

## PROVIDER BULLETIN

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# MO HEALTHNET REIMBURSEMENT OF MEDICARE CROSSOVER CLAIMS FOR SKILLED NURSING FACILITY BENEFITS

## CONTENTS

- **Overview of the change in reimbursement methodology for Medicare Part A and Medicare Advantage Plan/Part C Crossover Claims.**
- **Examples of Medicare Part A Crossover Claims under new methodology.**

The MO HealthNet Division (MHD) has filed Proposed and Emergency Amendments to the Nursing Facility Regulation 13 CSR 70-10.015 to implement a change in the reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part A and Medicare Advantage/Part C inpatient skilled nursing facility benefits. Effective for dates of service beginning April 1, 2010, MHD will no longer automatically reimburse the coinsurance or cost sharing amount determined by Medicare or the Medicare Advantage Plan for inpatient nursing facility services. MHD will now determine the MO HealthNet reimbursement for the coinsurance or cost sharing amount of crossover claims which will be limited to the fee-for-service (FFS) amount that would be paid by MHD for those services as follows:

- If the FFS amount that would be paid by MHD for the coinsurance days is **equal to or less than ( $\leq$ )** the amount paid by Medicare or the Medicare Advantage Plan for the coinsurance days, MHD will pay \$0. (see Example 1 in the enclosed chart)
- If the FFS amount that would be paid by MHD for the coinsurance days is **more than ( $>$ )** the amount paid by Medicare or the Medicare Advantage Plan for the coinsurance days, MHD will pay the lower of:
  - The difference between the FFS amount that would be paid by MHD for the coinsurance days and the amount paid by Medicare or the Medicare Advantage Plan for the coinsurance days (see Example 2 in the enclosed chart); or
  - The coinsurance amount (see Example 3 in the enclosed chart).

Examples of this methodology related to Medicare Part A crossover claims are included at the end of this bulletin for educational purposes only and do not represent actual claims data or all scenarios.

This change will have a minimal impact on nursing facilities because MHD expects approximately 99.89% of the cost to the nursing facilities to be recovered through Medicare reimbursement (i.e., the coinsurance not paid by MO HealthNet for Medicare Part A may be claimed as a bad debt for Medicare reimbursement and the allowable bad debt will be reimbursed by Medicare at 100%). Based on an analysis of nursing facility crossover claim expenditures for SFY 2009, 99.89% were related to Medicare Part A crossover claims which are eligible for Medicare reimbursement. Only 0.11% of the SFY 2009 expenditures were related to Medicare Advantage Plan/Part C crossover claims which are not eligible for reimbursement by Medicare.

During the initial year of implementation, nursing facilities may experience a delay of approximately eighteen (18) months in receiving the reimbursement from Medicare for the allowable bad debt depending on cost reporting deadlines and the facility's fiscal year end. After the first year of implementation the Medicare Administrative Contractor (MAC) may make bi-weekly interim payments for the increased allowable Medicare bad debts in accordance with 42 CFR §413.355. To assist with cash flow issues, the nursing facility may contact the MAC and request their current interim payments be adjusted to reflect the increased bad debts rather than having to wait for the first cost report that reflects the increased bad debts. The decision to adjust the interim payments will be up to the MAC and MHD does not have any authority over the decision since it is independent from the MAC. Your industry association may have additional information regarding this matter.

This change in reimbursement of Medicare Part A and Medicare Advantage/Part C coinsurance and cost sharing amounts will be automatically implemented by MHD and requires no action on the part of the nursing facility. However, the nursing facilities must properly report the allowable bad debt on their Medicare cost report to receive the reimbursement from Medicare. This change falls within the normal scope of Medicare reporting and therefore, no additional staff will be needed.

To assist nursing facilities with identifying the amounts they can report as allowable bad debt for Medicare reimbursement, MHD will utilize an adjustment reason code of OA45 and a remark code of N59 which will be reflected on the facility's remittance advice.

**Examples of Medicare Part A Crossover Claims  
Using New Reimbursement Methodology**

**Assumptions for All Examples:**

Date Participant Admitted into NF	03/01/10
Dates of Service (DOS) on claim	03/01/10 – 03/31/10
Medicare Paid 100% for DOS *	03/01/10 – 03/20/10
Coinsurance Days -10 in these examples	03/21/10 – 03/31/10

**Calculation for Coinsurance Days Only:**

Description	Example 1	Example 2	Example 3
	MHD FFS ≤ Medicare Pmt. MHD Pays \$0	MHD FFS > Medicare Pmt. MHD Pays Diff.	MHD FFS > Medicare Pmt. MHD Pays Coins.
Medicare Rate Per Day (varies by person)	\$324.12	\$199.27	\$148.76
Less Coins. per day amount **	\$137.50	\$137.50	\$137.50
Equals the Medicare Pd. Amt. per Coins. Day	\$186.62	\$61.77	\$112.26
Multiplied by the Coins. Days	10	10	10
Equals Medicare Pd. Amt. for all Coin. Days	\$1,866.20	\$617.70	\$112.60
MHD NF Rate (varies by NF)	\$137.18	\$132.43	\$155.61
Multiplied by the Coins. Days	10	10	10
MHD FFS Amount	\$1,371.80	\$1,324.30	\$1,556.10
Less Medicare Pd. Amt. for all Coins. Days	\$1,866.20	\$617.70	\$112.60
Diff. between MHD FFS & Medicare Pmt	(\$494.40)	\$706.60	\$1,443.50
Coins. Amt. Billed to MHD	\$1,375.00	\$1,375.00	\$1,375.00
<b>New MHD Payment</b>	<b>\$0.00</b>	<b>\$706.60</b>	<b>\$1,375.00</b>
Bad Debt for NF (MHD Savings)	\$1,375.00	\$668.40	\$0.00

\* Medicare Part A covers the first 20 days of a benefit period at 100%. For Medicare Advantage Plan claims, the days covered at 100% will vary.

\*\* Medicare Part A coinsurance amount per day is a set, for 2010 it is \$137.50 per coinsurance day. For Medicare Advantage Plan claims, this amount will vary.

**Provider Bulletins** are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

**MO HealthNet News:** Providers and other interested parties are urged to go to the MHD Web site at <http://dss.missouri.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

**MO HealthNet Managed Care:** The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One for the red or white card.

**Provider Communications Hotline**  
**573-751-2896**