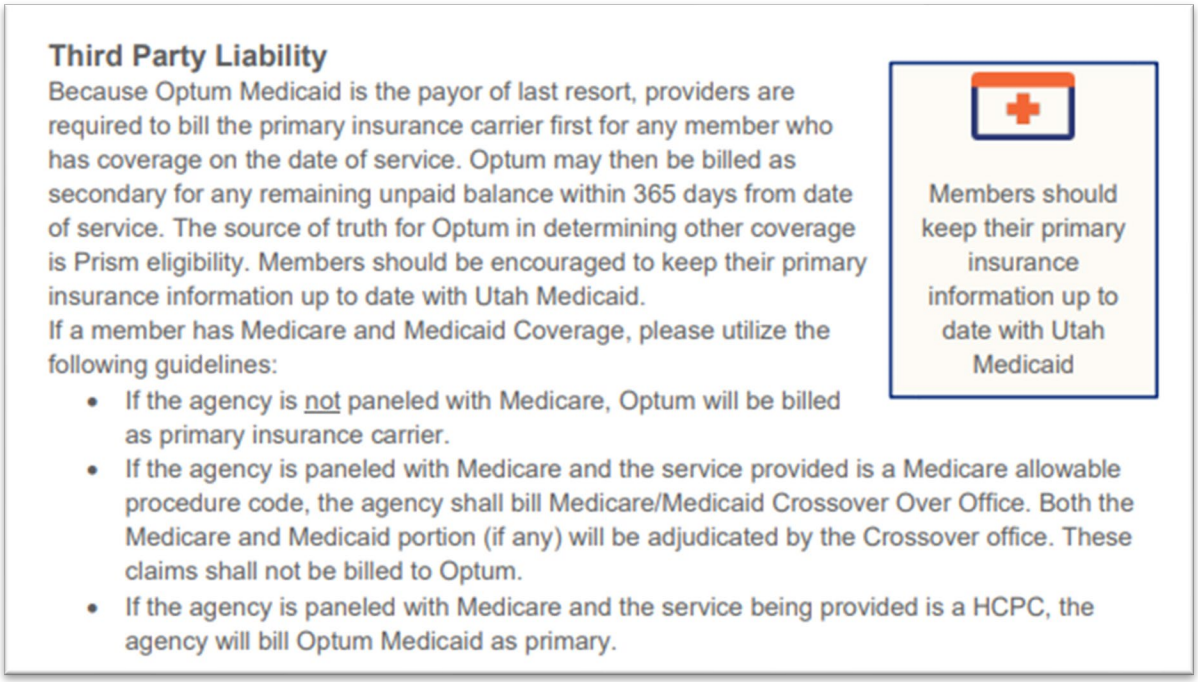
Optum Utah TPL Rules Workflow

Dual Eligible Traditional Medicare with Medicaid

Members who are dual eligible with Original Medicare will have claims that are submitted to the "Crossover Office." A Crossover Claim means a claim for an enrollee who is also a Medicare beneficiary where Medicare pays a portion of the claim and Medicaid is billed for any remaining deductible and/or coinsurance or copayment amounts.

Per the Optum Provider Manual for Medicaid Services, "If the agency is paneled with Medicare and the service provided is a CPT code, the agency shall bill Medicare/Medicaid Crossover Office. Both the Medicare and Medicaid portion (if any) will be adjudicated by the Crossover office. These claims shall not be billed to Optum.

Provider Manual



Third Party Liability

Because Optum Medicaid is the payor of last resort, providers are required to bill the primary insurance carrier first for any member who has coverage on the date of service. Optum may then be billed as secondary for any remaining unpaid balance within 365 days from date of service. The source of truth for Optum in determining other coverage is Prism eligibility. Members should be encouraged to keep their primary insurance information up to date with Utah Medicaid.

If a member has Medicare and Medicaid Coverage, please utilize the following guidelines:

- If the agency is not paneled with Medicare, Optum will be billed as primary insurance carrier.
- If the agency is paneled with Medicare and the service provided is a Medicare allowable procedure code, the agency shall bill Medicare/Medicaid Crossover Over Office. Both the Medicare and Medicaid portion (if any) will be adjudicated by the Crossover office. These claims shall not be billed to Optum.
- If the agency is paneled with Medicare and the service being provided is a HCPC, the agency will bill Optum Medicaid as primary.

Members should keep their primary insurance information up to date with Utah Medicaid

The Utah Medicaid All Inclusive Master Searchable Provider Manual also reflects the same, stating that "If the provider accepts assignment for Medicare Part A or Part B, the Crossover claim is sent to Medicaid Crossovers automatically from the intermediary. If the provider does not accept assignment, a claim is not sent automatically, and the provider must submit the claim directly to Medicaid Crossovers." Further, "Payment is reported on the Crossover section of the Medicaid Remittance Statement. The Medicare and Medicaid payment are considered payment in full."

Documents/manuals/pdfs/Medicaid+Provider+Manuals/All+Inclusive+Master+Searchable+Provider+Manual/All_InclusiveMasterSearchableProviderManual11-24.pdf

Medicare/Medicaid Crossover Claims

To ensure prompt processing, the Medicaid provider's NPI must be on the claim. The deadline for filing a Crossover claim is 365 days from date of service or six months after Medicare disposition. Medicaid may then consider payment of a Medicare deductible and co-insurance, even if the Medicare intermediary or carrier crosses the claim to Medicaid after more than a year has passed since the date of service. Medicaid may also consider such a claim for payment if Medicare notifies only the provider and does not electronically forward the claim to Medicaid.

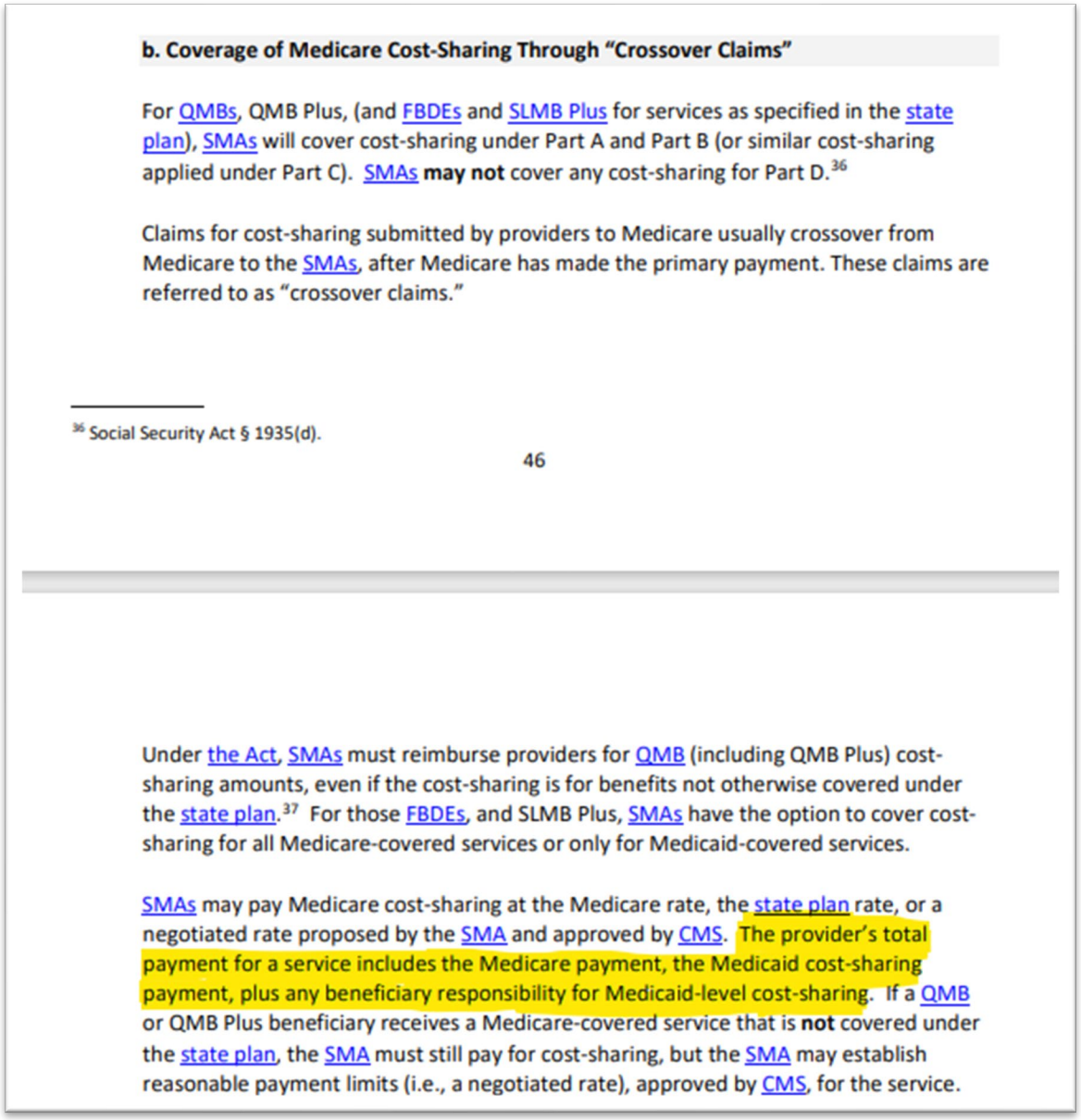
If the provider accepts assignment for Medicare Part A or Part B, the Crossover claim is sent to Medicaid Crossovers automatically from the intermediary. If the provider does not accept assignment, a claim is not sent automatically, and the provider must submit the claim directly to Medicaid Crossovers.

Payment is reported on the Crossover section of the Medicaid Remittance Statement. The Medicare and Medicaid payment are considered payment in full.

Submit claims directly to Medicaid Crossovers. Instructions are online at https://medicaid.utah.gov/ under Coordination of Benefits.

Finally, per the *Coordination of Benefits and Third-Party Liability (COB/TPL) in Medicaid 2020* handbook via Medicaid.gov, on page 46 under Chapter II, section E-6, paragraph b, *Coverage of Medicare Cost-Sharing Through "Crossover Claims*," it states "For qualified Medicare beneficiaries (QMBs), the State Medicaid Agency (SMA) will cover cost-sharing under Part A and Part B. Claims for cost-sharing submitted by providers to Medicare usually crossover from Medicare to the SMAs, after Medicare has made the primary payment. These claims are referred to as "crossover claims." The section goes on to state that "The provider's total payment for a service includes the Medicare payment, the Medicaid cost-sharing payment, plus any beneficiary responsibility for Medicaid-level cost sharing."

COB TPL Training and Handbook



b. Coverage of Medicare Cost-Sharing Through "Crossover Claims"

For QMBs, QMB Plus, (and FBDEs and SLMB Plus for services as specified in the state plan), SMAs will cover cost-sharing under Part A and Part B (or similar cost-sharing applied under Part C). SMAs **may not** cover any cost-sharing for Part D.[36]

Claims for cost-sharing submitted by providers to Medicare usually crossover from Medicare to the SMAs, after Medicare has made the primary payment. These claims are referred to as "crossover claims."

[36] Social Security Act § 1935(d).

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Under the Act, SMAs must reimburse providers for QMB (including QMB Plus) cost-sharing amounts, even if the cost-sharing is for benefits not otherwise covered under the state plan.[37] For those FBDEs, and SLMB Plus, SMAs have the option to cover cost-sharing for all Medicare-covered services or only for Medicaid-covered services.

SMAs may pay Medicare cost-sharing at the Medicare rate, the state plan rate, or a negotiated rate proposed by the SMA and approved by CMS. The provider's total payment for a service includes the Medicare payment, the Medicaid cost-sharing payment, plus any beneficiary responsibility for Medicaid-level cost-sharing. If a QMB or QMB Plus beneficiary receives a Medicare-covered service that is **not** covered under the state plan, the SMA must still pay for cost-sharing, but the SMA may establish reasonable payment limits (i.e., a negotiated rate), approved by CMS, for the service.

Dual Eligible Medicare Advantage with Medicaid

For members enrolled in a Medicare Advantage plan and a Medicaid Managed Care Plan, the Coordination of Benefits Agreement (COBA) process does not apply. Optum is not an integrated Medicare Advantage Plan, so the provider may need to submit a separate claim to the Medicaid Crossover for any applicable cost-sharing. These claims shall not be billed to Optum. (Per DHHS, Medicare Advantage and Traditional Medicare plans are treated the same by Medicaid Crossover.)

Medicaid as Secondary with No Patient Responsibility (PR)

In instances where Medicaid is secondary and the Crossover Office determines that the claim was paid in full by Medicare, and there is no PR identified, that is considered payment in full. There is a $0 payment for the PR portion. These claims shall not be billed to Optum.

Under-Licensed/Lower Level Licensure Providers and/or HCPCS Codes

As confirmed by Utah State Medicaid, if a lower level/under-licensed provider not covered by Medicare renders the service, then those claims need to be submitted to Optum as primary.

As confirmed by Utah State Medicaid, if the service billed is a HCPCS Code not covered by Medicare, then those claims need to be submitted to Optum as primary.