



MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

ISSUE DATE

June 29, 2007

EFFECTIVE DATE

January 1, 2007

NUMBER

03-07-05

SUBJECT

Revised MA Bulletin 03-07-01: Billing Instructions -
Medicare Non-Coverage for Medicare Eligible Nursing
Facility Residents

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PURPOSE:

The purpose of this bulletin is to reissue Medical Assistance Bulletin 03-07-01 regarding the correct billing procedures when a Medicare Part A eligible resident receives services that are not covered by Medicare. This is also to notify providers that effective March 1, 2007, claims will be denied if not billed as instructed when residents have Medicare Part A eligibility but the services are not covered by Medicare.

SCOPE:

This bulletin applies to all nursing facilities that are licensed and enrolled in the Medical Assistance (MA) Program.

BACKGROUND:

55 Pa Code § 1101.64 sets forth that MA is the payer of last resort. Therefore, all other payers must be billed prior to billing MA. However, there are circumstances that occur in which a provider knows that Medicare will not cover the service. For example, the resident did not have a qualifying hospital stay, or the resident's condition does not meet the definition of skilled nursing care under Medicare. The billing provider's claim submission to the MA Program must indicate that there was no Medicare payment or denial. Claims **must** be completed correctly to ensure that they are not **denied** on Error Status Code ESC 2550. ESC 2550 sets when the resident has Medicare Part A but has no Medicare denial or payment indicated.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap/

PROCEDURE:

Providers should refer to the Billing Guides for instructions regarding the completion and submission of claims to the MA Program for services provided. The Billing Guides are available on the DPW Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap/ under Provider Information. Providers using private software vendors should contact their software vendor if needed in regard to completing and entering Medicare information. On December 18, 2006 training was made available to software vendors.

When billing MA, providers must indicate why there is no Medicare payment on their claims when a resident is eligible for Medicare Part A or the claim will deny on ESC 2550. Please use the appropriate billing guides related to the method you use to submit your claims to MA.

Note: The UB-04 will replace the UB-92 beginning July 1, 2007. Please visit the DPW Office of Medical Assistance Programs website for current updates and instructions regarding the invoice revision.

UB-92/UB-04

When submitting claims via the UB-92/UB-04 for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed:

UB-92 Form Locators 24-30 (Condition Codes) or UB-04 Form Locators 18-28 (Condition Codes) – Enter Condition Code **X4**, when one of the following criteria is applicable to the nursing facility service for which you are billing:

UB-92 Form Locator 84 (Remarks) or

UB-04 Form Locator 80 (Remarks) – Enter the statement below that applies:

- There was no 3-day prior hospital-stay.
- The resident was not transferred within 30-days of a hospital discharge.
- The resident's 100 benefit days are exhausted.
- There was no 60 day break in daily skilled care.
- Medical Necessity Requirements are not met.
- Daily skilled care requirements are not met.

For example, if there was no 3-day prior hospital stay; enter "No 3-day prior hospital stay".

All other Form Locators on the UB-92/UB-04 must be completed as per the appropriate billing guide.

PES

To submit a claim using PES when the resident is Medicare Part A eligible but the services are not eligible for Medicare payment, you must complete the following information on the Crossover Tab:

Release of Medical Data – Select "A" for appropriate release of information on file.

Benefits Assignment – Select "Y" for yes.

Reason Code – Enter a **35** if Medicare Benefits are exhausted.

Enter a **50** if one of the following reasons applies to why Medicare does not cover the services on the claims:

- There was no 3-day prior hospital-stay.

- The resident was not transferred within 30-days of a hospital discharge.
- The resident's 100 benefit days are exhausted.
- There was no 60 day break in daily skilled care.
- Medical Necessity Requirements are not met.
- Daily skilled care requirements are not met.

Reason Code Amount – Enter the amount you are billing to MA.

Claim Filing Ind Code – Select **MA** for Medicare Part A

Adjustment Group Code – Select **PR**.

Medicare ICN – If you do not have a Medicare ICN, please enter (111111111111) in this field.

Full Medicare Days – Leave blank.

Paid Date – Indicate the date that the resident's Medicare coverage exhausted or the date that the services were denied by Medicare. If you do not have a date to enter, please use the resident's date of admission.

Paid Amount – Enter 0.00 as the Paid Amount. NOTE: The field will display .00

Policy Holder (Heading) Carrier Code – Enter the appropriate Carrier Code for the Medicare Part A carrier for the resident (i.e. 600)

Internet

Submitting a claim via the Internet for the same circumstance, you would complete the **Other Insurance** section as follows:

Carrier Code - Enter the appropriate Carrier Code for the Medicare Part A carrier for the resident (i.e. 600).

Claim Filing Code - Enter the "MA" from the dropdown menu.

Release of Medical Data? Enter "Y" for yes.

Benefits Assigned? Enter "Y" for yes.

Adjustment Group Code / Reason Code / Amount - This area is separated into three columns below the heading:

Adjustment Group Code – First column, select **PR**.

Reason Code – Second column - Enter one of the following codes in the second column as a Reason Code:

Enter a **35** if Medicare Benefits are exhausted.

Enter a **50** if one of the following reasons applies to why Medicare does not cover the services on the claims:

- There was no 3-day prior hospital-stay.
- The resident was not transferred within 30-days of a hospital discharge.
- The resident's 100 benefit days are exhausted.
- There was no 60 day break in daily skilled care.
- Medical Necessity Requirements are not met.
- Daily skilled care requirements are not met.

Reason Code Amount – Third column, enter the amount you are billing to MA.

Paid Date – Indicate the date that the resident's Medicare coverage exhausted or the date that the services were denied by Medicare. If you do not have a date to enter, please use the resident's date of admission.

Leave the other fields in this section blank.

Electronic Billing (Private Software Vendors)

When submitting an electronic claim, nursing facilities should submit their claims using:

Medicare ICN - Enter all ones (11111111111111) for the Medicare ICN field.

The following items are in Loop 2320 and are required fields:

CAS01 - Adjustment Group Code: Enter a **PR**.

CAS02 – Adjustment Reason Code:

Enter a **35** if Medicare Benefits are exhausted.

Or, Enter a **50** if one of the following reasons applies to why Medicare does not cover the services on the claims:

- There was no 3-day prior hospital-stay.
- The resident was not transferred within 30-days of a hospital discharge.
- The resident's 100 benefit days are exhausted.
- There was no 60 day break in daily skilled care.
- Medical Necessity Requirements are not met.
- Daily skilled care requirements are not met.

CAS03 – Billed Amount: Enter amount being billed to MA. Do not use zeros or leave blank.

The Paid Amount is also entered in Loop 2320:

AMT01 – Enter Qualifier **N1**.

AMT02 – Enter **0.00**.

The Paid Date information is in Loop 2330B:

DTP01 – Enter Date and Time Qualifier **573**.

DTP02 – Enter Time Period Format Qualifier **D8**.

DTP03 – Enter date that benefits were exhausted or the resident's date of admission.