Job Aid

Professional Crossover Claim Submission

This job aid provides step by step instructions to submit a Professional Crossover Claim in the MESA portal. Please read the instructions thoroughly and follow all directions.

Review the Steps to Submit a Professional Crossover Claim

Steps	Description
Step 1	Login to the Portal. The **Portal Home** screen Displays.
Step 2	The following steps will review how to submit a Professional Crossover Claim in MESA: Hover over the **Claims** tab on the menu bar. A list of claim types displays below. • Select **Submit Claim Prof**.
Step 3	The Portal displays the "Submit Professional Claim": Step 1 page. • Select **Claim Type** Crossover Professional.

Steps	Description
	Submit Professional Claim: Step 1 * Indicates a required field. Claim Type Crossover Professional
Step 4	• Complete the **Provider Information** section. NOTE: There will be information already generated in this section. Complete additional fields if applicable to the claim being submitted. **Provider Information** Billing Provider ID ID Type NPI Name Taxonomy Performing Provider ID ID Type NPI Name _ Taxonomy _ Referring Provider ID ID Type NPI Name _ Taxonomy _ Supervising Provider ID ID Type NPI Name _ Taxonomy _
Step 5	• Complete the **Member Information** section. NOTE: Once the Member ID is entered, the system will generate the remaining fields in this section. Verify the fields populate correctly. **Member Information** *Member ID Last Name _ First Name Birth Date _ Address Address Line 2 City State Zip Code 🛈
Step 6	• Complete the **Claim Information** section. NOTE: The "**Include Other Insurance"** check box is selected based on the Claim Type selected. NOTE: Everything with a red asterisk * must be completed. **Claim Information** Date Type Date of Current 🛈 Accident Related Admission Date 🛈 Patient Number Authorization Number *Transport Certification ◯ Yes ⦿ No *Does the provider have a signature on file? ◯ Yes ⦿ No *Does the provider accept assignment for claim processing? ◯ Yes ⦿ No ◯ Clinical Lab Services Only *Are benefits assigned to the provider by the patient or their authorized representative? ◯ Yes ⦿ No ◯ N/A *Does the provider have a signed statement from the patient releasing their medical information? ◯ Yes ⦿ No Include Other Insurance ☑ Total Charged Amount $0.00
Step 7	• Complete the **Medicare Crossover Details** section. • Review all sections on Submit Professional Claim: Step 1 page. If all the information entered is correct select **Continue** to move on to Step 2.

Steps	Description
	Medicare Crossover Details Allowed Medicare Amount $0.00 Co-insurance Amount [0.00] Deductible Amount [0.00] Psychiatric Services Amount [0.00] Medicare Payment Amount [0.00] Medicare Payment Date❶ [ ] 📅 Copay Amount [0.00] **[Continue]** **[Cancel]**
Step 8	The Portal displays the "Submit Professional Claim": Step 2 page. The previous information that was entered in step 1 will display at the top of the page in step 2. • Review the previously submitted information and scroll down. **Submit Professional Claim: Step 2** ❓ * Indicates a required field. Claim Type Crossover Professional **Provider Information** Billing Provider ID ID Type NPI Name Taxonomy **Patient and Claim Information** Member ID Member Gender Birth Date Total Charged Amount **Medicare Crossover Details** Allowed Medicare Amount $0.00 Co-insurance Amount $0.00 Deductible Amount $0.00 Psychiatric Services Amount $0.00 Medicare Payment Amount $0.00 Medicare Payment Date _ Copay Amount $0.00
Step 9	• Enter the **Diagnosis Code** then select **Add**. NOTE: Everything with a red asterisk * needs to be complete if the section is applicable to the claim. **Diagnosis Codes** ➖ Select the row number to edit the row. Click the **Remove** link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code. | #	Diagnosis Type	Diagnosis Code	Action
1				 1 *Diagnosis Type [ICD-10-CM ▼] *Diagnosis Code❶ [ ] **[Add]** [Reset]
Step 10	Scroll down to the **Other Insurance Detail** panel. NOTE: If there is other insurance information already populated that is out of date, select the **Remove** button under the **Action** column. • Select the **plus sign** to add any other insurance.

Steps	Description
	Other Insurance Details ▬ Enter the carrier and policy holder information below. Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section. **NOTE:** Please click **Remove** to discard any unrelated "Other Insurance", prior to submitting claim. Refresh Other Insurance **#** | **Carrier Name** | **Carrier Code** | **Group #** | **COB Payer Paid Amount** | **Remittance Date** | **Action** ⊞ Click to add a new other insurance.
Step 11	The required fields to be completed for the Other Insurance Details section depend on the selection in the **Claim Filing Indicator** dropdown. Select **16 (Medicare Part C), MA (Medicare Part A), or MB (Medicare Part B)** for the Claim Filing Indicator and the additional fields will not be displayed. Anything selected other than 16, MA, or MB will require additional fields to complete the Other Insurance Details section. • Select MB-Medicare Part B from the **Claim Filing Indicator** dropdown. • Select **Add Insurance**. **Other Insurance Details** ▬ Enter the carrier and policy holder information below. Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section. **NOTE:** Please click **Remove** to discard any unrelated "Other Insurance", prior to submitting claim. Refresh Other Insurance **#** | **Carrier Name** | **Carrier Code** | **Group #** | **COB Payer Paid Amount** | **Remittance Date** | **Action** ⊟ Click to collapse. *Claim Filing Indicator [MB-Medicare Part B ⌄] [Add Insurance] [Cancel Insurance]
Step 12	Other Insurance displays on line #1 for Medicare Part B. • Select the **plus sign** to add another Other Insurance. **Other Insurance Details** ▬ Enter the carrier and policy holder information below. Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section. **NOTE:** Please click **Remove** to discard any unrelated "Other Insurance", prior to submitting claim. Refresh Other Insurance **#** | **Carrier Name** | **Carrier Code** | **Group #** | **COB Payer Paid Amount** | **Remittance Date** | **Action** 1 | Claim Filing Indicator: 'Medicare Part B' | | | | | Remove ⊞ Click to add a new other insurance.
Step 13	• Select LM-Liability Medical for the **Claim Filing Indicator**. The additional fields display once the selection is made. • Complete the additional other insurance fields that are required.

Steps	Description
	o Link to Carrier Codes • Complete the Outpatient Adjudication Information section if applicable. • Once all the information is entered select **Add Insurance**. NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim. **Carrier table:** | #	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	Action
---	---	---	---	---	---	---
1	Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'					Remove	 ☐ Click to collapse. *Claim Filing Indicator: 17-Dental Maintenance Organization *Carrier Name: ___ *Carrier Code: ___ *Subscriber Last Name: ___ *First Name: ___ Subscriber Address: ___ City: ___ State: ___ Zip Code: ___ Country: ___ *Subscriber ID: ___ *Group #: ___ Group Name: ___ Insurance Type: ___ *Payer Responsibility: ___ *Relationship to Subscriber: ___ *COB Payer Paid Amount: 0.00 *Remittance Date: ___ Remaining Patient Liability: ___ *Release of Information: ___ Assignment of Benefits: ___ Patient Signature Source Code: ___ **Outpatient Adjudication Information** Reimbursement Rate: ___ Claim HCPCS Payable Amount: ___ Remark CoMS 1: ___ Remark Code 2: ___ Remark Code 3: ___ Remark Code 4: ___ Remark Code 5: ___ Non-payable Professional Component Amount: ___ Claim ESRD Payment Amount: ___ **Add Insurance** **Cancel Insurance**
Step 14	• After the other insurance has been added, select the number **2 hyperlink** to proceed to view the other insurance sub-panel. NOTE: Users can only view the Other Insurance Reasons sub-panel if the Claim Filing Indicator is anything other than 16 (Medicare Part C), MA (Medicare Part A), or MB (Medicare Part B). The user **MUST** select on the number hyperlink after adding insurance in order to view it.

Steps	Description
	Other Insurance Details — Enter the carrier and policy holder information below. Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section. NOTE: Please click **Remove** to discard any unrelated "Other Insurance", prior to submitting claim.
Step 15	Scroll down to the **Other Insurance Reason** section. • Fill out the Other Insurance Reasons section and select **Add Reason**. NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim. • Once the Other Insurance Reasons are added select **Save Insurance** and move on to the next section.
Step 16	The Portal displays the "Submit Professional Claim": Step 3 page. The previous information that was entered in step 1 and step 2 is displayed at the top of the page on step 3. • Scroll down to view the additional sections on this page. NOTE: Select the plus and minus for each section to expand and collapse the section.

Within the Step 15 row, a form is shown:

Other Insurance Details

Refresh Other Insurance

#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	Action
1	Claim Filing Indicator: 'Medicare Part B'					Remove
2	test	test	test	$0.00	11/30/2022	Remove

Click to add a new other insurance.

Other Insurance Reasons

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Group Code	Reason	Amount	Units of Service	Action

Click to collapse.

*Group Code
*Reason
*Amount 0.00   Units of Service

Add Reason   Cancel Reason

Save Insurance   Cancel Insurance

Click to add a new other insurance.

Steps	Description

Submit Professional Claim: Step 3

* Indicates a required field.

Claim Type Crossover Professional

Provider Information

Billing Provider ID	ID Type NPI	Name
Taxonomy		

Patient and Claim Information

Member ID	
Member	Gender
Birth Date	Total Charged Amount

Medicare Crossover Details

Allowed Medicare Amount	$0.00	Co-insurance Amount	$0.00
Deductible Amount	$0.00	Psychiatric Services Amount	$0.00
Medicare Payment Amount	$0.00	Medicare Payment Date	_
Copay Amount	$0.00		

Expand All | Collapse All

Diagnosis Codes ☐

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code
1	ICD-10-CM	R071-CHEST PAIN ON BREATHING

Other Insurance Details ☐

#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date
1	Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'				
2	test	test	test	$0.00	12/09/2022

Step 17	• Fill out the required information for the **Service Details** section.
	  ○ Complete the **Medicare Crossover Details** section if applicable.
	  ○ Complete the **NDCs for Svc. #1** panel if applicable.
	• Once all information has been completed, select **Add**.
	NOTE: The system requires that the Medicare Crossover Details amounts at the header level (the section completed in Step 1) are balanced against the Medicare Crossover Details amounts at the service line level (the section displayed here in Step 2). The amount for each corresponding field should balance out. An **edit** will be displayed when the amounts are not balanced.
	NOTE: If values are not completed at both the header level and the details level, the system will not try to balance them.

Steps	Description
Step 18	• Select the **1 hyperlink** in the Svc # column to view the Other Insurance Details for Svc # 1 section.
Step 19	If any insurance was added with a Claim Filing Indicator value other than 16, MA, or MB then the Other Insurance Details for Svc # 1 section displays and can be completed. If the Other Insurance Details for Svc # 1 section is displayed then the Other Carrier dropdown will only display the insurance carrier options with Claim Filing Indicator values other than 16, MA, or MB. • Complete the required information for the **Other Insurance Details for Svc # 1** section if applicable. • Select **Add Insurance** then select **Save** to save the service line detail if information was added to this section. NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim.

Steps	Description
	Service Details Select the row number to edit the row. Click the **Remove** link to remove the entire row. 	Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
---	---	---	---	---	---	---	---
1	12/07/2022	12/08/2022	02-Telehealth Provided other than in Patient's Home	01232-ANESTH AMPUTATION OF FEMUR		1.000 Unit	Remove | 1 *From Date ⓘ [12/07/2022] 📅 To Date ⓘ [12/08/2022] 📅 *Place of Service [02-Telehealth Provided other than in Patient's Home ▾] EMG [▾] *Procedure Code ⓘ [01232-ANESTH AMF] Modifiers ⓘ [____] [____] [____] [____] *Diagnosis Pointers [1 ▾] [▾] [▾] [▾] Charge Amount [____] *Units [1.000] *Unit Type [Unit ▾] EPSDT ☐ Clia Number [____] Authorization Number [____] Referring Provider ID [____] 🔍 ID Type NPI Taxonomy _ Performing Provider ID [____] 🔍 ID Type NPI Taxonomy _ **Medicare Crossover Details** Allowed Medicare Amount $0.00 Co-insurance Amount [0.00] Deductible Amount [0.00] Psychiatric Services Amount [0.00] Medicare Payment Amount [0.00] Medicare Payment Date ⓘ [____] 📅 Copay Amount [0.00] **NDCs for Svc. # 1** If applicable, only one NDC/UPN is allowed per service detail line. When adding an NDC/UPN, the Code Type, Quantity and Unit of Measure fields are required. Additionally, NDC/UPN information is required when adding or saving NDC/UPN with prescription information (Prescription Number, Prescription Type, Prescription Date). Code Type [____ ▾] NDC/UPN ⓘ [____] Quantity [____] Unit of Measure [____ ▾] Prescription Number [____] Prescription Type [____ ▾] Prescription Date ⓘ [____] 📅 **Other Insurance Details for Svc. # 1** Click the row number to edit the row. Click the **Remove** link to remove the entire row. | #	Carrier Code	Procedure Code	Modifiers	COB Payer Paid Amount	Remittance Date	Paid Units	Remaining Patient Liability	Bundled Line	Action
---	---	---	---	---	---	---	---	---	---	 ⊟ Click to collapse. *Other Carrier [____ ▾] Bundled into Line # [0] *Procedure Code ⓘ [____] Modifiers ⓘ [____] [____] [____] [____] COB Payer Paid Amount [0.00] *Remittance Date ⓘ [____] 📅 *Paid Units [0.00] Remaining Patient Liability [____] [Add Insurance] [Cancel Insurance] [Save] [Reset] [Cancel]
Step 20	• Select the **plus sign** in the Attachments section to attach a copy of the EOMB. NOTE: It is required to submit the Explanation of Medicare Benefits (EOMB) with all Medicare Crossover claims.

Steps	Description

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
⊞	Click to add attachment.				

Back to Step 1   Back to Step 2   Submit   Cancel

Step 21	• Select FT-File Transfer or NotSpecified-Not Specified from the **Transmission Method** dropdown. This selection affects the fields that display. • Complete the additional required fields for this section and select **Add**. NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim. **Attachments** Click the **Remove** link to remove the entire row. 	#	Transmission Method	File	Control #	Attachment Type	Action	 ⊟ Click to collapse. *Transmission Method FT-File Transfer *Upload File Choose File No file chosen *Attachment Type Description Add Cancel Back to Step 1 Back to Step 2 Submit Cancel If NotSpecified-Not Specified was selected for the Transmission Method, an Attachment Control Number (ACN) needs to be added in the Control # field. NOTE: A unique Attachment Control Number (ACN) must be created for each claim if NotSpecified-Not Specified is selected as the Transmission Method. In addition, a Claim Attachment Form must accompany each EOMB and must identify the Provider's NPI and ACN as it was entered in the Attachments section. **The Claim Attachment Form is located at: Forms - Mississippi Division of Medicaid**. **Attachments** Click the **Remove** link to remove the entire row. 	#	Transmission Method	File	Control #	Attachment Type	Action
1	FT-File Transfer	Medicare EOMB.pdf (36K)	20221202122716197843	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)	Remove	 ⊟ Click to collapse. *Transmission Method NotSpecified-Not Specified *Control # *Attachment Type Description Add Cancel Back to Step 1 Back to Step 2 Submit Cancel
Step 22	The attachments display in the Attachments section.

Steps	Description
	• Review the information entered for Step 3 and select **Submit**. **Attachments** — Click the **Remove** link to remove the entire row. | #	Transmission Method	File	Control #	Attachment Type	Action
---	---	---	---	---	---
1	FT-File Transfer	Medicare EOMB.pdf (36K)	20221202122716197843	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)	Remove
2	NotSpecified-Not Specified	_	123	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)	Remove	 ⊞ Click to add attachment. Back to Step 1 Back to Step 2 Submit Cancel
Step 23	The Portal displays the **Confirm Professional Claim** page. Review all the information entered for this claim. Select the plus and minus to expand and collapse each section. Expand All and Collapse All to expand and collapse all the sections at once. At the bottom of the page, select Back to Step 1, 2, or 3 to go back and edit the information entered for this claim. • Once reviewing the claims information entered has been completed, select Confirm to confirm the claim submission. **Confirm Professional Claim** Select Print Preview **before** you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system. Claim Type Crossover Professional **Provider Information** Billing Provider ID ID Type NPI Name Taxonomy Performing Provider ID _ ID Type _ Name _ Taxonomy _ Referring Provider ID _ ID Type _ Name _ Taxonomy _ Supervising Provider ID _ ID Type _ Name _ Taxonomy _ **Member Information** Member ID Gender Member Birth Date Address Address Line 2 City State Zip Code **Claim Information** Date Type _ Date of Current _ Accident Related _ Admission Date _ Patient Number _ Authorization Number _ Transport Certification No Does the provider have a signature on file? No Does the provider accept assignment for claim processing? No

Steps	Description

Are benefits assigned to the provider by the patient or their authorized representative? No

Does the provider have a signed statement from the patient releasing their medical information? No

Total Charged Amount $0.00

Medicare Crossover Details

Allowed Medicare Amount $0.00		Co-insurance Amount $0.00	
Deductible Amount $0.00		Psychiatric Services Amount $0.00	
Medicare Payment Amount $0.00		Medicare Payment Date _	
Copay Amount $0.00			

Expand All | Collapse All

Diagnosis Codes ▬

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code
1	ICD-10-CM	R071-CHEST PAIN ON BREATHING

Other Insurance Details ▬

#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date
1	Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'				
2	test	test	test	$0.00	12/09/2022

Service Details ▬

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount
1	12/07/2022	12/08/2022	02		01232		1	1.000 Unit	☐	$0.00

Attachments ➕

Back to Step 1 Back to Step 2 Back to Step 3 Print Preview Confirm Cancel

Step 24	The Portal returns the Submit Crossover Professional Claim: Confirmation page. NOTE: The confirmation page displays. ALL Crossover claims go to a PENDING status to verify the EOMB. NOTE: If the claim has an attachment with a not-specified transmission method then the Confirmation page has an Attachments Coversheet(s) button for the cover page. NOTE: It is required to mail the attachment after submitting the claim when a not-specified value is selected for the transmission method.

Submit Crossover Professional Claim: Confirmation ?

Crossover Professional Claim Receipt

Your Crossover Professional Claim was successfully submitted. The claim status is Pending In Process.

The Claim ID is 2322346000001.

Click **Attachment Coversheet(s)** to view the claim attachments coversheet(s).

Click **Print Preview** to view the claim details as they have been saved on the payer's system.

Click **Copy** to copy member or claim data.

Click **New** to submit a new claim.

Click **View** to view the details of the submitted claim.

Attachment Coversheet(s) Print Preview Copy New View

Change History

The following change history log contains a record of changes made to this document:

Version #	Published/ Revised	Author	Section/Nature of Change
1.0	12/14/2022	Gainwell	Initial publication
1.1	06/02/2023	Gainwell	Updated providers display to show CCO information based on CR1925.