Crossover Claims

PURPOSE

Crossover claims are claims for a member who is eligible for ND Medicaid and Medicare, including Medicare Advantage, Dual Special Needs Plans (D-SNP) and Medicare Supplemental Plans (Extended Plans).

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled with ND Medicaid on the date of service. Servicing providers acting as a locum tenens provider must be enrolled with ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the Automated Voice Response System by dialing 1.877.328.7098.

- Members who are eligible for Medicaid and Medicare.

Members enrolled in the federally administered Medicare program are referred to as dual eligible. Medicare currently consists of four parts:

- **Medicare Part A** includes coverage for inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, home health care;
- **Medicare Part B** includes coverage for doctor and other health care providers' services, outpatient care, durable medical equipment, home health care and some preventive services;
- **Medicare Part C** (Medicare Advantage) combines coverage of Medicare Part A, B, and D includes other supplemental benefits like vision and dental. Dual Special Needs Plans (DSNP) are a type of Medicare Part C coverage; and
- **Medicare Part D** is prescription drug coverage.

Medicare is the primary insurer for all dual eligible members. Medicaid may be required to pay some or all the member's Medicare premium, deductible, and coinsurance costs,

depending on if the member is eligible under one of the following types of Medicare Savings Programs:

- **Qualified Medicare Beneficiaries (QMB)** Medicaid will pay Part B premiums; Part A premiums (in some instances), deductibles, coinsurance and copayments (for services and items Medicare covers).
- **Special Low-Income Medicare Beneficiaries (SLMB)** Medicaid will pay the Part B premium only.
- **Qualifying Individual (QI1)** Medicaid will pay Part B premium only. These individuals cannot be eligible for Medicaid.

Refer to the Member Eligibility manual for additional information regarding eligibility including information regarding limited coverage categories.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled with ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

The Procedure Code Look-up Tool can be used to identify if a procedure code is covered by ND Medicaid along with code specific details such as ORP requirements, Service Authorization requirements, and current rates.

SERVICE AUTHORIZATION REQUIREMENTS

No service authorization required.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

CLAIM FORM

Professional claims must be billed using the CMS 1500 claim form or the HIPAA compliant 837p format.

Institutional claims must be billed using the UB04 claim form or the HIPAA compliant 837i format. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

CLAIM REQUIREMENTS

A claim for a member with Medicare coverage must be submitted to Medicare prior to being submitted to ND Medicaid. ND Medicaid must receive an original Medicare crossover claim submission within one hundred eighty (180) days from the date on the Medicare Explanation of Benefits (EOB). Claims must be submitted with Medicare payment information on the claim. This time limit may be extended only if there are situations involving member or provider retroactive eligibility.

Professional Claims (HCFA 1500 or 837p)

When submitting primary Medicare information on a professional claim, the payment, member responsibility and any other claim adjustments must be listed at the line level of each claim.

For professional claim submissions when a Medicare Supplemental (Extended) policy is primary, two (2) EOBs are required.

For professional claim submissions when a Medicare Advantage (Part C) policy is primary, one (1) EOB is required.

Claims must be submitted as a Medicare crossover using the correct claim filing indicator code of (MB) on 837p transactions.

Institutional Claims (UB04 or 837i)

When submitting primary Medicare information on an outpatient claim, the payment, member responsibility and any other claim adjustments must be listed at the line level of each claim.

When submitting primary Medicare information on inpatient claims, the payment, member responsibility and any other claim adjustments must be listed at the header of each claim.

For institutional claim submissions when a Medicare Supplemental (Extended) policy is primary, two (2) EOBs are required.

For institutional claim submissions when a Medicare Advantage (Part C) policy is primary, one (1) EOB is required.

Claims must be submitted as a Medicare crossover using the correct claim filing indicator code of (MA) on 837p transactions.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

RELATED POLICIES

Claims Guidance policy
Client Share (recipient liability)

CONTACT

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POLICY UPDATES

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Section	Updates
	New policy created