Clinic

Attention: All Hospital Outpatient Department and Freestanding Clinics

In this Newsletter:

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Contact Details

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Payment of Medicare Part B Coinsurance Will Change

Effective Date Is Now <u>January 1, 2012</u>

<u>Hospital Outpatient Department and Diagnostic and Treatment Center Claims (Article 28 facilities)</u>

Pursuant to Medicaid Redesign Team Proposal #164 (MRT #164), a change to New York State Social Services Law directs the Medicaid program to limit Medicaid payment for Medicare Part B coinsurances. The limitation of Part B coinsurances applies to practitioners, hospital outpatient departments and diagnostic and treatment centers (Article 28 facilities).

Hospital Outpatient Department and Diagnostic and Treatment Center Claims (Article 28 facilities) were notified that effective December 29, 2011, eMedNY systems changes will be implemented limiting Medicaid payment for Medicare Part B coinsurance amounts for Medicare/Medicaid crossover claims for dates of service on or after October 1, 2011.

The effective date has been changed to **<u>January 1, 2012 for dates of service on or after January 1, 2012.</u>**

These changes will effect Medicaid payments for crossover claims as well as claims processing procedures. Please read the following information carefully.

<u>Clinic Billing Requirements</u>

- Providers of Institutional Claims May No Longer "Opt-Out" of the Crossover Process
  Effective for dates of service on or after January 1, 2012, all claims submitted to Medicare on the institutional claim form (837i) will be processed through the eMedNY System. This means that the choice to "opt out" of the crossover process is no longer available for institutional claims submitted on the 837i (clinic claims submitted to Medicare on the 837p will continue to be paid through the "opt-out" crossover process as appropriate).

- Valid Rate Codes Must be Reported on ALL Crossover Claims
  Effective January 1, 2012, Medicare Part B crossover claims must contain valid New York State Medicaid rate codes. All claims must have a **valid** rate code when submitted to CMS as a Medicare/Medicaid crossover. If the claim crosses over to Medicaid without a valid rate code, that claim will deny with edit 02176, RATE CODE INVALID ON DIRECT CROSSOVER.

Claims containing valid Medicaid rate codes submitted to Medicare should appear in the following format:

Example – Rate code ‘1400’ should appear on the claim to Medicare as ‘14.00’. The reason for this is Medicare has an edit that will reject a claim if the sum of the Value Code Amount is greater than the Claim Charge Amount.

Please note that the Medicare and Medicaid payment (if any) must be accepted as full payment by the provider. The Medicaid enrollee cannot be billed for any portion of the claim that Medicaid does not pay.

For claiming questions, please contact Computer Sciences Corporation (CSC) at (800) 343-9000.

For Medicaid policy questions, please contact the Office of Health Insurance Programs at (518) 473-2160.

For Medicaid managed care or Family Health Plus enrollees, please call the enrollee’s health plan.

The Department has attempted to ensure that the information contained in these notifications is as accurate as possible. However, no e-mail transmittals or materials provided are intended to constitute legal or medical advice.