

APPENDIX J: Medicare crossover claim payment methodology

Professional services

Refer to [WAC 182-502-0110](#) for full details; this guide provides a summary of these rules as follows:

- ProviderOne compares Apple Health's allowed amount to Medicare's allowed amount for the service, selects the lesser amount of the two, and then deducts Medicare's payment from the amount selected.
- If there is a balance due, ProviderOne pays the client's cost sharing liability (deductible, coinsurance, or co-pay) up to the lesser of the allowed amounts.
- If there is no balance due, ProviderOne does not make any crossover claim payment because Medicare's payment exceeds Apple Health's calculated allowed amount.
 - As of 12/20/2015, for QMB clients ProviderOne began paying such claims at \$0.00 instead of denying with CARC 23.
- When Apple Health does not cover the service, pricing on QMB clients will use either Medicare's allowed or a Medicaid State Plan rate appropriate to the service, whichever is less; HCA has the option to use a CMS approved negotiated rate instead and will pursue this option over time.

ProviderOne cannot make direct payments to clients to cover the client's cost sharing liability (deductible, coinsurance, or co-pay) amount of a Part B Medicare claim. ProviderOne can pay these costs to you on behalf of the client when:

- You accept assignment; and
- Total reimbursement to you from Medicare and ProviderOne does not exceed the rate in Apple Health's fee schedule.

HCA is revising procedure codes that may be non-covered by Apple Health, but the services are covered. If the service is covered by Apple Health, but the code is not, ProviderOne may pay as follows:

MEDICARE ALLOWED – MEDICARE PAID = AGENCY PAYMENT

ProviderOne payment on crossover claims equals the lesser of the Apple Health allowed amount minus the Medicare or Part C plan payment toward the client's cost sharing liability. Payment from Medicare or the Part C plan and ProviderOne cannot exceed Apple Health's allowed amount for the service.

- The crossover claim payment cannot exceed the client's cost sharing liability.
- No payment will be made if the Medicare or Part C plan payment exceeds Apple Health's allowed amount for the service.

Institutional services

Outpatient hospital

Payment equals the lesser of the Apple Health allowed amount minus the Medicare paid amount up to the client's cost sharing liability (deductible, coinsurance, or co-pay). Total payment to you from Medicare and the agency does not exceed Apple Health's allowed amount.

RHC-Rural Health Clinic

For RHCs who bill for Medicare encounter services, payment equals the Rural Health Clinic (RHC) per diem rate on file with the agency, minus the Medicare paid amount. These RHC claims are submitted using type of bill (TOB) 71x and billing provider taxonomy 261QR1300X.

FQHC-Federally Qualified Health Clinic

For Federally Qualified Health Centers (FQHCs) who bill for FQHC Services, payment equals the Medicare coinsurance amount. These FQHCs bill crossover claims using TOB 77x and billing provider taxonomy 261QF0400X.

Inpatient hospital for client with both Medicare Part A and Part B coverage

Payment equals the lesser of the Apple Health allowed amount minus the Medicare paid amount, up to the client's cost sharing liability (deductible, coinsurance, or co-pay).

Dual-eligible clients with a commercial Medicare supplement

ProviderOne will adjust any payment amounts if the client has a commercial Medicare supplement policy and that entity makes a payment after Medicare. In that case the formula is:

$$\text{MEDICARE PAYMENT} + \text{COMMERCIAL INSURANCE PAYMENT} - \text{TOTAL MEDICAID ALLOWED AMOUNT} = \text{AGENCY PAYMENT}$$