Medicare Advantage Crossover 837s Project
Overview

Providers currently submit Medicare Advantage claims via state-specific paper claim forms or via the MS Envision Web Portal. The proposed solution is to allow providers to submit these claims via HIPAA 837P/837I transactions with new identifiers in order to validate and process them as Medicare Advantage crossover claims.
Medicare Advantage Crossover Claim Types

- Medicare Part A – Inpatient crossover claims
- Medicare Part B – Crossover claims
- Medicare UB-04 Part B – Crossover claims
Advantage Crossover Claim – Medicare Part C

- These claims can be filed electronically through the EDI Online portal.
- EDI changes are updated in the ANSI ASC X12N 5010 Companion Guides (837I and 837P).
- Medicare Advantage COB information is needed for crossover claim processing.
- Providers must submit test files and verify 835s before moving to production submissions.
- No changes for Medicare Advantage crossover paper claims and Envision Web Portal claim submission.
- The Submitter Name “ADVANTAGE/MEDICARE-PART-C” should be used and submitted in a separate file.
Advantage Crossover Claim – 837P Changes

What information should be included in 837P?

- The Submitter Name in Loop 1000A, Segment NM103 “ADVANTAGE/MEDICARE-PART-C“ should be used for 837P claims.
- Providers need to use a value of ‘MB’ to identify Medicare Advantage claims in Loop 2320 Segment SBR09.
- Payer Paid Amount at claim level needs to be sent in Loop 2320 Segment AMT02.
- Payer Paid Amount at line level needs to be sent in Loop 2430 Segment SVD02.
- Use CARC 253 (Sequestration - reduction in federal payment) for reporting Sequestration Amount.
- Line Adjustment Group Code, Reason Code and Adjustment Amount needs to be sent in Loop 2430 CAS segment.
Advantage Crossover Claim – 837I Changes

What information should be included in 837I?

- The Submitter Name in Loop 1000A, Segment NM103 “ADVANTAGE/MEDICARE-PART-C” should be used for 837I claims.
- Providers need to use a value of ‘MA’ to identify Medicare Advantage claims in Loop 2320 Segment SBR09.
- Payer Paid Amount at claim level needs to be sent in Loop 2320 Segment AMT02.
- Claim Adjustment Group Code, Reason Code, and Adjustment Amount need to be sent in Loop 2320 CAS segment.
- Use CARC 253 (Sequestration - reduction in federal payment) for reporting Sequestration Amount.
- Payer Paid Amount at line level needs to be sent in Loop 2430 Segment SVD02.
- Line Adjustment Group Code, Reason Code, and Adjustment Amount need to be sent in Loop 2430 CAS Segment.
Advantage Crossover Claim – WINASAP5010 Software Changes

What should be done for Medicare Crossover claim processing using WINASAP 5010?

• WINASAP5010 software needs to be installed on the computer.

• Set up a new Trading Partner with the Trading Partner name and contact information.

• For Medicare crossover claims, the organization name should be entered as “ADVANTAGE/MEDICARE-PART-C”.

• If you are using the same PC for submitting traditional crossover claims and Medicare Advantage crossover claims, the organization name should be changed every time to “ADVANTAGE/MEDICARE-PART-C” when submitting and extracting Medicare Advantage crossover claims.

• It is recommended that you use two different computers for traditional claims and Medicare crossover claims for WINASAP.
## Top Denials

<table>
<thead>
<tr>
<th>Denial Code</th>
<th>Description</th>
<th>Resolution</th>
<th>Claim Adjustment Reason code (CARC)</th>
<th>Remark Reason Code (RARC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0032</td>
<td>Claim Type Cannot Be Assigned</td>
<td>Billing provider type is not compatible with the type of bill. Correct and resubmit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0118</td>
<td>Medicare Allowed Amount Conflict</td>
<td>Medicare Coinsurance Amount is higher than the acceptable range based on Medicare allowed amount. Correct and resubmit.</td>
<td>16</td>
<td>M79</td>
</tr>
<tr>
<td>0611</td>
<td>Medicare Amounts Less Than Zero</td>
<td>Verify that the Deductible, Blood Deductible, Coinsurance, Paid, Allowed, Copay and Sequestration Amounts are &gt;= 0.</td>
<td>16</td>
<td>MA04</td>
</tr>
<tr>
<td>0718</td>
<td>No Deductible or Coinsurance on Crossover Claim</td>
<td>Verify that the Deductible, Coinsurance or Copay on Crossover Claim when Medicare Paid is &gt; 0.</td>
<td>16</td>
<td>MA04</td>
</tr>
<tr>
<td>0834</td>
<td>Net Claim Charge Conflict – Crossovers</td>
<td>Verify that the Net Claim Charge is within a +/- $2.00 variance of the Total Charge - (Medicare Paid Amount - TPL Amount - Non-Medicare Copay Amount).</td>
<td>16</td>
<td>M54</td>
</tr>
<tr>
<td>1211</td>
<td>Medicare Deductible Greater Than Yearly Amount</td>
<td>Verify that the Medicare Deductible Amount is numeric and less than the established limits.</td>
<td>16</td>
<td>M54</td>
</tr>
<tr>
<td>1213</td>
<td>No Medicare Advantage Coverage/ID</td>
<td>Verify that the beneficiary has Medicare Advantage coverage for the date of service.</td>
<td>16</td>
<td>M54</td>
</tr>
<tr>
<td>1214</td>
<td>Medicare Sequestration Reduction Amount is Not Valid</td>
<td>Verify that the Sequestration Amount is 2% of Medicare Paid amount.</td>
<td>16</td>
<td>M54</td>
</tr>
<tr>
<td>1215</td>
<td>Medicare Copay Amount is Not Valid</td>
<td>Verify that the Medicare Copay Amount is numeric and less than the established limits.</td>
<td>16</td>
<td>M54</td>
</tr>
</tbody>
</table>
Advantage Crossover Claim - Tips

- Providers can send test files with Interchange Control Header (ISA15 Usage Indicator) as ‘T’ for crossover claim testing.
- Check Companion Guides for more updates.
  
  http://edisolutionsmmis.portal.conduent.com/gcro/ms-guides
Testing Instructions

Please follow the instructions below for test files submission:

• Providers can submit 837 test files for Medicare Advantage/Part-C crossover Part A and Part B claims.
• Test files can be submitted at any time; our system will accept and process the test files weekly on Thursdays.
• Submit 837 X12 test files with the same approved Submitter ID and the submission method currently used for production data.
• Use “T” in the Interchange Control Header (ISA15 Usage Indicator) to indicate that the file is a TEST file. Restrict test file to have 100 claims or less.
• Please refer to changes mentioned in the provider communication manual for specific segment information.
• Responses for test claims will be available weekly on Thursday night.
• See results by processing the returned TA1, 999, 277CA and 835 X12 files with the “T” flag.
Helpful Hints – FAQs

What is meant by the traditional crossover?

When Medicare providers submit claims for Medicare/Medicaid beneficiaries, Medicare will pay the claim, apply a Deductible/Coinsurance or Copay Amount, and then automatically forward the claim to Medicaid.

Note: Medicare Advantage claims can only be submitted by providers and will not be crossed over automatically.

What do I do if my Medicare crossover claim is not electronic?

The claims can be submitted via hardcopy claim or through the Web Portal along with a copy of the Medicare EOMB.

Are there any changes to traditional crossover payment?

There are no changes in submission of traditional crossover claim processing. Providers can not directly submit traditional crossovers in 837 X12 format.
Helpful Hints – FAQs

Will there be any changes to Medicaid remittance for Medicare crossover claims?

There will be no changes to the content of the Medicaid paper remittance or the Medicaid electronic 835 remittances.

Do I need to submit test files for crossover claim testing?

Yes, providers must submit test files and verify 835s before moving to production submissions.

What if a crossover claim is rejected or denied by Mississippi Medicaid?

If it appears the claim has been inappropriately rejected or denied by Mississippi Medicaid, the provider should contact the Conduent Provider Support line at 1-800-884-3222 for guidance on how to proceed.
Helpful Hints – FAQs

Can a 276 Status Request be submitted for a crossover claim?

Yes

What should be changed in WINASAP for submitting Medicare Advantage crossover claims?

Providers will need to set up a WINASAP application and configure Trading Partner setup similar to traditional crossover claims. The only change on the Trading Partner setup screen is that organization name should be changed to "ADVANTAGE/MEDICARE-PART-C".

What is Sequestration Amount? Is it needed for Medicare crossover claims?

Yes, Sequestration is a mandatory payment reduction in the Medicare Fee-For-Service (FFS) program. The Sequestration Amount should be submitted on Medicare crossover claims with Claim Adjustment Reason Code '253'. This is currently 2% of Medicare or Medicare Advantage Plan Paid Amount.
Helpful Hints – FAQs

What COB values should be represented in the crossover claim?

For the crossover claim to process, Mississippi Medicaid needs Medicare Advantage Plan Paid Amount and the applicable patient responsibility amounts, as well as Sequestration Amount. These are Coinsurance, Deductible, Blood Deductible (UB-04), and Copay. The claim should be balanced at claim level or line level.

Can I upload the Advantage crossover claims the same as regular Fee-For-Service claims in EDI online?

Yes, they may be uploaded the same as regular Fee For Service claims.

What if the Submitter name in Loop 1000A, Segment NM103 is entered other than “ADVANTAGE/MEDICARE-PART-C”?

The claim will be treated as a Fee For Service claim and will be denied.
Helpful Hints – FAQs

What if the provider submits Medicare Advantage claims and other private third party coverage electronically?

Claims for beneficiaries with both Medicare Advantage coverage and other private third party coverage may be billed electronically. It is very important to identify both the Medicare Advantage and the Other Commercial Insurance using the correct payer ID.

Can traditional tertiary crossover claims be processed electronically?

No, traditional tertiary crossover claims should be submitted in paper format only. The traditional electronic crossover claims cannot be submitted by providers, and there is no change in that process.