Medicaid Reimbursement for Medicare and MAP Secondary Claims

Information posted February 5, 2010

Reminder: Texas Medicaid reimburses certain claims for dual-eligible clients enrolled in Medicare or Medicare Advantage Plans (MAP).

Medicare Parts A and B

Providers are allowed to file Medicare primary paper claims to TMHP for payment of coinsurance or deductibles for claims that fail to crossover from Medicare electronically. Providers that submit a paper crossover claim must submit a completed claim form along with a Medicare Remittance Advance Notice (MRAN) in one of the following approved formats:

- Medicare Remit Easy Print (MREP).
- PC-Print.
- Paper MRAN from Medicare or a Medicare intermediary.
- TMHP standardized MRAN form.

Paper crossover claims that contain multiple MRAN forms with conflicting information are returned to the provider or denied. MRANs must be submitted with a completed claim form, must be legible, and must identify one client per page. Providers must not submit handwritten MRANs. Claims that do not meet these standards will be returned to the provider without processing.

Providers must submit the appropriate paper claim form with the MRAN form.

- CMS-1500 paper claim form for professional services.
- UB-04 CMS-1450 paper claim form for institutional services.

Crossover claims that are submitted with the wrong paper claim form will be denied.

Medicare Part C/ Medicare Advantage Plan (MAP) Information

Providers now receive information about a client's Medicare Part C eligibility through TexMedConnect or Electronic Data Interchange (EDI). In response to an eligibility inquiry, providers will receive the client's Medicare Part C eligibility effective date, end date, and add date (the date the eligibility was added to the TMHP system).

Additionally, the Managed Care segments section of TexMedConnect displays the CMS Contract ID and a link to a list of MAP carrier names and telephone numbers.

For more information, refer to the list of MAP carriers on the TMHP website at www.tmhp.com under the "Software, Fee Schedules, Reference Codes" heading as well as on the EDI home page.

Medicare Denials (Not a Benefit/Exceeds Benefit Limitations)

TMHP is processing claims for Medicare Qualified Medicaid Beneficiary (MQMB) clients enrolled in a MAP. TMHP considers a claim for reimbursement if the claim meets the following requirements:

- The date of service is on or after January 1, 2008
- The MAP denied the claim for one of the following reasons:
    - Not a benefit.
    - Services exceed benefit limitations.
- Services included in the claim are benefits of Texas Medicaid.

Claims must first be submitted to the MAP. If the MAP issues a denial that indicates "not a benefit" or "exceeds benefit limitations", the claim can be submitted to TMHP with a copy of the MAP explanation of benefits (EOB) attached.

TMHP will not process claims that were denied by the MAP for reasons other than "not a benefit" or "exceeds benefit limitations."

Contracted and Non-Contracted MAPs

Contracted MAPs

The Texas Health and Human Services Commission (HHSC) now contracts with MAPs and offers a per-client-per-month payment. The payment to the MAP includes all costs associated with the Medicaid cost sharing for dual-eligible clients. TMHP does not reimburse the co-payment, coinsurance, or deductible amounts for these claims.

MAPs that contract with HHSC will reimburse providers directly for the cost sharing obligations that are attributable to dual-eligible clients enrolled in the MAP. These payments are included in the capitated rate paid to the Health Maintenance Organization (HMO) and must not be billed to TMHP or a Medicaid client.

Non-Contracted MAPs

Coinsurance and Deductibles

Beginning January 4, 2010, TMHP will process claims with dates of service on or after January 1, 2008, for coinsurance and deductibles for dual-eligible clients who are enrolled in a MAP that is not contracted with HHSC.

Providers must submit claims for coinsurance and deductibles using the revised MRAN/MAP templates. Providers must attach the appropriate claim to the completed MRAN form. The new templates and instructions are available on this website on the Medicare/Medicaid Dual Eligibility Claims web page and will be published in the May/June 2010 *Texas Medicaid Bulletin,* No. 229.

Date of services January 1, 2008 – January 3, 2010

Beginning January 3, 2010, providers may submit claims to TMHP with dates of service on or after January 1, 2008. Providers will have until March 31, 2010, to submit claims with dates of service from January 1, 2008, through January 3, 2010. Claims that are submitted may initially be denied for exceeding the filing deadline; however, TMHP will reprocess these claims. No action on the part of the provider is required.

Date of service on or after January 4, 2010

Claims with dates of service on or after January 4, 2010, must be submitted to TMHP following current claim filing deadlines.

TMHP will not reprocess the following claims:

- Claims with dates of service on or after January 4, 2010.
- Claims with dates of service from January 1, 2008, through January 3, 2010, that are submitted after March 31, 2010.
- Claims that were denied for reasons other than filing deadline.

MRANs must be submitted with a completed claim form, must be legible, and must identify only one client per page. Providers must not submit handwritten MRANs. Claims that do not meet these standards will not be processed and will be returned to the provider.

HMO and PPO Copayments

TMHP has resumed processing Medicare HMO and Preferred Provider Organization (PPO) copayment claims for dates of service on or after January 1, 2008.

These copayment claims are considered only for Qualified Medicare Beneficiary (QMB) or Medicaid Qualified Medicare Beneficiary (MQMB) dual-eligible clients who are enrolled in a MAP that is not contracted with HHSC. Providers should file Medicare copayment claims using the following codes: CP003, CP004, CP007, or CP008.

MAP Contracted Status/Services	HMO/PPO Copayment	Coins/Deductible	Medicaid only (Not a Medicare benefit/exceeds benefit limitation
Contracted with HHSC	Reimbursement is included in the payment from HHSC to MAP. MAP reimburses the provider	Reimbursement is included in the payment from HHSC to MAP. MAP reimburses the provider.	Bill to TMHP
Not contracted with HHSC	Bill to TMHP	Bill to TMHP	Bill to TMHP