North Carolina Medicaid Special Bulletin



An Information Service of the Division of Medical Assistance

Published by EDS, fiscal agent for the North Carolina Medicaid Program

Number V August 2004

Attention:

Medicare Part B Billers

Medicare Part B Effective September 6, 2004

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As previously published in the September 2002 Special Bulletin VI, the Division of Medical Assistance is required by the N.C. General Assembly to apply Medicaid pricing when processing claims for Medicare/Medicaid dually eligible recipients. In an effort to simplify the claims filing procedures documented in the September 2002 Special Bulletin VI, DMA will return to processing claims for professional services directly from Medicare.

Effective with date of service September 6, 2004, claims filed to Medicare will be crossed over automatically to Medicaid for payment if a Medicare Crossover Request form is on file with Medicaid for that provider and Medicare and Medicaid have matching data for the recipient. It is the Providers responsibility to check the Medicaid Remittance and Status Report to verify that the claim was crossed over from Medicare. Providers may verify that their Medicare provider number is cross-referenced to their Medicaid provider number by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888. If your Medicare provider number is not cross-referenced to your Medicaid provider number, you must complete and submit the Medicare Crossover Request form (available on page 20 or from DMA's website at http://www.dhhs.state.nc.us/dma/forms.html) and submit it by fax or mail to the fax number or address listed on the form. Claims will pay to the Medicaid provider number indicated on the claim filed to Medicare, claims will pay to the Medicaid provider number indicated on the Medicaid provider Neglection in the Medicaid provider number indicated on the Medicaid provider Neglection in the Medicaid provider number indicated on the Medicaid provider Neglection in the Neglec

Note: If you have more than more one Medicaid provider number, you should indicate on the Medicare claim the Medicaid provider number for which you want to receive payment.

Claims that do not crossover and have been paid by Medicare can be filed as an 837 professional transaction completing the Coordination of Benefits (COB) loop. Refer to the implementation guide at http://wpc-edi.com and the N.C. Medicaid HIPAA Companion Guide on DMA's website at http://www.dhhs.state.nc.us/dma/hipaa/compguides.html for instructions on completing the 837 professional transaction.

Claims that do not crossover and have been paid by Medicare can also be filed on a CMS-1500 claim form. The paper claim form must be submitted with the Medicare voucher attached.

The return to crossovers for professional services impacts Medicaid administrative policies, procedures, and billing guidelines for Medicare/Medicaid recipients.

Administrative Policy

Reimbursement requires compliance with all Medicaid guidelines. Medicaid's payment or non-payment is considered payment in full. The following administrative policies apply to 837 professional transactions and CMS 1500 claim forms for Medicare crossover claims.

Copayments

Services covered by **both** Medicare and Medicaid are not subject to a Medicaid copayment. However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be responsible for the appropriate Medicaid copayment. Refer to the May 2004 General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide for specific copayment requirements.

Carolina ACCESS Primary Care Providers

Services covered by **both** Medicare and Medicaid are not subject to Carolina ACCESS primary care provider referral authorization.

Prior Approval

Medicaid does not require prior approval for Part B services that are covered by Medicare. However, if Medicare does not cover a service and Medicaid requires prior approval, the provider must obtain prior approval.

24-Visit Limitation

Services covered by **both** Medicare and Medicaid are not subject to Medicaid's 24-visit limit per state fiscal year (July 1 through June 30).

Hysterectomy, Sterilization, and Abortion Consents/Statement

Procedures covered by **both** Medicare and Medicaid do not require sterilization consent forms, hysterectomy statements or abortion statements in order to receive reimbursement for the procedures. However, if Medicare does not cover the procedure, Medicaid requires the appropriate consent form/statements to be submitted. Forms must be mailed to the address listed on the form.

Durable Medical Equipment Span Dates

Durable Medical Equipment (DME) claims that currently span dates of service when filed to Medicare will be paid a percentage of the Medicare coinsurance and deductible when the "to" date of service is on or after September 6, 2004. Medicaid will not reimburse for future dates of service as Medicare does. Claims for future dates of service must be refiled to Medicaid after the "to" date of service on the claim has passed.

Optical Refractions

If a recipient has Medicare and there is no medical diagnosis, the provider needs to follow the Medicare guidelines when billing Medicare. However, Medicare does not cover refractions. So, if the patient also has Medicaid, the provider should bill Medicaid for refraction (CPT code 92015) with a refractive diagnosis. A copayment will be deducted for services not covered by Medicare unless the recipient qualifies for specific copayment exemptions.

Psychiatric Reductions

If Medicare reduces payment to the provider as a result of a psychiatric reduction, the psychiatric reduction cannot be billed to Medicaid. This psychiatric reduction is the recipient's responsibility.

Billing Guidelines

Effective with dates of service September 6, 2004, professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B Reimbursement schedule. DMA established this Part B Reimbursement schedule to allow DMA to achieve aggregate Medicaid pricing for claims. The payment percentages are determined by the provider type and specialty. Providers cannot bill the recipient for the remaining balance. Medicaid's payment or non-payment is considered payment in full.

When a claim is denied by Medicare as non-covered, providers may file the claim to Medicaid. Providers must not override Medicare when Medicare denies the services for lack of medical necessity. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, providers must resubmit the claim to Medicaid through the 837 professional transaction (dental providers must file using the 837 dental transaction) using the instructions outlined in the PWK segment of the companion guide in the 2300 loop or on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached. (A copy of the form is available on page 21 or from DMA's website at http://www.dhhs.state.nc.us/dma/forms.htm.) In order to ensure proper reimbursement, providers cannot file dates of service that have a from date of service prior to September 6, 2004 and a to date of service equal to or after September 6, 2004. Any claims – except DME – that span crossover processing versus Medicare TPL processing cannot be billed on the same claim form. Refer to the following instructions for how to bill for services provided to dually eligible recipients.

Note: Claim examples may not accurately reflect real medical situations nor correct Medicaid reimbursement rates for your provider type and specialty. For exact Medicaid reimbursement amounts refer to the Part B Reimbursement Schedule, which will be available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm beginning September 6, 2004.

CMS-1500 Claim Forms

Example 1: Medicare/Medicaid Only

When the recipient has both Medicare and Medicaid coverage and no other insurance, the provider must file the claim directly to Medicare. **The Medicare claim will cross over automatically** to Medicaid if the provider is setup for crossover. If the claim does not crossover to Medicaid the provider must file the claim directly to Medicaid. The provider is required to submit an 837 professional transaction completing the COB loop or a paper CMS-1500 form attaching the Medicare voucher. **DO NOT INDICATE MEDICARE PAYMENT IN BLOCK 29**.

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Payment Calculation

Example 1 – Provider/Specialty Type with a 75% Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance
500.00	400.00	.00	100.00

Total Medicare	Part B Reimbursement	Medicaid Payment
Coinsurance/Deductible	Schedule Payment %	
100.00	75.00%	75.00

Medicare Paid	Medicaid Payment	Total Payment
400.00	75.00	475.00

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

PROVIDER, JOE 123 ANY STREET ANY CITY, NC 12345

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Example 2: Medicare/TPL/Medicaid

When the recipient has Medicare, Medicaid, and commercial insurance, which is primary to Medicaid, the provider must indicate the commercial insurance payment in block 29 and attach the Medicare voucher to the paper CMS-1500 form. **DO NOT INDICATE MEDICARE PAYMENT IN BLOCK 29**. For the 837 professional transaction, the provider must complete the COB loop for Medicare and the commercial insurance.

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Payment Calculation

$\begin{tabular}{ll} \hline \textbf{Example 2} - \textbf{Provider/Specialty Type with a 65\% Part B Reimbursement Payment Percentage} \\ \hline \end{tabular}$

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance
500.00	400.00	.00	100.00

Total Medicare	Part B Reimbursement	Medicaid Payable	Commercial	Medicaid Payment
Coinsurance/Deductible	Schedule Payment %	Charge	Insurance	
	•		Payment	
100.00	65.00%	65.00	15.00	50.00

Medicare Paid	Commercial Insurance	Medicaid Payment	Total Payment
	Payment		
400.00	15.00	50.00	465.00

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

PROVIDER, JOE 123 ANY STREET ANY CITY, NC 12345

	PROVID NUMBE		8900000		REPORT	SEQ. NUMBER			DATE	09/30/200	4	PAGE	2	
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Example 3: Medicare Non-Covered Services

When a claim is denied by Medicare as non-covered, the provider may file the claim to Medicaid. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, the provider must resubmit the claim to Medicaid through the 837 professional transaction (dental providers must file using the 837 dental transaction) using the instructions outlined in the PWK segment of the companion guide in the 2300 loop or on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached. The claim will be reviewed to determine if payment is appropriate. The payment percentage is determined by the provider type and specialty.

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Payment Calculation

$\begin{tabular}{ll} \hline \textbf{Example 3} - \textbf{Provider/Specialty Type with a 65\% of Part B Reimbursement Payment Percentage} \\ \hline \end{tabular}$

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance		
0.00	0.00	.00	.00		

Total Medicaid Billed	Part B Reimbursement	Medicaid Payment
Amount	Schedule Payment %	
100.00	N/A*	62.90

*Note: Part B Reimbursement Schedule for Medicare non-covered services does not apply.

Medicare Paid	Medicaid Payment	Total Payment
0.00	62.90	62.90

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Example 4: Medicare Non-Covered and Commercial Insurance Payment

When a recipient has Medicare, Medicaid, and commercial insurance which is primary to Medicaid, and the claim is denied by Medicare as non-covered, providers may file the claim to Medicaid. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, providers can resubmit the claim to Medicaid through the 837 professional transaction (dental providers must file using the 837 dental transaction) using the instructions outlined in the PWK segment of the companion guide in the 2300 loop and completing the COB loop. Providers can also file on paper with the commercial insurance payment amount entered in block 29, and the Medicare voucher and a Medicaid Resolution Inquiry form attached. The claim will be reviewed to determine if the payment is appropriate.

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Payment Calculation

Example 4 – Provider/Specialty Type with a 65% Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance
0.00	0.00	.00	.00

	Total Medicaid Billed Amount	Part B Reimbursement Schedule	Medicaid Payable Charge	Commercial Insurance Payment	Medicaid Payment
		Payment %			
ĺ	100.00	N/A*	96.86	83.21	13.65

*Note: Part B Reimbursement Schedule for Medicare non-covered services does not apply.

Medicare Paid	Commercial Insurance Payment	Medicaid Payment	Total Payment	
0.00	83.21	13.65	96.86	

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Example 5: Medicare Paid and Commercial Insurance Non-Covered

When the recipient has Medicare, Medicaid, and commercial insurance, and the commercial insurance denies the service, the provider must submit a paper claim with the Medicare voucher and the commercial insurance denial attached to the claim. **DO NOT INDICATE MEDICARE PAYMENT IN BLOCK 29**.

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Payment Calculation

Example 5 – Provider/Specialty Type with a 75% Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare Coinsurance		
500.00	400.00	.00	100.00		

Total Medicare	Part B Reimbursement	Medicaid Payable	TPL Payment
Coins/Deductible	Schedule Payment %	charge	
100.00	75.00%	75.00	0.00

Medicare Paid	Commercial Payment	Medicaid Payment	Total Payment	
400.00	0.00	75.00	475.00	

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

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Example 6: Medicare Applies 100 Percent of Payment Toward the Deductible

When the recipient has both Medicare and Medicaid, and Medicare applies 100 percent of the Medicare allowable toward the Medicare deductible, the claim will pay a percentage reduction of the deductible. **The Medicare claim will cross over automatically** if a Medicare Crossover Request form is on file with Medicaid for that provider and Medicare and Medicaid have matching data for the recipient. If the claim does not crossover to Medicaid, the provider can submit an 837 professional transaction completing the COB loop or the provider can file a paper CMS-1500 form with the Medicare voucher attached.

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PROVIDER, JOE

123 ANY STREET

Payment Calculation

Example 6 – Provider/Specialty Type with a 75% Part B Reimbursement Payment Percentage

Medicare Allowed	Medicare Paid	Medicare Deductible	Medicare
			Coinsurance
100.00	00.00	100.00	0.00

Total Medicare	Part B Reimbursement	Medicaid Payment
Coinsurance/Deductible	Schedule Payment %	
100.00	75.00%	75.00

Medicare Paid	Medicaid Payment	Total Payment
0.00	75.00	75.00

				REWITTANGE AND STATE	O NEF	JI ()			CITY, NC	12345			
	PROVID	ER NUMBER	8900000	REPORT SEQ. NUMBER			DATE	09/30/200	4	PAGE	2		
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REMITTANCE AND STATUS REPORT

NORTH CAROLINA MEDICAID

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Medicaid Reimbursement Method Reference Guide

Date of Service	Payment Method	Reference
Prior to 10-01-2001	Paid 100% of coinsurance and deductible	NCXIX State Plan
From 10-01-2001	Medicaid allowable for professional services is calculated based on 95 percent of the Medicare allowed amount and compared to the	March 2002 Special Bulletin Number I
through 09-30-2002	coinsurance and deductible. Medicaid pays the lesser of the two.	http://www.dhhs.state.nc.us/dma/bulletin.htm
From 10-01-2002	Medicaid deducts the Medicare payment amount from the Medicaid maximum allowable amount and the difference is paid to the	September 2002 Medicaid Special Bulletin VI
through 09-05-2004	provider.	http://www.dhhs.state.nc.us/dma/bulletin.htm
After 09-06-2004	Medicare part B services will be paid according to the Medicaid	August 2004 Medicaid Special Bulletin V
	Part B Reimbursement schedule.	http://www.dhhs.state.nc.us/dma/bulletin.htm

Medicare Part B Reference Sheet for Crossover Changes for Professional Services

For dates of service 09-06-2004-to present:

Example	Filing Instructions
Medicare/Medicaid	Claims will crossover directly from Medicare. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached. If filed as an 837 professional transaction the COB loop must be completed. Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block
Medicare/TPL/Medicaid	29. These are automatically deducted at the time the claim is processed for payment. Claims must be filed directly to Medicaid. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached and block 29 must indicate the commercial insurance payment. A voucher from the commercial insurance is not needed when the commercial insurance payment is entered in block 29. Do not
	enter Medicare payments, copayment amounts or previous Medicaid payments in block 29. These are automatically deducted at the time the claim is processed for payment. If filed as an 837 professional transaction, the COB loop must be completed for both Medicare and commercial insurance.
Medicare Non-Covered Services	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction (dental providers may file using the 837 dental transaction) overriding Medicare. Or, providers can file the claim to Medicaid on a CMS-1500 form (dental providers may file using the ADA form) with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.
Medicare Non-Covered and Commercial Insurance Payment	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction (dental providers may file using the 837 dental transaction) overriding Medicare and completing the COB loop for the commercial insurance. Or, providers can submit a CMS-1500 form (dental providers may file using the ADA form) to Medicaid with commercial insurance payment entered in block 29 (field 32 for the ADA form), and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim. A voucher from the commercial insurance is not needed when payment is entered in block 29 (field 32 for the ADA form).
Medicare Paid and Commercial Insurance Non-Covered	All providers must submit the claim to Medicaid on a CMS-1500 form with the Medicare voucher, commercial insurance denial, and a Medicaid Resolution Inquiry form attached. Medicaid will review the commercial insurance denial to determine if Medicaid will pay the claim. Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29. These are automatically deducted at the time the claim is processed for payment.
Medicare Applies 100 Percent of Payment Towards the Deductible	Claims will crossover directly from Medicare. If filed as an 837 professional transaction, the COB loop must be completed. If filed on paper all providers must bill on a CMS-1500 form with the Medicare voucher attached.

For dates of service from 10-01-2002 through 09-05-2004:

Example	Filing Instructions			
Medicare/Medicaid	Claims must be filed directly to Medicaid. Medicaid deducts the Medicare payment amount from the Medicaid allowable amount and the difference is paid to the provider. If claim is filed as an 837 professional transaction (dental providers may file using the 837 dental transaction), the COB loop must be completed. If claim is filed on paper, the provider must enter the Medicare payment amount including any Medicare penalties and/or outpatient psychiatric reduction in block 29 (field 32 for the ADA form).			
Medicare/Commercial Insurance/Medicaid	Claims must be filed directly to Medicaid. If claim is filed as an 837 professional transaction (dental providers may file using the 837 dental transaction), the COB loop must be completed for both Medicare and commercial insurance. If claim is filed on a CMS-1500 form (dental providers may file using the ADA form), the provider must total both the Medicare payment and the commercial insurance payment and enter the total payment amount including any Medicare penalties and/or outpatient psychiatric reduction in block 29 (field 32 for the ADA form). Medicaid deducts the total amount from the Medicaid allowable amount and the difference is paid to the provider. Paper claims must be submitted with both the Medicare voucher and the commercial insurance voucher attached.			
Medicare Non-Covered Services	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file using the 837 professional transaction overriding Medicare. Dental providers may file using the 837 dental transaction (no Medicare override is required). Or, providers can file the claim to Medicaid on a CMS-1500 form (dental providers may file using the ADA form) with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.			
Medicare Non-Covered and Commercial Insurance Payment	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction overriding Medicare and completing the COB loop for the commercial insurance. Dental providers must file using the 837 dental transaction (no Medicare override is required) and completing the COB loop for the commercial insurance. Or, providers can submit a CMS-1500 form (dental providers may file using the ADA form) to Medicaid with commercial insurance payment entered in block 29 (field 32 for the ADA form), and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim. A voucher from the commercial insurance is not needed when payment is entered in block 29 (field 32 for the ADA form).			
Medicare Paid and Commercial Insurance Non-Covered	Claims must be filed directly to Medicaid. When the recipient has Medicare, commercial insurance, and Medicaid and the commercial insurance denies the service, the provider must submit a CMS-1500 form (dental providers may file using the ADA form) with the Medicare payment amount including penalties and outpatient psychiatric reduction in block 29 (field 32 for the ADA form) and attach the commercial insurance denial to the claim.			
Medicare Applies 100 Percent of Payment Towards the Deductible	Claims must be filed directly to Medicaid. When the recipient has both Medicare and Medicaid coverage and Medicare applies 100 percent of the Medicare allowable toward the Medicare deductible, the provider must submit a CMS-1500 form (dental providers may file using the ADA form) with the Medicare voucher attached to the claim. The claim will pay a percentage of the deductible up to the Medicaid allowed amount.			

For dates of service from 10-01-2001 through 09-30-2002:

Example	Filing Instructions
Medicare/Medicaid	Claims will crossover directly from Medicare. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached. If filed as an 837 professional transaction the COB loop must be completed. Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29. These are automatically deducted at the time the claim is processed for payment.
Medicare/Commercial Insurance/Medicaid	Claims must be filed directly to Medicaid. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached and block 29 must indicate the commercial insurance payment. A voucher from the commercial insurance is not needed when the commercial insurance payment is entered in block 29. Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29. These are automatically deducted at the time the claim is processed for payment. If filed as an 837 professional transaction, the COB loop must be completed for both Medicare and commercial insurance.
Medicare Non-Covered Services	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction (dental providers may file using the 837 dental transaction) overriding Medicare. Or, providers can file the claim to Medicaid on a CMS-1500 form (dental providers may file using the ADA form) with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.
Medicare Non-Covered and Commercial Insurance Payment	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file electronically using the 837 professional transaction (dental providers may file using the 837 dental transaction) overriding Medicare and completing the COB loop for the commercial insurance. Or, providers can also submit a CMS-1500 form (dental providers may file using the ADA form) to Medicaid with commercial insurance payment entered in block 29 (field 32 for the ADA form), and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim. A voucher from the commercial insurance is not needed when payment is entered in block 29 (field 32 for the ADA form).
Medicare Paid and Commercial Insurance Non-Covered	All providers must submit the claim to Medicaid on a CMS-1500 form with the Medicare voucher, commercial insurance denial, and a Medicaid Resolution Inquiry form attached. Medicaid will review the commercial insurance denial to determine if Medicaid will pay the claim. Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29. These are automatically deducted at the time the claim is processed for payment.
Medicare Applies 100 Percent of Payment Towards the Deductible	Claims will crossover directly from Medicare. If filed as an 837 professional transaction, the COB loop must be completed. If filed on paper, all providers must bill on a CMS-1500 form with the Medicare voucher attached.

For dates of service prior to 10-01-2001:

Example	Filing Instructions			
Medicare/Medicaid	Claims will crossover directly from Medicare. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached. If filed as an 837 professional transaction the COB loop must be			
	completed. Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29. These are automatically deducted at the time the claim is processed for payment.			
Medicare/Commercial Insurance/Medicaid	Claims must be filed directly to Medicaid. If filed on paper to Medicaid, all providers must use the CMS-1500 form with the Medicare voucher attached and block 29 must indicate the commercial insurance payment. A voucher from the commercial insurance is not needed when the commercial insurance payment is entered in block 29. Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29. These are			
	automatically deducted at the time the claim is processed for payment. If filed as an 837 professional transaction,			
	the COB loop must be completed for both Medicare and commercial insurance.			
Medicare Non-Covered Services Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, pro using the 837 professional transaction overriding Medicare. Dental providers may file using the 837 transaction (no Medicare override is required). Or, providers can file the claim to Medicaid on a CM with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review determine if Medicaid will pay the claim. Dental providers may file the ADA form without a Medicaid medicaid medicaid.				
	Medicaid Resolution Inquiry form attached.			
Medicare Non-Covered and Commercial Insurance	Claims must be filed directly to Medicaid. When a claim is denied by Medicare as non-covered, providers may file using the 837 professional overriding Medicare and completing the COB loop for the commercial insurance. Dental			
Payment	providers may file using the 837 dental transaction (no Medicare override is required). Or, providers can also			
Tayment	submit a CMS-1500 form to Medicaid with commercial insurance payment entered in block 29 and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim. A voucher from the commercial insurance is not needed when payment is entered in block 29 (field 32 for the ADA form). Dental providers may file using the ADA form with the commercial insurance payment entered in field 32 with no Medicare voucher or Medicaid Resolution Inquiry form attached.			
Medicare Paid and	All providers must submit the claim to Medicaid on a CMS-1500 form with the Medicare voucher, commercial			
Commercial Insurance Non-Covered	insurance denial, and a Medicaid Resolution Inquiry form attached. Medicaid will review the commercial insurance denial to determine if Medicaid will pay the claim. Do not enter Medicare payments, copayment amounts or previous Medicaid payments in block 29. These are automatically deducted at the time the claim is processed for payment.			
Medicare Applies 100	Claims will crossover directly from Medicare. If filed as an 837 professional transaction, the COB loop must be			
Percent of Payment	completed. If filed on paper all providers must bill on a CMS-1500 form with the Medicare voucher attached.			
Towards the Deductible				

Medicare Crossover Reference Request

Prov	vider Name:					
Contact Person (required):			Telephone (required):			
and	ct the appropriate <i>Medicare Carrier/Intermediary/DMER</i> your <i>Medicare</i> and <i>Medicaid</i> provider numbers. If this s cessed. These are the only carriers for which EDS can cu	ectio	n is not completed, the form will not be			
M	edicare Part A Intermediaries					
	Riverbend GBA Medicare Part A (Tennessee)		Palmetto Medicare Part A (South Carolina)			
	http://www.riverbendgba.com		http://www.palmettogba.com*			
	Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina) http://www.palmettogba.com		AdminaStar Medicare Part A (Illinois, Indiana, Ohio, and Kentucky) http://www.adminastar.com * Carefirst of Maryland Medicare Part A (Maryland)			
	Trailblazer Medicare Part A (Colorado, New Mexico and Texas)		http://www.marylandmedicare.com/pages/mdmedicare/mdmedicaremain1.htm*			
	http://www.the-medicare.com		Veritus Medicare Part A (Pennsylvania)			
	United Government Services Medicare Part A (Wisconsin) http://www.ugsmedicare.com		http://www.veritusmedicare.com* First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida)			
			http://www.floridamedicare.com *			
<i>M</i> :	edicare Part B Carrier CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho)	<i>Me</i>	Palmetto Regional DMERC Palmetto Region C DMERC (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky,			
	http://www.cignamedicare.com AdminaStar Medicare Part B (Indiana and Kentucky) http://www.adminastar.com* Palmetto Medicare Part B (South Carolina)		Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands); http://www.palmettogba.com			
	http://www.palmettogba.com*					
*Tr	ading Partners currently in testing phase.					
	ion to be taken:					
	•					
	Medicare Provider number:	:	Medicaid Provider number:			
	Change - This is used to change an existing provider num Medicare Provider number:					

Mail completed form to:

P.O. Box 300009 Raleigh, NC 27622 FAX: 1-919-851-4014 1-800-688-6696



Medicaid Resolution Inquiry

Mail To:

EDS Provider Services P O Box 300009 Raleigh, NC 27622

TO BE USED BY EDS ONLY Remarks:					
Signature of Ser	nder:	Date:	Phone #:		
Please Specify I	Reason for Inquiry Re	equest:			
			RA Date:		
			Recipient ID:		
	er:and Address:				
	ADJUSTMENTS	WILL NOT BE PRO	CESSED FROM THIS	FORM.	
	CLAIM, RAS, AND ALL RELATED INFORMATION MUST BE ATTACHED.				
NOTE:	PLEASE USE THIS FORM FOR OVERRIDES AND INQUIRIES ONLY .				
Please Check:	☐ Medicare Overri	de □Time Limit (Override Third Party C	Override	

4905 Waters Edge Drive, Raleigh, NC 27606 1-800-688-6696 www.dhhs.state.nc.us/dma PVS011 Revised 7/8/03

Medicare Part B Seminar Schedule

Seminars for Medicare Part B Crossovers are scheduled for August and September 2004. This seminar will focus on changes for providers as a result of returning to crossovers effective date of service September 6, 2004. Medicaid billing personnel, supervisors, and office managers are encouraged to attend.

Each site will have two sessions – a morning and an afternoon session. The morning seminars will begin at 9:00 a.m. and end at 11:00 a.m. The afternoon sessions will begin at 1:00 p.m. and end at 3:00 p.m. Providers are encouraged to arrive at least 15 minutes before the session begins to complete registration. Lunch will not be provided at the seminars. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the seminars by completing and submitting the registration form on page 23 or by registering online at http://www.dhhs.state.nc.us/dma/provsem.htm. Please indicate on the registration form the session you plan to attend.

Monday, August 30, 2004

Greenville Hilton 207 Greenville Blvd SW Greenville, NC

Thursday, September 2, 2004

Holiday Inn Select 5790 University Parkway Winston Salem, NC Wednesday, September 1, 2004 Jane S. McKimmon Center 1101 Gorman Street Raleigh, NC

Directions to the Part B Seminars

Greenville Hilton – Greenville

Take US 64 east to US 264 east. Follow 264 east to Greenville. Once you enter Greenville, turn right on Allen Road. After traveling approximately 2 miles, Allen Road becomes Greenville Boulevard/Alternate 264. Follow Greenville Boulevard for approximately 2½ miles. The Greenville Hilton is located on the right.

Jane S. McKimmon Center - Raleigh

Traveling East on I-40

Take exit 295 and turn left onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Traveling West on I-40

Take exit 295 and turn right onto Gorman Street. Travel approximately one mile. The McKimmon Center is located on the right at the corner of Gorman Street and Western Boulevard.

Holiday Inn Select - Winston-Salem

Take I-40 to NC Hwy 52 north. Travel approximately 8 miles to exit 115B, University Parkway South. The hotel is located on the right.

Medicare Part B Seminar Registration Form

(No Fee)

Provider Name	Provider Number		
Address			
City, Zip Code			
Contact Person	E-mail Address		
Telephone Number	Fax Number		
1 or 2 (circle one) person(s) will attend the seminar at _		_ on	
	(location)		(date)

Provider Services Return to:

EDS

P.O. Box 300009 Raleigh, NC 27622

FAX: 919-851-4014 Gary H. Fughay, Director Division of Medical Assistance Department of Health and Human Services

Cheryll Collier
Executive Director
EDS