March 28, 2008

We appreciate the information provided in the memorandum from [REDACTED] dated January 14, 2008. However, we feel the issue has become confused [REDACTED] and from presenting information in pieces rather than as a complete picture. Also, some information you were previously given was not completely accurate. With this letter, we are hoping to review the entire issue and our explanations.

ORIGINAL QUESTION:
The original question [REDACTED] was whether [REDACTED] [the Statewide Entity (SE)] should be paying claims for recipients who were eligible for Medicare since the Medical Assistance Division (MAD) and the CLTS MCOs has the responsibility for paying “Medicare crossover” claims.

ANSWER TO THE ORIGINAL QUESTION:
MAD clarified that our fiscal agent, ACS [and as of August 1 the CLTS MCOs] does indeed process the “Medicare crossover” claims. However, the term “Medicare crossover claims” really means only those claims where the Medicare intermediary or carrier pays the claim and calculates a Medicare co-insurance and/or deductible.

MAD clarified that there are several instances where [REDACTED] [the SE] is responsible for paying a claim for an individual who is eligible for Medicare. The [REDACTED] memorandum acknowledges receiving those instructions. Some examples where [REDACTED] [the SE] will process claims for individuals who are Medicare-eligible are:

- Medicare denies the service as not a benefit or for some other non-administrative reason. The claim must then be evaluated for Medicaid coverage. By a non-administrative reason, we mean the denial isn’t due to the error of the provider (such as an invalid diagnosis code, or failure to file the claim timely, etc.) We can provide [REDACTED] [the SE] with our list of the national standard adjustment reason codes we classify as administrative denials and the ones we classify as non-administrative if that would help [REDACTED] [the SE] pay or deny claims appropriately.
• The recipient is not really eligible for Medicare. This doesn’t happen often. But if Medicare denies the claim stating the individual is not really eligible for Medicare, we consider that denial reason is considered “non-administrative” unless the provider made an error in the recipient ID number when filing with Medicare.

• The recipient has chosen a Medicare replacement plan. In these instances, the claim is not paid by a Medicare carrier or intermediary. Rather, the claims are paid by a Medicare replacement plan, usually an HMO or SNP. Paying the co-payments associated with this type of plan are not considered “crossover claims” and therefore become [the SE’s] responsibility.

• The recipient’s Medicare benefits are exhausted. Again, this denial reason is considered a non-administrative denial. [The SE] then evaluates the claim for coverage.

• When [the SE] knows that a service is not covered by Medicare, such as [Comprehensive Community Support Services], case management, etc., [the SE] should not require the provider to show that Medicare denied the claim. This is described in more detail, below.

MEDICARE AS A POTENTIAL PAYER:
We would like to describe how the Medicaid Program handles a claim when the recipient is eligible for Medicare. [The SE] should apply the same principles to behavioral health claims.

When Medicaid receives a claim for a recipient also eligible for Medicare, with only a few exceptions, MAD has ACS deny the claim when all of the following are true:

1. The recipient is eligible for Medicare on the dates of service. We maintain the dates a recipient is eligible for Medicare parts A, B, and D on the individual’s eligibility record in our MMIS system.

2. The service is covered by Medicare. We know when Medicare will very likely cover the service because we keep indicators showing Medicare coverage of a procedure in our procedure file in our MMIS system.

3. There is no indication the provider filed the claim with Medicare and received a non-administrative denial.

If all the above are true, we deny the claim telling the provider to file the claim with Medicare. We do the same things with other insurance coverage.

On this topic, there is one statement made in the memorandum that is too general in its implication. The last sentence on page 1 states: “Federal regulations require a Medicaid
program to reject a claim where the existence of third party liability is known at the time the claim is filed.”

In addition to the existence of third party liability, there is a responsibility to suspect that the third party does cover the service. Perhaps more than most states, New Mexico Medicaid verifies coverage of insurance and maintains a detailed matrix on what the insurance resource will cover for a particular recipient. Examples of the result of this verification and detailed information are:

- A dental claim is only denied if the recipient has insurance that covers dental services. A dental service is not denied if the individual has a medical plan that does not cover dental service.

- A claim for Medicare co-insurance and deductible is denied if the recipient has insurance that functions as a Medigap plan.

- A claim for hospitalization is only covered if the insurance covers inpatient hospitalization.

- The point we are trying to make is that a claim is denied because of knowledge that the third party resource covers the service. It is not denied if it is known the insurance will not cover the service.

**BEHAVIORAL HEALTH ISSUES:**

In the Medicaid fee-for-service physical health programs, MAD follows the federal requirements very precisely. However, possibly unlike some states, we do not deny claims for third party coverage when we know the policy does not cover the service.

The challenge for each payer, including **VALUEOPTIONS** [the SE], with regard to behavioral health services is how to detect a claim that could be paid by Medicare. The issues with behavioral health services are much more complicated than for physical health:

- Medicare coverage of behavioral health services varies substantially by the type of provider covering the service. Some providers are not covered at all. Some providers are covered only for limited areas of service such as testing.

- Medicare coverage for behavioral health services may differ based on the place of service. Medicare will cover some providers’ services in nursing facilities and hospitals but not in an office setting.

- For recipients there is a limited annual benefit for behavioral health of only a few hundred dollars. A recipient seeing a psychiatrist in an office setting may exhaust benefits after only a few visits. However, applying that limitation is complex. Some years ago in order to extend more behavioral health benefits to recipients, most facility-based outpatient services ceased to be included the dollar amount count toward
exhausting the benefits. So a recipient may have exhausted Medicare benefits in one setting but not another.

EXPECTATIONS:
Essentially, we want [the SE] to deny claims that should be paid by Medicare. However, [the SE] cannot accomplish this by denying claims solely because of the presence of Medicare eligibility. [The SE] must consider whether Medicare can cover the provider of the service; whether the service is covered by Medicare; and whether the provider is even allowed to file the claim with Medicare to obtain a denial statement.

We want to ensure [the SE] is sensitive to the following:

- Medicare Part A payments are often made based on the provider’s self-determination of coverage. Medicare Part A relies on the providers to only send in claims that they know meet Medicare Part A coverage criteria. [the SE] cannot ask a provider to file a claim to the Medicare intermediary that the provider knows Medicare Part A should not cover because the provider may incur penalties for doing so.

- For a provider for which Medicare covers some services but not all services, [the SE] cannot routinely deny services for Medicare coverage when it is predictable Medicare will deny the claim. A provider should not have to file claims with Medicare that we all know that Medicare will not pay because of Medicare coverage rules. So [the SE] must be as precise as possible in determining if Medicare should pay on the claim.

- The above concept extends to claims that Medicare will not pay due to the place of service. For example, if therapy in a nursing facility is covered for the provider, but routine office therapy is not, [the SE] should not expect the provider to continually file claims with Medicare for services that are not in Medicare’s benefit package.

- If a recipient’s Medicare coverage is exhausted for office-based services early in the year, the provider should not continually have to file a claim with Medicare to receive additional notices that the benefits are exhausted. Whether this is handled by the provider indicating information on the claim or attaching an earlier EOB can be determined by [the SE].

We want and expect [the SE] to deny claims appropriately for Medicare coverage. But we don’t want [the SE] to interpret this as an acknowledgement as a blanket approval to deny all claims for which the individual has Medicare coverage without consideration given to whether Medicare benefits really encompass the service provided or the provider rendering the service.

We would be glad to work with [the SE] on appropriate definitions and this process that [the SE] implements.
RECIPIENTS WITH ONLY QMB COVERAGE
The memorandum cited restrictions on coverage for recipients with only QMB coverage under Medicaid.

For these recipients, the most common coverage by Medicaid is for Medicare co-insurance and deductibles following Medicare payment which is paid by the MAD fiscal agent. However, payment of copayments from Medicare replacement plans for these recipients should be paid by [VALUEOPTIONS [the SE]]. However, we need to discuss that issue further with [the SE].

Reimbursement limits on paying the copayments from Medicare replacement plans apply for all recipients, not just QMB-only recipients.

PROVIDERS WHO CHOOSE NOT TO PARTICIPATE IN MEDICARE
We believe that [VALUEOPTIONS [the SE]] can deny a claim for a service which Medicare would have covered if the only reason for not covering the service is that the provider has chosen not to participate in the Medicare Program. However, we have the following concerns:

- MAD does not believe this has been a major issue for providers in the past. Therefore, we want to make certain that [VALUEOPTIONS [the SE]] can tell the difference between the situations where a provider is not filling with Medicare because it is known that Medicare will not pay for the service vs. when the provider is choosing not to participate in Medicare. The claims should be handled differently.

- If the limitation is that Medicare doesn’t cover the provider at all, of course the provider is not going to be able to enroll with Medicare to even get a claim denied. Again, we are trying to make certain that [VALUEOPTIONS [the SE]] knows Medicare coverage rules well enough that a claim is not denied in error.

- We think [VALUEOPTIONS [the SE]] understands that a recipient has a choice of providers. There is nothing that compels a recipient to choose to go to a psychiatrist, for example, rather than an LISW, just because Medicare would cover the psychiatrist and may not cover the LISW for a specific service or setting.

We hope this helps clarify the issue and concerns. We recognize this is a complicated area and would be glad to continue to work with [VALUEOPTIONS [the SE]] on how to best accomplish this.

Should you have any questions on this matter, please contact Geri Cassidy who will work with the appropriate staff to help answer your questions.

Sincerely,

Carolyn Ingram, Director