



## Behavioral Health Dual Coverage – Medicare/Medicaid

### Frequently Asked Questions

**QUESTION 1:** Is an authorization for behavioral health services from Medicaid (CT BHP) required when a member is dually covered (Medicare/Medicaid)?

**ANSWER:**

- I. **Traditional Medicare A, covered service** = CT BHP authorization is required *only* when Medicare denies payment for the service. If Medicare makes payment, including partial payment, no authorization is needed from CT BHP.

The following information about **institutional** claims comes from Chapter 11 “Institutional Other Insurance and Medicare Billing Guides” of the Medicaid Provider Manual which can be accessed at [www.ctdssmap.com](http://www.ctdssmap.com)

-If Medicare coverage exists, the **claim** must first be submitted to Medicare for reimbursement of services.

-If Medicare made payment or allowed the **claim**, the claim should be automatically transmitted to HP by Medicare. This should occur within 45 days of the provider’s receipt of the Medicare Explanation of Medicare Benefit (EOMB). This claim is called a crossover claim. If this automatic transmission does not occur, the provider should submit the crossover claim to HP. If a provider’s crossover claims are not routinely submitted automatically to HP by Medicare, the provider should contact HP to determine the cause.

-If Medicare denied the **claim**, Medicare will not send the claim to HP. The provider must submit this claim to HP. This claim is no longer a crossover claim. A claim denied by Medicare is considered a straight Medicaid claim.

-If the **claim** is submitted to HP on a UB-04 paper claim form, the EOMB **must** be sent with the claim when Medicare has made a payment. If Medicare has denied the claim, the EOMB **should not** be sent with the claim. If Medicare does deny the claim, the provider must fill out the corresponding fields on the UB-04 claim form appropriately to have the claim processed. Please note that crossover claims may be submitted to HP electronically which is the most efficient method to submit this type of claim. The EOMB guidelines listed below must be followed:

1. Providers must submit **one** paper **claim** attached to **one** EOMB when Medicare made a payment. No EOMB is required when Medicare denies the claim.
2. **Claims** with multiple EOMBs attached to one claim or multiple claims attached to one EOMB will not be processed and will be returned to the provider.
3. The patient name, dates of service and submitted charge on the EOMB must be exactly the same on the paper claim.
4. The number of detail lines submitted on the **claim** must have corresponding detail lines on the EOMB.
5. Columns that indicate Medicare billed amount, allowed amount, paid amount, coinsurance and deductible must appear on the EOMB.
6. When submitting a UB-04 paper **claim**, providers must submit an original red claim form.

- II. **Traditional Medicare B, covered service** = CT BHP authorization is required *only* when Medicare denies payment for the service.

The following information about professional claims is excerpted from Chapter 11 “Professional Other Insurance and Medicare Billing Guides” of the Medicaid Provider Manual which can be accessed at [www.ctdssmap.com](http://www.ctdssmap.com):

-If Medicare coverage exists, the **claim** must first be submitted to Medicare for reimbursement of services.

-If Medicare made payment or allowed the **claim**, the claim should be automatically transmitted to HP by Medicare. This should occur within 45 days of the provider's receipt of the Medicare Explanation of Medicare Benefit (EOMB). This **claim** is called a crossover claim. If this automatic transmission does not occur, the provider should submit the crossover claim to HP. If a provider's crossover claims are not routinely submitted automatically to HP by Medicare, the provider should contact HP to determine the cause.

-If Medicare denied the **claim**, Medicare will not send the claim to HP. The provider must submit this claim to HP. This claim is no longer a crossover claim. A claim denied by Medicare is considered a straight Medicaid claim.

-If the **claim** is submitted to HP on a CMS-1500 paper claim form, the EOMB **must** be sent with the claim when Medicare has made payment. If Medicare has denied the claim, the EOMB **should not** be sent with the claim. Please note that crossover claims may be submitted to HP electronically which is the most efficient method to submit this type of claim. The EOMB guidelines listed below must be followed:

1. Providers must submit **one** paper **claim** attached to **one** EOMB when Medicare made a payment. No EOMB is required when Medicare denies the claim.
2. Claims with multiple EOMBs attached to one **claim** or multiple claims attached to one EOMB will not be processed and will be returned to the provider.
3. The patient name, detail dates of service, procedure codes and modifiers (if any), and billed amounts (each line) on the EOMB must be exactly the same on the paper claim.
4. The number of detail lines submitted on the **claim** must have corresponding detail lines on the EOMB.
5. Columns that indicate Medicare billed amount, allowed amount, paid amount, coinsurance and deductible must appear on the EOMB.
6. When submitting a CMS-1500 paper **claim**, providers must submit an original red claim form.

Clinic Providers, who allow performers who are not eligible to enroll in the Medicare program to service clients with Medicare coverage, must obtain a denial letter from CMS indicating the categories of clinicians who are not eligible to enroll with Medicare. The letterhead of the 'not eligible to enroll' denial letter must clearly state CMS or Medicare. Medicare 'not eligible to enroll' denial letters must be updated annually with the issue date of the letter within one year of the date(s) of service on the claim. The providers' name must also be on the letter for future audit purposes. The 'not eligible to enroll' denial letter must be retained by the provider in the client's file. The provider must indicate Medicare Not Applicable in field 9D of the CMS-1500 claim form, and must include the date of the letter on the claim form. This letter **should not** be attached to the paper claim. Requests for 'not eligible to enroll' denial letters should be sent to:

National Government Services  
P.O. Box 7052  
Indianapolis, IN 46207-7052

In lieu of the Medicare 'Not Eligible To Enroll' denial letters for clinic services requested through NGS, providers may submit a copy of the list of suppliers not eligible to participate in Medicare as valid Medicare denial documentation, The list is documented in Section 6.2.1 of the Medicare Provider Integrity Manual, Chapter 10 which is located on the CMS Web site, [www.cms.hhs.gov/Manuals/IOM](http://www.cms.hhs.gov/Manuals/IOM). A copy of this page must be stored in the client's file for audit purposes and does not need to be submitted with the claim to HP. The Medicare denial date submitted on the claim would represent the date the documentation was printed. Each year the provider must validate this list to ensure it continues to be valid documentation for future claims).

III. **Managed Medicare A and/or B (In-Network Provider)** = CT BHP authorization IS required when Medicare denies payment for the service and/or when the service is not covered by Medicare. The guidance provided in items I and II above apply.

IV. **Managed Medicare A and/or B (Out-of-Network Provider), service not covered** = CT BHP authorization IS required.

*Note: Medicaid (CT BHP) is always payer of last resort*

**QUESTION 2:** When should I request behavioral health authorization from CT BHP for claims denied by Medicare?

**ANSWER:** Providers must seek authorization from CT BHP within 21 days of the date of the denial on the EOMB. This process will require sending the medical record for retrospective review. Please send medical record to:

**Connecticut Behavioral Health Partnership  
Attention: Appeals Department  
500 Enterprise Drive/Suite 4D  
Rocky Hill, CT 06067  
Phone: (860) 263-2161**

**QUESTION 3:** May the provider seek behavioral health authorization from the secondary payer Medicaid when the provider receives a denial of authorization from Medicare for additional days originally requested?

- Example: Medicare has approved 3 inpatient days, although the provider requested from Medicare 5 inpatient days.

**ANSWER:** Yes. The provider may seek authorization from CT BHP. However, if appropriate, the provider is to pursue Medicare appeal rights immediately; then outreach to Medicaid to initiate the clinical review and authorization process for the additional days. The member must meet medical necessity and appropriateness.

**QUESTION 4:** What does it mean when the eligibility verification response says, "Medicare covered services only"?

**ANSWER:** Benefits are limited to payment of Medicare co-insurance. To learn more about special programs such as the Qualified Medicare Beneficiary/QMB and the Specified Low-Income Beneficiary/SLMB, please visit the DSS website (<http://www.ct.gov/dss/site/default.asp>) or the state website (<http://www.ct.gov/>) and then click on 2-1-1; enter keyword QMB or Medicare Savings programs.

**QUESTION 5:** Will Medicaid satisfy any Medicare member deductible, co-insurance, or co-payment responsibility; and is a behavioral health authorization from Medicaid required to satisfy the member responsibilities?

**ANSWER:**

1. For crossover **claims** for **Inpatient service(s)**, Medicaid will satisfy/pay deductible, co-insurance, or co-payment member responsibilities without a CT BHP authorization on file.
2. For crossover **claims** for **Outpatient or Professional service(s)**, Medicaid will only pay up to the Medicaid allowed amount. Medicaid calculates the member responsibility based on the Medicaid allowance minus the Medicare payment; and will not pay greater than the Medicare deductible, co-insurance, or co-payment. No CT BHP authorization is needed.
  - a. For Outpatient or Professional claims; if the Medicare payment is greater than or equal to the Medicaid allowance, Medicaid will pay zero.

For QMB or SLMB members if Medicare denies the **claim**, Medicaid will not process the claim because the QMB and SLMB benefit only applies to the Medicare deductible, co-insurance or co-payment.

**QUESTION 6:** If Medicare denies a **claim** because the service is not a Medicare covered service will Medicaid Process the claim?

**ANSWER:** Yes, if it is a Medicaid covered service, Medicaid will process and pay for the services at the Medicaid fee schedule. CT BHP prior authorization and registration requirements must be met.

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**MORE INFORMATION TO COME!**

**Contact Us:**

*To speak with a CT BHP representative, please contact the Connecticut Behavioral Health Partnership at 877-552-8247. For routine inquiries, we are available Monday – Friday, 9AM – 7PM EST. To pre-certify an inpatient admission, clinical staff is available 24/7 to assist you.*