Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2016-71**
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TO: Federally Qualified Health Centers
RE: Reimbursement for Services Performed on Dually Eligible (Medicare/Medicaid) Patients

This provider bulletin is to remind Federally Qualified Health Centers (FQHCs) that the HUSKY Health plan is the payer of last resort for members who are dually eligible for Medicare and Medicaid. All encounters for services provided to any HUSKY Health member who is dually eligible for coverage under the Medicare and Medicaid programs must be submitted to the Medicare plan prior to being remitted to the HUSKY Health plan.

Reimbursement by the HUSKY Health Plan for Denied Medicare Claims

If services provided to dually eligible members are denied for reimbursement by the Medicare plan, and the service is eligible for Medicaid reimbursement, FQHCs may submit those claims for reimbursement. Note, however, that the Department will not reimburse denied Medicare claims if the denial was based on incorrect claim submission to the Medicare plan. Please refer to the "Billing Instructions" of this provider bulletin for more information about submitting claims for Medicare reimbursement.

Reimbursement by the HUSKY Health Plan for Approved Medicare Claims

The Department will reimburse the difference between the amount paid by Medicare and the Medicaid encounter rate.

Reminder: Medicare crossover claims are reimbursed at the full Medicaid FQHC clinic encounter rate for procedure code T1015, minus the Medicare payment. As a result, the Medicaid payment could be greater than or less than the coinsurance and/or deductible amount reflected on the Explanation of Medicare Benefits (EOMB).

Documentation and Auditing

All documentation must be in compliance with Sec. 17b-262-1004 of the regulations of Connecticut state agencies. Also, as required by that regulation, all of the required documentation for encounters must be retained in the member's medical file and it must be available to the Department upon request.

FQHCs must also retain a copy of the Explanation of Medicare Benefits (EOMB) as part of the member's file for auditing purposes. The Department may disallow and recover any amounts paid to FQHCs for which the required documentation is not maintained and not provided to the Department upon request.

Billing Instructions

FQHCs should refer to Provider Manual Chapter 8, Section 8.5 to obtain billing instructions for dually eligible members. This manual can be accessed from the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com, by selecting "Information" then "Publications" and scrolling down to the Provider Manuals section of the page. From the Chapter 8 drop down menu, select "Federally Qualified Health Center".

Providers, who have received documentation from the Centers for Medicare and Medicaid Services (CMS) confirming their ineligibility to enroll as a Medicare provider, should refer to Provider Manual Chapter 8 FQHC as instructed above and/or Chapter 5 on the CMAP Web site for billing instructions.

FQHCs should refer to the Medicare claim processing manual and related articles found on CMS.gov to review the billing instructions for submitting claims to Medicare for FQHCs' encounters.

If you have any questions regarding this bulletin, please contact the Provider Assistance Center at 1-800-842-8440.