SECTION II - MEDICARE/MEDICAID CROSSOVER ONLY

CONTENTS

200.000 MEDICARE/MEDICAID CROSSOVER ONLY GENERAL INFORMATION

The following sections provide participation requirements for each provider type whose services are included in this manual.

201.000 Arkansas Medicaid Participation Requirements for Medicare/Medicaid Crossover Only Providers Located in the State of Arkansas — 10-15-09

Providers of Medicare (Title XVIII) covered services who are interested in participating in the Medicaid (Title XIX) Program solely for the Arkansas Medicaid payment of Medicare coinsurance and deductible amounts (for services not covered by Medicaid) and/or do not meet the enrollment criteria for other Medicaid programs, must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual to be eligible to participate in the Arkansas Medicaid Program.

Providers must be enrolled in the appropriate Title XVIII (Medicare) Program and accept Medicare assignment on all claims filed on behalf of dually Medicare / Arkansas Medicaid beneficiaries, including Qualified Medicare Beneficiaries (QMB).

202.000 Providers in Arkansas and Bordering States — 10-15-09

Providers of Title XVIII (Medicare) covered services in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as routine services providers if they meet the participation and enrollment criteria as specified in Section 201.000.

Routine Services Provider

A. Provider is enrolled in the program as a regular Medicare/Medicaid Crossover Only provider of routine services.

B. Reimbursement will only be for beneficiary cost share for paid Medicare-covered services.

C. Claims must be filed according to the specifications in this manual.

202.100 Providers in States Not Bordering Arkansas 3-1-11

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as Medicare/Medicaid Crossover Only limited services providers only after they have provided services to an Arkansas Medicaid Qualified Medicare Beneficiary (QMB) and have a claim or claims for Medicare cost share to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and documentation, as outlined in Section 140.000 of this manual, along with a claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit contact information.**

B. Providers must be enrolled in the appropriate Title XVIII (Medicare) Program and accept Medicare assignment on all claims filed on behalf of dually eligible Medicare/Arkansas Medicaid beneficiaries, including Arkansas Medicaid QMBs.

C. Limited services providers remain enrolled for one year.

1. If a limited services Medicare/Medicaid Crossover Only provider provides services to another Arkansas Medicaid/Medicare dually eligible beneficiary during the year of enrollment and bills Medicaid, either manually, electronically or by automated crossover, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period, the provider may file any subsequent claims electronically, manually, or by means of automatic crossover through the original Medicare plan.
3. Limited services providers with the necessary capability (see Section 241.000) are strongly encouraged to file subsequent claims electronically or through the Arkansas Medicaid website. Front-end processing of electronic and web-based claims ensures prompt adjudication and facilitates reimbursement.

203.000 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

210.000 PROGRAM COVERAGE

211.000 Scope 9-1-24

The Arkansas Medicaid Program covers certain services provided to persons eligible for Medicaid through the Qualified Medicare Beneficiary (QMB) Program.

The QMB program was created by the Medicare Catastrophic Coverage Act and uses Medicaid funds to assist low income Medicare beneficiaries. If a person is eligible for the QMB program,

Medicaid will pay the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance on other medical services. Medicaid will also pay the Medicare Part A premium, the Medicare Part A hospital deductible and the Medicare Part A coinsurance.

Persons eligible through the QMB program do not receive the full range of Medicaid benefits. For a QMB eligible, Medicaid covers only those benefits listed above on Medicare-covered services. If the service provided to a QMB-eligible is not a Medicare-covered service, such as personal care or ambulance transportation to a doctor's office, Medicaid does not cover the service for that individual.

212.000 Medicaid Payment of Medicare Coinsurance/Deductible 04-01-07

The Omnibus Budget Reconciliation Act of 1989 requires the mandatory assignment of Medicare claims for "physician" services furnished to individuals who are eligible for Medicare *and Medicaid*, **including those eligible as Qualified Medicare Beneficiaries (QMBs).** According to Medicare regulations, "physician" services, for the purpose of this policy, are services furnished by physicians, dentists, optometrists, chiropractors and podiatrists.

Item 1-C. of the "Contract To Participate In The Arkansas Medical Assistance Program Administered By The Division Of Medical Services Title XIX (Medicaid)" further requires acceptance of assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any applicable deductible or coinsurance that may be due and payable under Title XIX (Medicaid). Services furnished to an individual enrolled under Medicare who is also eligible for Medicaid, including Qualified Medicare Beneficiaries (QMB) may only be reimbursed on an assignment related basis.

213.000 QMB Medicaid ID Card 04-1-07

QMB beneficiaries receive a Medicaid ID after a determination that they are eligible for the program. Providers must verify eligibility and category by one of the various electronic means available (See Sections 301.100 – 301.210 and 301.300 of this manual) or by contacting The Division of Medical Services Program Communications Unit **(View or print Program Communications Unit Contact Information)**. The category of service for a QMB is QMB-AA, QMB-AB or QMB-AD. Additionally, the electronic verification includes the statement "Limited to cost sharing of Medicare services."

214.000 Eligibility Criteria for QMB Program 7-15-12

This program has been designed to assist low income elderly and individuals with disabilities who are covered by Medicare Part A. The person must be 65 or older, blind or an individual with a disability and eligible for or enrolled in Medicare Part A. Arkansas Medicaid also covers Part B medical services coinsurance and deductible amounts for beneficiaries enrolled under the above criteria.

Beneficiaries interested in applying for the QMB Program should contact their local county Department of Human Services office. The applicant should call the county office to inquire about the eligibility criteria, what documents are needed to determine eligibility and whether an appointment is necessary.

215.000 Documentation Requirements 11-1-06

Providers of Medicare-Medicaid Crossover Only services must keep and properly maintain written records. At a minimum, the following records must be included in the provider's files.

215.100 General Records 11-1-06

Medicare-Medicaid Crossover Only providers must maintain a copy of the Arkansas Medicaid contract (form DMS-653) for participation in the Arkansas Medicaid Program.

215.200 Documentation in Beneficiary Files 10-15-09

Documentation and provider participation requirements are detailed within Section 140.000, Provider Participation, of this manual.

215.300 Record Keeping Requirements 10-15-09

Record keeping requirements including patient records, retention and review directives are detailed in Section 142.300 of this manual.

220.000 PRIOR AUTHORIZATION

Prior authorization is not applicable.

230.000 REIMBURSEMENT

Medicaid's payment toward the Medicare Part A and Part B coinsurance and/or deductible is full payment of the amount submitted to Medicaid from Medicare less the Medicaid coinsurance amount (Part A), for non-exempt Medicaid beneficiaries age 18 and older, applied on the first Medicaid covered day of an inpatient stay.

231.000 Rate Appeal Process 10-15-09

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the assistant director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the assistant director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

When the provider disagrees with the decision of the Assistant Director, Division of Medical Services, the provider may appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal.

240.000 BILLING PROCEDURES

241.000 Claim Filing Procedures 10-15-09

If medical services are provided to a patient who is entitled to and receives coverage within the original Medicare plan under the Social Security Act and also to Arkansas Medicaid benefits, it is necessary to file a claim only with the original Medicare plan. The claim should be filed according to Medicare's instructions and sent to the Medicare intermediary. The claim will automatically cross to Medicaid if the provider is properly enrolled with Arkansas Medicaid and indicates the beneficiary's dual eligibility on the Medicare claim form. Claims for Medicare beneficiaries entitled under the Railroad Retirement Act do not cross to Medicaid. Medicare Advantage Plans (like HMOs and PPOs) are health plan options that are available to beneficiaries, approved by Medicare, but run by private companies. These companies bill and

pay directly for benefits that are a part of the Medicare Program, as well as offering enhanced coverage provisions to enrollees. Since these claims are paid through private companies and not through the original Medicare plan directly, these claims will not automatically cross to Medicaid and the provider must request payment of Medicare covered services coinsurance and deductible amounts through Medicaid according to the instructions in Section 330.000, after the Medicare plan pays the claim.

The Arkansas Medicaid fiscal agent provides software and web-based technology with which to electronically bill Medicaid for professional crossover claims that do not automatically cross to Medicaid. Additional information regarding electronic billing can be located in Sections 301.000 through 301.200 of this manual. Providers are strongly encouraged to submit claims electronically or through the Arkansas Medicaid website. Front-end processing of electronically and web-based submitted claims ensures prompt adjudication and facilitates reimbursement.

Institutional providers and those without electronic billing or web-based capabilities must mail a red-ink original claim of the appropriate crossover invoice to the address on the top of the form (see examples of red-ink original forms in Section V of this manual). To order copies of the appropriate Medicare-Medicaid crossover invoice, please use the Medicaid Form Request (HP-MFR-001). **View or print form HP-MFR-001.** Indicate the quantity of each form required and send the request to the Provider Assistance Center (PAC). **View or print PAC contact information.** Instructions for filling out the invoice are included with the ordered forms.

241.100 Billing Instructions 04-1-07

The Medicaid Program is required by federal regulations to utilize all third party sources and to seek reimbursement for services that have also been paid by Medicaid. “Third party” means an individual, institution, corporation or public or private agency that is liable to pay all or part of the medical cost of injury, disease or disability of a Medicaid beneficiary. Examples of third party resources are:

A. Insurance Policies

1. Private health
2. Group health
3. Liability
4. Automobile and/or medical insurance
5. Family health insurance carried by an absent parent
6. Medicare supplements (“Medi-Gap”)

B. Worker’s Compensation

C. Veteran’s Administration

D. CHAMPUS

The Medicaid policies concerning the handling of cases involving Medicare/Medicaid coverage differ from the policies concerning other third party coverage.

Arkansas Rehabilitation Services (ARS) is not a third party source. If ARS and Medicaid pay for the same service, ARS must be refunded. See Section III of this manual for additional billing information.

241.200 Adjustments by Medicare 04-1-07

Any adjustment made by Medicare will not be automatically forwarded to Medicaid. If Medicare makes an adjustment that results in an overpayment or underpayment by Medicaid, submit an Adjustment Request Form,- Medicaid XIX available in Section V of this manual, with a copy of

the Medicare EOMB reflecting Medicare's adjustment. (**View or print Adjustment Request Form -Medicaid XIX HP-AR-004.**) Enter the provider's identification number and the patient's Medicaid identification number on the face of the Medicare EOMB.