Chapter 9

Medicare/Other Insurance Liability
GENERAL INFORMATION

AHCCCS has liability for payment of benefits after Medicare and all other first- and third-party payer benefits have been paid. Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

Providers who qualify for Medicare payment but have not applied to Medicare must register their National Provider Identifier (NPI) with Medicare and must bill Medicare before billing Medicaid for all Medicare covered services.

AHCCCS maintains a record of each recipient's coverage by Medicare and Other coverages. If a recipient's record indicates first- third-party coverage but no Medicare and/or insurance payment is indicated on the claim, the claim will be denied.

The initial claim must be submitted to AHCCCS within six months of the date of service, even if payment from Medicare or Other Insurance has not been received. The claim must be resubmitted with the primary coverage payment Remit/EOB within 12-months of the date of service (clean claim time frame). (Refer to Chapter 4 General Billing Rules for timely filing requirements.)

FIRST- AND THIRD-PARTY / OTHER COVERAGE

A.R.S. §36-2946 advises that “The Administration shall coordinate benefits provided under this article to a member so that any costs for services payable by the system are costs avoided or recovered from any available third party payor. … The system shall act as a payor of last resort for members unless specifically prohibited by federal law.”

A.A.C. R-9-22-1001 – Definitions
“In addition to the definitions in A.R.S. §36-2901, 36-2923 and 9 A.A.C. 22 Article 1, the following definitions apply to this Article:

“Cost avoid” means to deny a claim and return the claim to the provider for a determination of the amount of the first- or third-party liability.

“First-party liability” means the obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

“Third-party” means a person, entity or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.
“Third-party liability” means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan.”

A.A.C. R-22-1003 Cost Avoidance section A advises that the Administration’s reimbursement responsibility is limited to no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability.

Section C advises that the requirement to “cost avoid” applies to all AHCCCS-covered services under Article 2 of this Chapter. The only exception provided by Rule is that the Administration shall pay the full amount of the claim according to the Capped Fee-For-Service schedule and then seek reimbursement when:

1. The claim is for labor and delivery and postpartum care; or
2. The liability is from an absent parent, and the claim is for prenatal care or EPSDT services.

Coordination of benefits with first- or third-parties includes, but is not limited to the following:

- Private health insurance
- Employment-related disability and health insurance
- Long-term care insurance
- Other federal programs not excluded by statute from recovery
- Court ordered or non-court ordered medical support from an absent parent
- State worker’s compensation
- Automobile insurance, including underinsured and uninsured motorists insurance
- Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust
- First-party probate estate recovery
- Adoption-related payment
- A tortfeasor

An AHCCCS registered provider agrees to accept the Capped Fee-For-Service schedule as payment in full.
If the first- or third-party coverage paid more than the Capped Fee-For-Service scheduled amount then no further reimbursement is made by AHCCCS.

For example, a provider bills $4,500.00 for a surgical procedure:
- the first-party plan allowed $1,388.23, paid $1,110.58 and shows a 20% coinsurance amount of $277.65;
- the AHCCCS Capped Fee-For-Service schedule allows $753.21 for the surgery

There will be no AHCCCS payment, as the provider has already been paid more than the Capped Fee-For-Service scheduled amount. The provider must accept the $1,110.58 as payment in full and cannot balance bill the recipient for any amount.

Should more than one coverage plan make payment and the total paid by the multiple coverage plans is more than the AHCCCS Capped Fee-For-Service schedule then there will be no AHCCCS payment and the provider cannot balance bill the recipient for any amount.

If the first- or third-party payor denies a covered service the provider must follow the plan’s appeal process and exhaust all remedies before AHCCCS can consider the covered service. The provider must submit a copy of plan’s final appeal decision to AHCCCS with the claim resubmission or the claim may be denied as incomplete.

**MEDICARE**

**A. AHCCCS MEDICARE ELIGIBILITY DEFINITIONS**

**QMB Only** – a Qualified Medicare Beneficiary under the Federal QMB program. This individual has Medicare coverage but does not qualify for Medicaid. AHCCCS can only reimburse the provider for the Medicare deductible and coinsurance. If Medicare denies the service and upholds the denial upon the provider’s appeal, then AHCCCS makes no payment. Refer to Arizona Administrative Code (A.A.C.) R9-29-301.

**QMB Dual** – this individual qualifies under the federal QMB program and has AHCCCS. Per A.A.C. R9-29-302, AHCCCS will pay the following costs for FFS recipients when the services are received from an AHCCCS registered provider and the service is covered:

1. a. By Medicare only, then AHCCCS pays only the Medicare deductible/coinsurance
   b. By Medicaid only, then AHCCCS pays the FFS rate
   c. By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible/coinsurance.
2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance.
A.A.C. R9-29-302.E. advises: “A QMB Dual eligible member who receives services under 9 A.A.C. 22, Article 2 or 9, A.A.C. 28, Article 2 from a registered provider is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges.”

**Non-QMB Dual** – this individual does not qualify for the federal program but is eligible for both Medicare and Medicaid (also known as “Dual Eligible”). Per A.A.C. R9-29-303 AHCCCS will pay the following costs for FFS recipients when services are received from an AHCCCS registered provider and the service is covered:

1. a. by Medicare only, then AHCCCS shall *not* pay the Medicare deductible or coinsurance or copay
   b. by Medicaid only, the AHCCCS pays the FFS rate
   c. by both Medicare and Medicaid, then AHCCCS pays the Medicare deductible, coinsurance or copay.
2. When services are received from a non-registered provider and the service is covered, then AHCCCS does *not* pay the Medicare deductible/coinsurance.

**B. GUIDELINES FOR “DUAL ELIGIBLE” RECIPIENTS**

A Medicare provider must accept Medicare allowable as the total compensation for services rendered. Based on the recipient’s eligibility, when appropriate, AHCCCS may reimburse up to the Medicare deductible, coinsurance or copay for services, including recipients enrolled with a Medicare Advantage HMO plan. Contact the Medicare Advantage HMO plan for information regarding covered services and prior authorization requirements.

Services that are not Medicare covered but are AHCCCS covered may be reimbursed by AHCCCS if the service is medically necessary and meets the AHCCCS eligibility and reimbursement requirements.

If Medicare denies a covered service based on medical necessity or if the service was not delivered in the appropriate setting, the service will not be paid by AHCCCS.

If Medicare denies a covered service the provider must follow the Medicare appeal process and exhaust all remedies before AHCCCS can consider the covered service. The provider must submit a copy of Medicare’s final appeal decision to AHCCCS with the claim resubmission or the claim may be denied as incomplete.

If a recipient is *eligible* for Medicare Part D then AHCCCS does not cover prescription medications or Part D copay amounts.

AHCCCS will not pay for more than the recipient’s financial responsibility for the service (e.g., any deductible, coinsurance, and/or co-pay as indicated above).
C. **MEDICARE CROSSOVER CLAIMS**

AHCCCS has established an automated crossover process for fee-for-service claims.

When a provider submits a claim to Medicare for an AHCCCS recipient the claim is automatically crossed over to AHCCCS when Medicare issues payment. Providers should not submit claims to AHCCCS for paid Medicare claims for Dual eligible AHCCCS recipients or QMB recipients. All crossover claims are identified on the provider’s Medicare remittance advice.

Denied and adjusted Medicare claims are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS within the timely filing requirements. A copy of the RA/EOMB must accompany the claim to AHCCCS. (Refer to Chapter 4 General Billing for timely filing requirements and the claim resubmit process.)

**FILING PAPER OR ONLINE CLAIMS AFTER MEDICARE / FIRST- AND THIRD-PARTY PAYOR PAYMENT**

**Note:** for purposes of this billing manual chapter the following abbreviations are defined:

- EOMB means explanation of Medicare benefits
- EOB means explanation of benefits by First- and Third-Party payor
- RA means remittance advice

Each of these documents show payment details of a provider’s claim for services.

Denied Medicare claims are not automatically crossed over to AHCCCS. Read the Medicare RA/EOMB carefully to determine if the claim crossed over to AHCCCS or if the provider must submit the claim and the Medicare RA/EOMB to AHCCCS. Read the Medicare reason codes carefully to determine if the Medicare appeal process must be followed before AHCCCS can determine reimbursement.

Adjusted Medicare claims are not automatically crossed over to AHCCCS at this time. The provider must resubmit the claim to AHCCCS with a copy of the original Medicare RA/EOMB and the adjustment RA/EOMB with all of the reason codes displayed. Claims submitted with only the Medicare adjustment RA/EOMB may be denied by AHCCCS as incomplete. If the Medicare RA/EOMB is submitted to AHCCCS without the reason code page(s) the claim may be denied as incomplete.

These claims must achieve clean claim status within 12 months from the date of service, as long as the initial claim submission to AHCCCS was within 6 months from the date of service.
Providers must submit a separate RA/EOMB/EOB with each claim form. If a provider submits multiple claims for a recipient but includes only one copy of the RA/EOMB or EOB, the payment document will be attached to the claim with highest coinsurance and deductible amount. The other claims in the package will be denied for lack of a Medicare RA/EOMB or Other Coverage RA/EOB.

Always attach a copy of the Medicare / Third Party Payor’s RA/EOB to each claim submitted.

Always include the Medicare RARC/CARC key page(s) for the RA/EOMB.

Always include the Remark/Reason Code key page(s) for the Other payor’s RA/EOB.

Note: failure to submit the remark/reason code key page(s) with the RA/EOMB/EOB are considered incomplete claims and will result in claim denial.

**FOR RECIPIENTS WITH MEDICARE/OTHER COVERAGE BUT THE SERVICE IS NOT COVERED BY MEDICARE/OTHER PLAN**

If the recipient has Medicare/Other coverage but the service is not covered by Medicare/Other coverage or the provider has received no reimbursement from Medicare or Other coverage, the provider should “zero fill” Field 24J (shaded area) and submit the claim within the appropriate time frame, with the EOB/EOMB.

1. Leaving the field blank will cause the claim to be denied.
2. Zeros indicate that no payment was received.
3. If payment from Medicare or a Medicare Advantage plan is received after the provider has been reimbursed by AHCCCS, the claim to AHCCCS must be adjusted. (see Chapter 4 for submission instructions on claim adjustments)

**Example 1:** Provider reports no payment received from Medicare in section J
If a covered service is denied by Medicare/Other coverage, the provider’s claim to AHCCCS also will be denied unless the provider has obtained authorization from Utilization Management/Care Management (UM/CM).

The Medicare RA/EOMB may combine each individual line charge into a single charge for the entire claim and issue payment based on the total charges. The RA/EOMB may not show a coinsurance amount for each billed charge.

For AHCCCS to correctly process and reimburse claims, providers must follow these steps to prorate the total coinsurance amount and allocate it to each line of the claim.

a. Divide the coinsurance amount by the total covered charges allowed by Medicare as shown on the RA/EOMB.
b. Multiply the charges on each line by the percentage calculated in Step 1.
c. Enter the prorated coinsurance amounts calculated in Step 2 on the CMS 1500.

Example 2: Provider submits a three-line claim to AHCCCS.

- Total covered charges allowed by Medicare $4,210.00
- Medicare paid amount $3,368.00
- Coinsurance $ 842.00

1. Divide the coinsurance amount by the total covered charges allowed by Medicare.
   \[ \frac{842.00}{4,210.00} = 0.20 \]  
   Coinsurance is 20% of total charges

2. Multiply the charges per line by the percentage calculated in Step 1.

<table>
<thead>
<tr>
<th>LINE</th>
<th>BILLED CHARGES X PER CENT</th>
<th>PRORATED COINSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2,900.00 X .20</td>
<td>580.00</td>
</tr>
<tr>
<td>2</td>
<td>270.00 X .20</td>
<td>54.00</td>
</tr>
<tr>
<td>3</td>
<td>1,040.00 X .20</td>
<td>208.00</td>
</tr>
<tr>
<td>Total</td>
<td>4,210.00 X .20</td>
<td>842.00</td>
</tr>
</tbody>
</table>

3. Enter the amounts calculated in Step 2 on the corresponding lines of CMS 1500. If the deductible has been met, enter zero (Ø) on each line.
For Other first- and third-party payors, perform the same calculations to the paid amount and enter only the prorated paid amount in Field 24 J.

D. UB-04 CLAIMS WITH MEDICARE/OTHER INSURANCE

When a provider finds it necessary to file a UB-04 claim with AHCCCS for a recipient who also is covered by Medicare or other insurance, the provider must report Medicare and other insurance information on the claim to AHCCCS.

For recipients and services covered by Medicare, providers must bill Medicare first. When payment is received, providers may bill AHCCCS for the coinsurance and deductible as shown on the Medicare RA/EOMB. Providers must attach a copy of the Medicare RA/EOMB to the UB-04 claim.

1. Medicare Part A
   a. Report the Part A deductible and coinsurance (if applicable) amounts and appropriate value codes in Fields 39A and 40A.
   b. Use value code A1 to indicate Part A deductible and A2 for Part A coinsurance.

   **Example 3:** Provider reports Medicare Part A deductible of $812 and no coinsurance.

<table>
<thead>
<tr>
<th>39 VALUE CODE</th>
<th>40 VALUE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE</td>
<td>AMOUNT</td>
</tr>
<tr>
<td>a</td>
<td>A1</td>
</tr>
<tr>
<td>b</td>
<td>812</td>
</tr>
<tr>
<td>c</td>
<td>00</td>
</tr>
<tr>
<td>d</td>
<td></td>
</tr>
</tbody>
</table>

2. Medicare Part B - Inpatient
   a. Report Medicare Part B as the payer and the Part B paid amount in Fields 50B and 54B.

   **Example 4:** Provider reports Medicare Part B Inpatient payment of $312.

<table>
<thead>
<tr>
<th>50 PAYER</th>
<th>51 PROVIDER NO.</th>
<th>52 REL. 53 ASG. INFO</th>
<th>54 PRIOR PAYMENTS</th>
<th>55 EST. AMOUNT DUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>B. MEDICARE PART B</td>
<td>00</td>
<td>312</td>
<td>00</td>
</tr>
</tbody>
</table>
3. Medicare Part B - Outpatient
   a. Report the Part B deductible (if applicable) and coinsurance amounts and appropriate value codes in Fields 39B and 40B.
   b. Use value code B1 to indicate Part B deductible and B2 for Part B coinsurance.

Example 5: Provider reports outpatient Part B coinsurance of $125.

<table>
<thead>
<tr>
<th>39 VALUE CODE CODE</th>
<th>40 VALUE CODE CODE</th>
<th>41 VALUE CODE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE AMOUNT</td>
<td>CODE AMOUNT</td>
<td>CODE AMOUNT</td>
</tr>
<tr>
<td>a</td>
<td>b</td>
<td>c</td>
</tr>
<tr>
<td>B2</td>
<td>125</td>
<td>00</td>
</tr>
</tbody>
</table>

4. First- and Third-party payors
   a. Report the payor’s name and payment amount in Fields 50A and 54A or 50B and 54B. (List all First- and Third-party payors & payments)
   b. Attach a copy of the payor’s RA/EOB to the UB-92 claim.

Example 6: Provider reports a first- and third-party payment total of $1,275.00.

<table>
<thead>
<tr>
<th>50 PAYER</th>
<th>51 PROVIDER NO.</th>
<th>52 REL. 53 ASG INFO BEN</th>
<th>54 PRIOR PAYMENTS</th>
<th>55 EST AMOUNT DUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>XYZ Insurance</td>
<td></td>
<td>1,225</td>
<td>00</td>
</tr>
<tr>
<td>B</td>
<td>Acme Benefits</td>
<td></td>
<td>50</td>
<td>00</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Providers may not “zero fill” the payment amount fields on hospital inpatient and outpatient claims, dialysis facility claims, and hospice claims. If a claim is denied by Medicare or Other coverage, providers should submit documentation of the denial with the UB-04 claim to AHCCCS.
E. Nursing Facility Claims with Medicare/Other Insurance

AHCCCS is responsible for reimbursement of Medicare coinsurance minus any Other coverage payment, minus the recipient’s share of cost (SOC).

When a nursing facility submits a claim to Medicare Part A intermediaries for an AHCCCS recipient who also is Medicare eligible, the claim is automatically crossed over to AHCCCS when Medicare issues payment.

Nursing facilities should not submit claims to AHCCCS for paid Medicare claims for dually eligible AHCCCS recipients or QMB recipients. All Medicare crossover claims are identified on the provider’s remittance advice.

When a recipient has exhausted the Medicare benefit for nursing facility coverage, the nursing facility must submit a claim to AHCCCS. The facility should “zero fill” the Medicare fields and submit the claim within the appropriate time frame. Leaving the fields blank will cause the claim to be denied. Zeros indicate that no payment was received.

Example 7: Provider reports no payment received from Medicare.

Value Code A2 = Medicare Part A Coinsurance

| CODE | AMOUNT |  |  |  |
|------|--------|  |  |  |
| A2   | 00     | 00 | | |
| b    |  |  |  |  |
| c    |  |  |  |  |

If payment from Medicare or Other first- or third-party payor is received later, the claim must be adjusted.

Denied and adjusted Medicare claims also are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS within the timely filing requirements.

A copy of the Medicare RA/EOMB must accompany the claim to AHCCCS.
F. RETROACTIVE POSTING OF MEDICARE ELIGIBILITY

Occasionally, AHCCCS learns that a recipient is eligible for Medicare after payment has been made to the provider. When that happens, AHCCCS recoups the money overpaid from future payments to the provider and advises the provider to bill Medicare.

AHCCCS contracts with Health Management Systems, Inc. (HMS) to identify inpatient hospital claims that are overpaid due to the late posting of Medicare eligibility.

AHCCCS will systematically identify all members with retroactive Medicare posting for whom the agency has paid claims from both hospitals and other providers, without consideration of the potential Medicare payment. A report is reviewed monthly and allows AHCCCS to recoup any overpayments from all provider types.

When AHCCCS recoups, providers should bill Medicare and follow the procedure outlined earlier in this chapter.