Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Medicare/Medicaid Crossover Only**

DATE: **April 1, 2007**

SUBJECT: **Provider Manual Update Transmittal #56**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
200.000	10-13-03	200.000	04-01-07
201.000	11-01-06	201.000	04-01-07
202.000	11-01-06	202.000	04-01-07
202.100	11-01-06	202.100	04-01-07
211.000	11-01-06	211.000	04-01-07
212.000	11-01-06	212.000	04-01-07
213.000	11-01-06	213.000	04-01-07
214.000	11-01-06	214.000	04-01-07
215.200	11-01-06	215.200	04-01-07
215.300	11-01-06	215.300	04-01-07
230.000	10-13-06	230.000	04-01-07
241.000	11-01-06	241.000	04-01-07
241.100	11-01-06	241.100	04-01-07
241.200	11-01-06	241.200	04-01-07

Explanation of Updates

Section 200.000 contains new text outlining required participation requirements of compliance with professional standards of care and conduct.

Sections 201.000, 202.000 and 202.100 contain updated information to clarify enrollment requirements.

Section 211.000 contains updated information regarding beneficiary inpatient hospital coinsurance responsibility.

Section 212.000 deleted non-applicable examples of claims payment for providers that do not accept Medicare assignment and includes new wording outlining previously established rules regarding acceptance of Medicare payment assignment.

Sections 213.000 and 214.000 contain updated clarification regarding beneficiary eligibility.

Sections 215.200 and 215.300 contain clarification wording and an informational change in the title of the Division of Medical Services Field Audit Unit to Program Integrity Unit.

Section 230.000 contains updated information regarding beneficiary inpatient hospital coinsurance responsibility.

Section 241.000 contains updated information regarding changes in Medicare that allow private insurance companies the ability to coordinate some Medicare covered services in lieu of the original Medicare Plan. Additional clarifications of claim submittal guidelines are included in this section and outdated information has been deleted.

Sections 241.100 and 241.200 have added references to additional help information contained in other sections of this manual. It additionally contains updated wording to reflect the change from an exclusive Arkansas Medicaid provider number and separate Medicare billing number to allow a nationally recognized provider identification number. Effective May 23, 2007, claims filed by electronic submission for payment to Arkansas Medicaid will require providers to use their nationally recognized provider identification number, when applicable.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

200.000 MEDICARE/MEDICAID CROSSOVER ONLY GENERAL INFORMATION

To participate in the Arkansas Medicaid Program, providers must adhere to all applicable professional standards of care and conduct. 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 04-01-07

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 following criteria:

A. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

B. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll or to remain enrolled, as Medicaid providers.

C. Provider 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 04-1-07

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 04-1-07

A. Providers in states not bordering Arkansas may enroll as Medicare/Medicaid Crossover Only closed-end providers after they have furnished services to an Arkansas Medicaid QMB and have a claim for Medicare cost share to file with Arkansas Medicaid. **View or print Provider Enrollment Unit contact information.** A non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, **www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx**, and submit a completed application and claim to the Medicaid Provider Enrollment Unit.

B. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

C. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll or to remain enrolled, as Medicaid providers.

D. 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 Qualified Medicare Beneficiaries (QMB).

E. Closed-end providers remain enrolled for one year.

1. If a closed-end Medicare/Medicaid Crossover Only provider treats 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 newer claim's last date of service, provided 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. Closed-end providers with the necessary capability (see section 241.000) are strongly encouraged to submit claims electronically or through the Arkansas Medicaid website. Front-end processing of electronic and web-based claims ensures prompt adjudication and facilitates reimbursement.

210.000 PROGRAM COVERAGE

211.000 Scope 04-1-07

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 not to exceed the Medicaid maximum allowable amount. Medicaid will also pay the Medicare Part A premium, the Medicare Part A hospital deductible and the Medicare Part A coinsurance, less the Medicaid coinsurance charge for inpatient admission. For non-exempt Medicaid beneficiaries age 18 and older, this coinsurance amount is 10% of the hospital's interim Medicaid per diem, applied on the first Medicaid covered day only.

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 Section III; 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 04--1-07

This program has been designed to assist low income elderly and disabled persons who are covered by Medicare Part A. The person must be 65 or older, blind or disabled 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 Health and 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.

215.200 Documentation in Beneficiary Files 04-1-07

The provider must contemporaneously establish and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary. All entries in a beneficiary's file must be signed and dated by the individual who provided the service, along with the individual's title. The documentation must be kept in the beneficiary's case file, along with the beneficiary's name, Medicaid identification number, and the date the service was provided.

215.300 Record Keeping Requirements 04-1-07

A. All records must be completed promptly, filed and retained for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer.

B. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary. When records are stored off-premise or are in active use, the provider may certify, in writing, that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

C. All documentation must be made available to representatives of the Division of Medical Services at the time of an audit conducted by the Medicaid Program Integrity Unit. All documentation must be available at the provider’s place of business. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the thirty-day period.

Failure to furnish records upon request may result in sanctions being imposed.

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.

240.000 BILLING PROCEDURES

241.000 Claim Filing Procedures 04-1-07

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. According to the terms of the Medicaid contract, a provider must "accept Medicare assignment under Title XVIII in order to receive payment under Title XIX for any appropriate deductible or coinsurance which may be due and payable under Title XIX."

When the original Medicare plan intermediary completes the processing of the claim, the payment information is automatically crossed to Arkansas Medicaid and the claim is processed in the next weekend cycle for Medicaid payment of applicable coinsurance and deductible. The transaction will usually appear on the provider's Medicaid RA within 3 weeks of payment by Medicare. If it does not appear within that time, the provider must request payment according to the instructions below.

Claims for Medicare beneficiaries entitled under the Railroad Retirement Act do not cross to Medicaid. The provider of services must request payment of coinsurance and deductible amounts through Medicaid according to the instructions below after Medicare pays the claim.

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 below after the Medicare plan pays the claim.

When a provider learns of a patient's Medicaid eligibility only after filing a claim to Medicare, the instructions below should be followed after Medicare pays the claim.

Instructions: EDS 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 Section III – 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 (EDS-MFR-001). **View or print form EDS-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 EDS-AR-004.**) Enter the provider's identification number and the patient's Medicaid identification number on the face of the Medicare EOMB.