LOUISIANA BLUE

providerTIDBIT

a guide to understanding our processes

Medicare Crossover Claims

Medicare crossovers are electronically filed claims that Medicare automatically forwards or "crosses over" to Blue Cross and Blue Shield of Louisiana when member information is available in the Medicare eligibility file. This process includes claims where Medicare is primary and Louisiana Blue is secondary.

All Blue Plans have established a standardized Medicare Crossover Agreement with the Centers for Medicare & Medicaid Services (CMS). This standard agreement requires that crossover claims be sent directly from the Medicare crossover carrier, Group Health Inc. (GHI), to the member's Blue Plan (information on BlueCard® members can be found on the backside of this guide).

This means all claims, regardless of the state where the service was rendered, will be sent directly to the member's Blue Plan. For example, Louisiana Blue receives crossover claims for our members even when the service was rendered in a state other than Louisiana.

How to Tell if a Medicare Claim Was Crossed Over

When a claim is crossed over to Louisiana Blue from Medicare, there will be a message beneath the patient's claim information on the Medicare remittance advice.

"Claim information forwarded to: BCBS of Louisiana-Supplemental"

This message indicates the claim was forwarded electronically from Medicare to Louisiana Blue for processing.

"Claim information forwarded to: BCBS of Louisiana-Other"

This message indicates the claim was forwarded electronically from Medicare to Louisiana Blue Federal Employee Program area for processing.

If the remittance advice does not contain a message similar to these examples, then the claim was not forwarded to Louisiana Blue or processing. Refer to the instructions on "Resubmitting a Claim That Did Not Crossover" on the reverse side of this guide.

Checking Claim Status on Crossover Claims

Please wait **21 days** from the Medicare remittance advice date before checking on the status of the crossover claim in iLinkBlue (www.lablue.com/ilinkblue) or by calling the Customer Care Center at 1-800-922-8866.

If after 21 days, the claim cannot be located in iLinkBlue, please contact EDI Services at 1-800-716-2299, option 3 or email EDIservices@lablue.com.

Please provide the following information:

- Provider NPI
- Member ID number
- Patient name
- Patient date of birth
- Date of service
- Amount charged

This publication is provided by the Health Services Division of Louisiana Blue. If you have a question regarding this document, please email provider.communications@lablue.com and reference the title listed on this publication.

18NW1741 R01/25

Last reviewed on: 01-29-25

Resubmitting a Claim That Did Not Crossover

For Louisiana claims that did not crossover automatically (except for Statutory Exclusions), the provider will need to wait **31 days** from the date shown on the Medicare remittance. Claims submitted before 31 days will be rejected on the Louisiana Blue Not Accepted Report.

After 31 days, the claim that did not crossover can be submitted electronically in the 837 format (if sending through a clearinghouse, verify that your clearinghouse allows the electronic submission of these claims) or on a paper claim form (CMS-1500 or UB-04) along with a copy of the Medicare remittance advice.

Reasons a Medicare Claim May Not Cross Over

1. The Blue Plan does not have the patient's Medicare Beneficiary Identifier (MBI) number in its files.
2. The MBI number on file with the Blue Plan is incorrect.

Services Excluded or Not Covered by Medicare

When a charge is considered excluded or not covered, providers are not required to wait the 31 days to file the claim. The claim should contain Modifier GY with the specific, appropriate Healthcare Common Procedure Coding System (HCPCS) code, if available. If there is not a specific HCPCS code, a "not otherwise classified code" (NOC) must be used with Modifier GY.

These claims can be filed electronically or on paper to Louisiana Blue.

BlueCard® (members of out-of-state Blue Plans)

When a Medicare claim is crossed over to an out-of-state Blue Plan, the Medicare remittance advice will have a message beneath the patient's claim information similar to the following example:

"Claim information forwarded to: BCBS of Texas"

Messages of this nature indicate the claim has been forwarded to the member's out-of-state Blue Plan. The state name will be listed in the message.

If the remittance advice does not contain a message similar to this example, then the claim was not forwarded electronically to the member's Blue Plan for processing. The participating provider must then file the claim along with a copy of the Medicare Remittance Advice with the provider's local Blue Plan.

Checking Claim Status on BlueCard Crossover Claims

If Medicare has forwarded the claim to the BlueCard member's plan, please allow **25-30 days** from the Medicare remittance advice date before contacting the member's Blue Plan.

For more information about the BlueCard program, please refer to *The BlueCard Program Provider Manual* found online at www.lablue.com/providers >Resources.

End