Under provisions of the Balanced Budget Act of 1997, a state is not required to pay for any expenses related to payment for deductibles, coinsurance, or co-payments for Medicare cost sharing for dually eligibles that exceed what the state's Medicaid program would have paid for such service for a beneficiary who is not a dually eligible. When a state's payment for Medicare cost-sharing for a dually eligible is reduced or eliminated, the Medicare payment plus the state's Medicaid payment is considered payment in full, and the dually eligible cannot be billed the difference between the provider's charge and the Medicare and Medicaid payment.

The Medicaid reimbursement for Medicare Part A crossover claims for dually eligible beneficiaries is restructured as follows:

(1) The Medicaid reimbursement combined with the Medicare reimbursement will not exceed what the Mississippi Medicaid program would have paid for such service for a beneficiary who is not dually eligible;

(2) All service limits will be applied to beneficiaries who are dually eligible when reimbursement is made toward covered services with service limits. Once the service limits are reached each state fiscal year, no additional payments will be made for these services.

(3) All providers must accept the Medicare and Medicaid payment as payment in full. The provider is prohibited from billing the beneficiary the balance between the provider's charge and Medicare and Medicaid payments.

Benefits for inpatient hospital services under the Mississippi Medicaid program are limited to thirty (30) inpatient days per fiscal year. This limitation is applicable to inpatient crossover claims. ~~The Medicare deductible period is not applied toward the thirty (30) inpatient days and services limits. Medicaid limits begin counting on the first coinsurance day. The thirty (30) day inpatient limitation starts on the first coinsurance day.~~ Each day of inpatient services will count toward the service limit. The deductible period is not exempt from the limit of 30 inpatient days per fiscal year.

~~If a beneficiary has a continuous hospitalization that carries over to a new fiscal year beginning July 1, another 30 days of coinsurance is available. This is also applicable to the lifetime reserve period if the beneficiary is utilizing the lifetime reserve days on or after July 1.~~

~~Medicare's lifetime reserve days are the sixty days that Medicare will pay for when the beneficiary is in the hospital for more than ninety (90) days and can be used only once.~~

All paper crossover claims billed for an inpatient hospital deductible must be billed with a bill type 111 (Hospital Inpatient Admit thru Discharge Claim) or 112 (Inpatient Hospital Interim – First Claim). If a claim is billed for an inpatient deductible and the type of bill is not 111 or 112, the claim will be denied with error code 024. The deductible must be billed with type of bill 111 or 112.

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid (dual) eligible. Refer to Third Party Recovery, Section 6, in this manual.

Medicare is the primary coverage for dual eligible beneficiaries; however, the hospice benefit is used simultaneously under both programs. The hospice benefit, and each period therein, is available only once in a lifetime for dual eligible beneficiaries. Conversely, the hospice benefit and each period therein, must be elected and revoked simultaneously under both programs.

For information on "Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles" for Part A crossover claims, refer to Provider Policy Manual Section 2.05.

~~**Section 36.05 is RESERVED FOR FUTURE USE.**~~

Medicare is the primary payor for dually eligible recipients, and providers are obligated to comply with the requirements covering the coordination between the two programs. Persons eligible for Medicare and Medicaid are entitled to all covered services available under both programs, but a claim must be filed with Medicare if Medicare covers the service.

For information on "Medicaid Cost Sharing for Medicare/ Medicaid Dually Eligibles" for Medicare Part A Crossover claims, refer to Provider Policy Manual Section 2.05.

Medicare is the primary payor for dually eligible recipients, and providers are obligated to comply with the requirements covering the coordination between the two programs. Persons eligible for Medicare and Medicaid are entitled to all services available under both programs, but a claim must be filed with Medicare if Medicare covers the services. A patient may not receive home visits under both programs simultaneously. For information on "Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles" for Medicare Part A crossover claims, refer to Provider Policy Manual Section 2.05

If Medicare does not cover nurse visits, physical therapy visits, or speech therapy visits because skilled services are not being provided, Mississippi Medicaid will not cover the services.

If Medicare does not cover aide visits because a skilled service is not being provided, the provider may request certification for the aide visits through the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO). If approved by the UM/QIO, the provider may bill Mississippi Medicaid for the aide visit. The only justification for billing Medicaid for aide visits on a dual eligible beneficiary is that (1) the beneficiary does not qualify for a Medicare skilled service, and (2) the provider has obtained certification for the visit through the UM/QIO.

Twenty-five home health visits per fiscal year limit is applicable for beneficiaries age 21 and over. For beneficiaries under age 21, the UM/QIO may approve medically necessary visits beyond the limit of twenty-five (25).