the co-insurance and/or deductible is "lesser than" the sum of the difference. Neighborhood pays $6.40.

Please note BH/SA (Behavioral Health and Substance Abuse) claims should be submitted directly to Beacon Health for consideration. Claims processed by Neighborhood for these services will deny "DENIED-RESUBMIT TO BEACON HEALTH".

Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.

This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.