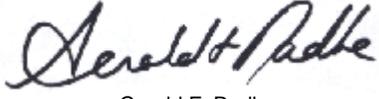


	<b>MEDICAL ASSISTANCE BULLETIN</b> COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	<b>SUBJECT</b>  Third Party Resources Edits 608 and 616	<b>BY</b>   Gerald F. Radke Deputy Secretary for Medical Assistance Programs
<b>NUMBER:</b>	99-91-05	
<b>ISSUE DATE:</b>	July 26, 1991	
<b>EFFECTIVE DATE:</b>	July 26, 1991	

**PURPOSE:**

The purpose of this bulletin is to instruct providers on correct billing procedures to follow when a recipient has third party insurance coverage in addition to Medical Assistance Program benefits.

**SCOPE:**

This bulletin applies to all providers enrolled in the Medical Assistance Program except inpatient hospital and nursing facility providers.

**BACKGROUND/DISCUSSION:**

The Department has seen an increase in the number of claims that are rejecting with Remittance Advice Explanation Codes 608 and 616. These remittance advice explanation codes advise that the patient has another third party resource or Medicare resource that must be properly utilized prior to billing medical assistance after receiving a denial or a partial payment from a third party resource. In most cases, these problems are due to incorrect completion of the appropriate Medical Assistance Program Invoice.

As federally mandated by the Social Security Act, Title XIX, and as required by medical assistance regulations in Chapter 1101, General Provisions, medical assistance is the "payor of last resort". Section 1101.64 of Chapter 1101, mandates that all other private or governmental health insurance benefits must be utilized before billing the Medical Assistance Program. Providers are required to make reasonable efforts to secure from the recipient sufficient information regarding such primary coverages necessary to bill such resources or programs.

Medical assistance will pay Medicare and other third party resource deductible and coinsurance amounts up to the established Medical Assistance Program fee for the service. **IF PAYMENT FROM MEDICARE OR ANOTHER RESOURCE EXCEEDS THE ESTABLISHED MEDICAL ASSISTANCE PROGRAM FEE FOR A SERVICE, NO ADDITIONAL PAYMENT WILL BE MADE BY MEDICAL ASSISTANCE AND, ENROLLED PROVIDERS MAY NOT BILL THE RECIPIENT FOR THE DEDUCTIBLE OR COINSURANCE AMOUNTS.** Chapter 1101, Section 1101.63, mandates that an enrolled provider may bill a medical assistance recipient only for a noncompensable service or item and, in these situations, the recipient must be told before the service is provided that the program does not cover it.

The "Resources" section on the recipient's Medical Services Eligibility (MSE) card may contain a resource code which will alert the provider that the recipient has another medical insurance resource. However, providers should not rely totally on the MSE card. If a resource code does not appear on the card, it is still the provider's responsibility to ask the recipient if he or she has any other medical insurance coverage which will pay for the service being provided. **REMEMBER: PROVIDERS MUST SEE THE RECIPIENT'S MSE CARD EACH TIME A COMPENSABLE SERVICE IS PROVIDED.**

**PROCEDURE:**

To comply with Department regulations regarding third party resources and to ensure correct and maximum reimbursement, providers must:

1. **ALWAYS** see the recipient's MSE card each time a service is provided to note the presence of any resource.
2. **ALWAYS** ask the recipient if there is any other medical insurance, in addition to medical assistance.
3. If, as a result of #1 or #2 above, the provider determines the presence of a third party resource which may cover the service, this resource **must** be billed prior to billing the Medical Assistance Program.
  - a. Bill the third party resource and wait for an Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB).

- b. Review the EOB or EOMB to determine the amount of payment from the third party resource.
- c. If the third party resource denied the claim or paid less than the Medical Assistance Program fee for the service, bill medical assistance following the instructions in the Billing Information Section of your provider handbook. If you received a denial because a specific service is not covered, maintain the denial in your file. It is not necessary to obtain a new denial each time the service is performed.
- d. If payment from the third party resource exceeded the Medical Assistance Program fee for the service, no additional payment is due from medical assistance and you should not bill medical assistance or the recipient.

If you receive a rejection for services provided with a Remittance Advice Explanation Code 608 or 616 and, you have billed the third party and received a denial, you should:

- 1. Verify that the insurance carrier and policy number that you billed is the same one identified on the remittance advice.
- 2. If the resource is the same, verify that you used the proper attachment type on the invoice.

If you did not bill the third party resource listed on the remittance advice, you should:

- 1. Contact the recipient to ascertain the current status of the third party coverage.
- 2. If recipient confirms the third party resource, bill the third party resource.
- 3. If recipient informs you there is no such third party resource, instruct the client to contact the local county assistance office (CAO) with the information. The local CAO will make the necessary adjustments to permit you to bill the Department.

**SPECIAL REMINDERS:**

- 1. When billing the Department after the receipt of a denial or payment from the third party insurance, please remember:

**Physician's Invoice or Medical Services/Supplies Invoice  
MA 319/319C**

No. of Attachments	Attachment Type	Attachment Type	Prior Auth / PL Ser. Rev. No.
40	41	42	43

Complete items 40, 41 and 42 (if necessary). **DO NOT ATTACH** the denial or payment notification. This notification must be retained in the provider's file for a period of four years.

**Drug Invoice  
MA 302/302C**

32 No. of Att	33 Attach Type	34 Attach Type	DPW Use	DPW Use

Complete items 32, 33 and 34 (if necessary). **DO NOT ATTACH** the denial or payment notification. This notification must be retained in the provider's file for a period of four years.

**Dental Services Invoice  
MA 300D**

No. of Attachments	Attachment Type	Attachment Type
40	41	42

Complete items 40, 41 and 42 (if necessary). DO NOT ATTACH the denial or payment notification. This notification must be retained in the provider's file for a period of four years.

**PLEASE REMEMBER:** If you receive payment from Medicare or a private insurance carrier, you **must** complete all applicable fields on the invoice in addition to the attachment type fields. For a Medicare payment this would include the Medicare Approved field, the Medicare Deductible field (if applicable), the Medicare Co-Insurance field (if applicable), and the Total Medicare Approved field. For a payment from a private insurance carrier, the Other Insurance Paid field must be completed. Please refer to instructions in your provider handbook.

2. For recipients who have a third party resource which requires some type of prior approval or prescreening (e.g., an HMO) and the failure to follow these instructions result in a denial of payment by the third party resource, the Department will **not** approve payment under the Medical Assistance Program.
3. If a client has a third party resource indicator on their MSE card, you should always ask to see the benefit card to obtain applicable information to bill the resource and to determine if, for example, there is Major Medical coverage. This will help avoid unnecessary delays in reimbursement.

By referring to the above information when third party resources exist, it is hoped that confusion concerning this billing issue can be eliminated.

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

Division of Outpatient Programs  
P.O. Box 8046  
Harrisburg, Pennsylvania 17105

Or call the appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at [www.dpw.state.pa.us/omap](http://www.dpw.state.pa.us/omap).