ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable N/A

Previous Agency Name, If Applicable N/A

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Name of Rule Update to Medicare and Medicaid Crossover Billing Rules

Newspaper Name Arkansas Democrat Gazette

Date of Publishing June 14 - 16, 2024

Final Date for Public Comment July 13, 2024

Location and Time of Public Meeting Zoom: https://us02web.zoom.us/j/86364429648. 07/26/24 at 11:00 a.m.

TOC not required

211.000 Scope

~~04-1-07~~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~~ 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.

TOC required

332.000 Patients With Joint Medicare-Medicaid Coverage

~~12-1-19~~9-1-24

The following provider types accept Medicare-Medicaid Crossovers: Ambulatory Surgical Center, Chiropractic, Clinics, Dental, Family Planning, Federally Qualified Health Center, Health Department, Hearing Services, Hemodialysis, Home Health, Hospital, Hyperalimentation, Independent Laboratory, Independent Radiology, Inpatient Psychiatric Services for Under Age 21, Nurse Practitioner, Nursing Home, Occupational, Physical and Speech-Language Therapy Services, Physician, Podiatrist, Prosthetics, Rehabilitation Center, Rural Health Clinic Services, Transportation, Ventilator Equipment and Visual Care.

Claim filing procedures for these provider types ~~are~~ begin in Section~~s~~ 332.100 and continue into the next Section 340.000, Medicare Crossover Billing Instruction~~through 332.300~~.

332.100 Medicare-Medicaid Crossover Claim Filing Procedures

~~8-1-21~~9-1-24

If medical services are provided to a patient who is entitled to and is enrolled with coverage within the original Medicare plan under the Social Security Act and also to Medicaid benefits, it is necessary to file a claim only with the original Medicare plan. The claim must be filed according to Medicare's instructions and sent to the Medicare intermediary. The claim should 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 provider contract, a provider must "accept Medicare assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any appropriate copayment, deductible, ~~or~~and coinsurance which may be due and payable under Title XIX (Medicaid)." See Section 142.700 for further information regarding Medicare/Medicaid mandatory acceptance of assignment for providers.

When the original Medicare plan intermediary completes the processing of the claim, the payment information is automatically crossed to Medicare's Coordination of Benefits Agreement (COBA) process and from there crossed to Arkansas Medicaid and the claim is processed in the next weekend cycle for Medicaid payment of applicable copayment, coinsurance, and deductible. The transaction will usually appear on the provider's Medicaid RA within four (4) to six (6) weeks of payment by Medicare. If it does not appear within that time, payment should be requested 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 copayment, co-insurance, and deductible amounts through Medicaid according to the instructions below, after Railroad Retirement Act Medicare pays the claim.

Medicare Advantage/Medigap 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 Medicare and pay directly through the private company 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 **do not** automatically cross to Medicaid; and the provider must request payment of Medicare covered services copayment, co-insurance, and deductible amounts through Medicaid according to the below instructions after the Medicare Advantage/Medigap 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~~ once Medicare pays the claim.

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

Providers must submit the copayment, deductible, and coinsurance at the detail level. Providers without electronic billing capability must mail the appropriate National Standard Claim Form (**CMS-1500** or **CMS-1450**) to the **Fiscal Agent**. Along with the National Standard Claim Form, providers must submit attachment DMS-600. (**View or print attachment DMS-600.**) Providers must also submit the Medicare Explanation of Benefits (EOMB). Claims must be submitted in the following order:

A. National Standard Claim Form

B. DMS-600

C. Medicare Explanation of Benefits (EOMB)

D. Other supporting or applicable documentation

Paper claims will be returned to the provider if not submitted in the above order.

340.000 MEDICARE CROSSOVER BILLING INSTRUCTIONS

340.100 Inpatient Claim - Medicare Part B Only (Medical Only) 9-1-24

A. For members with Medicare Part-B only and Medicaid coverage, providers must bill Medicare directly for inpatient ancillary charges that are covered by Medicare Part-B. The ancillary charges must be billed to Medicare on an institutional claim with Type of Bill 12x.

B. The Medicare Part B services will crossover to Medicaid for reimbursement of patient responsibility.

C. The Inpatient claim must be billed directly to Medicaid as a Medicaid Institutional claim with Type of Bill 11X. The accommodation and ancillary charges must be billed to Medicaid. Part-B payments that appear on the Medicare RA/EOMB, along with any payments received from Medicaid for the Part-B patient responsibility amounts must be entered into the prior payment fields on the CMS-1450 or equivalent electronic format field.

340.200 Inpatient Claim - Medicare Part A Exhausted 9-1-24

A. Provider must bill the Institutional claim with Type of Bill 11x directly to Medicare for services covered by Medicare Part A. The Medicare Part A claim will crossover to Medicaid for reimbursement of patient responsibility amounts.

B. After Medicare Part A is exhausted, using Medicare billing guidelines, all covered services under Medicare Part B are submitted to Medicare with a Type of Bill 12x. The claim will then crossover to Medicaid for reimbursement of patient responsibility.

C. The Inpatient claim must be billed directly to Medicaid as an Institutional claim with Type of Bill 11x. The accommodation and ancillary charges must be billed to Medicaid. Part-B payments that appear on the Medicare RA/EOMB, along with any payments received from Medicaid for the Part-B patient responsibility amounts must be entered into the prior payment fields on the CMS-1450 or equivalent electronic format field.

D. Medicaid as primary for any days Medicare Part A is exhausted or not eligible; Bill Type 11x.

1. The Statement Covers Period "Admit through discharge" is for the entire stay.
2. Include Occurrence Code A3 with the Medicare Part A exhaust date.
3. Covered days are the days in which Medicaid was primary. Use value code "80".
4. Non-covered days are the days Medicare was primary. Use value code "81".
5. Use value code "AB" to report the amount Medicare allowed for their Part-A coverage.
6. Attach documentation to the claim for proof of exhausted Part A benefits.

340.300 QMB Exhausts Medicare Part A 9-1-24

QMB members do not have Medicaid coverage; therefore, Medicaid has no payment liability until a 'QMB Beneficiary' is determined eligible for Medicaid.

340.400 Specialty Pharmacy Billing Instructions for Part B 9-1-24

For specialty pharmacy crossover claims, a provider must be enrolled as a Provider Type 41-Medicare/Medicaid Crossovers Only. Contact Provider Enrollment to assist with questions.

3450.000 OTHER PAYMENT SOURCES

3451.000 General Information 11-1-17

Many persons eligible for Arkansas Medicaid are covered by private insurance or may sustain injuries for which a third party could be liable. The following is an explanation of the patient's and the provider's roles in the detection of third-party sources and in the reimbursement of the third-party payments to the Medicaid Program for services that have been reimbursed by Medicaid.

The Arkansas Medicaid fiscal agent has a full-time staff of trained professionals available to assist with any questions or problems regarding third party liability, including payment of claims involving third party liability and requests for insurance information. Providers should contact the Provider Assistance Center (PAC) for any questions regarding third party liability. **View or print PAC contact information.**

3452.000 Patient's Responsibility 11-1-17

It is the responsibility of the beneficiary to report the name and policy number of any other payment source to the provider of medical services at the time services are provided. The beneficiary must also authorize the insurance payment to be made directly to the provider.

3453.000 Provider's Responsibility 11-1-17

It is the provider's responsibility to be alert to the possibility of third-party sources and to make every effort to obtain third-party insurance information. The provider should also inquire about liability coverage in accident cases and pursue this or notify Medicaid. It is the responsibility of the provider to file a claim with the third-party source and to report the third-party payment to the Medicaid Program. If a provider is aware that a Medicaid beneficiary has other insurance that is not reflected by the system, the insurance information should be faxed to the DMS Third Party Liability Unit. **View or print Third Party Liability Unit contact information.**

All Medicaid claims, including claims that involve third party liability, are filed on an assignment basis. In no case may the beneficiary be billed for charges above the Medicaid allowable on paid claims. A claim is considered paid even though the actual Medicaid payment has been reduced to zero by the amount of third party liability. This applies whether the third-party payment was reported on the original claim or was refunded by way of an adjustment or by

personal check. All paid services that are limited by the Medicaid Program count toward the patient's benefit limits even when the amount of Medicaid payment is reduced to zero by the amount of third party liability, except for Medicare crossover claims with no secondary payer other than Medicaid.

The system provides fields to capture any third party liability (TPL) information the provider may obtain. The provider is required to record TPL for each claim submitted.

When a provider enters an electronic claim for services to a beneficiary who has other insurance coverage for the service and enters a TPL paid amount of $0.00, the software prompts the user to enter the date of the denial HIPAA Explanation of Benefits (HEOB) or the date of the HEOB showing that the allowed amount was applied to the insurance deductible.

3560.000 REFERENCE BOOKS

3561.000 ICD Diagnosis and Procedure Code Reference 11-1-17

The Arkansas Medicaid Program uses the current version of the *International Classification of Diseases (ICD)* as a reference for coding primary and secondary diagnoses for all providers required to file claims with diagnosis codes completed. ICD procedure codes are also required for billing institutional inpatient hospital claims. Providers can order the ICD reference from various suppliers.

3562.000 HCPCS and CPT Procedure Code References 11-1-17

The State of Arkansas uses the HCFA Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of Level I-CPT codes, Level II-HCPCS national codes and Level III-HCPCS local codes. If applicable, the state-assigned codes are listed in the Billing Procedures section of this manual.

The *Current Procedural Terminology (CPT)* is the professional component of the Healthcare Common Procedure Coding System (HCPCS). CPT is a systematic listing of medical terms and identifying codes for reporting medical services provided by physicians. Each procedure or service is identified with a 5-digit code. The use of CPT codes simplifies the reporting of services.

The CPT book and the HCPCS-Level II book also include modifiers, which are used in conjunction with some procedure codes. Providers can order the CPT and HCPCS books from various suppliers.

3563.000 CMS-1450 (UB-04) Data Specifications Manual 11-1-17

Revenue codes and other data, which are used for institutional claims, can be found in the CMS-1450 (UB-04) Data Specifications Manual. Providers can order this manual by subscription.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Medicare/Medicaid Crossover claims

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ☑ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes ☑ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☑ No ☐

   If no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

General Revenue_____
Federal Funds_____
Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total_____

Next Fiscal Year

General Revenue_____
Federal Funds_____
Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total_____

(b) What is the additional cost of the state rule?

Current Fiscal Year

General Revenue -$63,000
Federal Funds -$162,000
Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total -$ 225,000.00

Next Fiscal Year

General Revenue -$63,000
Federal Funds -$162,000
Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total -$ 225,000.00

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year
$_____

Next Fiscal Year
$_____

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ -63,000.00

Next Fiscal Year
$ -63,000.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☑

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Statement of Necessity and Rule Summary
Update to Medicare and Medicaid Crossover Billing Rules

Statement of Necessity

Effective September 1, 2024, Medicaid updates billing rules for Medicare Crossover reimbursement and adds a new field to its Medicaid Management Information System to improve how the claims are paid and reported. A separate copayment field is added to the electronic claims system to allow Medicaid to identify the correct amounts being paid for Medicare copayments apart from coinsurance amounts.

Summary of Changes

Medicare/Medicaid Crossover Only, Section II, 211.000: Deleted the phrase and following sentence, "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."

Section III, 332.00: Updated the policy references for claim filing procedures.

Section III, 332.100: Corrected information throughout the section to add "copayment". Added the sentence, "Providers must submit the copayment, deductible, and coinsurance at the detail level."

Section III, 340.100 – 340.400: Added new sections to explain crossover billing rules for Medicaid reimbursement of Medicare primary claims. These sections also provide the claims billing instructions for the different types of Medicare/Medicaid crossover claims.

Section III, 345.00 – 363.00 – Section numbering was changed to account for the new section added above. No content changes were made.

NOTICE OF RULEMAKING

The Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective September 1, 2024, the Division of Medical Services (DMS) updates the billing rules for Medicare Crossover reimbursement and adds a new field to its Medicaid Management Information System to improve how the claims are paid and reported. DMS adds a separate copayment field to electronic claims to identify the correct amounts being paid for Medicare copayments apart from coinsurance amounts. These updates result in cost savings of $225,000.000 per year.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **July 13, 2024**. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at ar.gov/dhszoom.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at (501) 320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin. 4502201653

Elizabeth Pitman, Director
Division of Medical Services