	MEDICAL ASSISTANCE BULLETIN **COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE**	
	SUBJECT Billing Instructions for Medicare Part B Claims	**BY** Darlene C. Collins, M.Ed., M.P.H. Deputy Secretary for Medical Assistance Programs
NUMBER:	99-96-10	
ISSUE DATE:	January 6, 1997	
EFFECTIVE DATE:	January 22, 1997	

PURPOSE:

The purpose of this bulletin is to provide you with instructions to be used when billing the Office of Medical Assistance Programs directly for Medicare Part B claims.

SCOPE:

This bulletin applies to all outpatient providers enrolled in the Medical Assistance (MA) Program who bill for Medicare Part B services.

DISCUSSION:

The Department has identified two situations in which providers **must** bill MA directly for the Medicare Part B deductible and/or coinsurance. They are:

I. Medicare Part B claims processed by an INTERMEDIARY.

II. Medicare Part B claims processed by a CARRIER that do **not** automatically cross over to MA.

PROCEDURE:

I. MEDICARE PART B CLAIMS PROCESSED BY AN INTERMEDIARY.

A. For claims with dates of service prior to January 1, 1996, you should continue to follow previously established Medicare procedures.

B. For claims with dates of service January 1, 1996 and after, please use the following billing instructions.

Billing Instructions:

IMPORTANT: When submitting hardcopy invoices for Medicare Part B services, using either the HCFA-1500 or the MA 319, only one claim line is allowed per invoice. Claims will be rejected if more than one claim line is submitted.

1. **1.HCFA-1500 Invoices**

When submitting HCFA-1500 invoices, please follow the instructions in MA Bulletin 99-94-15. Pay particular attention to the instructions for the completion of Block 19. Complete Blocks 24A, 24C, and 24D as follows:

Block 24A: (Dates of Service – From & To) – Complete this Block using the "From and Thru" dates that appear on the Medicare Remittance Advice.

Blocks 24C and 24D: (Type of Service P Procedure Code) – **W1868 is a new Procedure Code that is to be used only for Medicare Part B deductible and coinsurance amounts for services rendered on or after January 1, 1996, which were processed by an intermediary.** When billing for payment of the Medicare deductible and/or coinsurance amounts for outpatient services, always use **W1868** as the Procedure Code,

and **DC** as the Type of Service. **DO NOT USE THIS PROCEDURE CODE FOR DATES OF SERVICE PRIOR TO JANUARY 1, 1996.**

2. **MA 319 Invoices**

When submitting MA 319 invoices, please follow the instructions outlined in the Billing Information Section of your provider handbook. Pay particular attention to the instructions for the completion of Blocks 40 and 41. Complete Blocks 29A, 29B 29C, 29H, and 29I as follows:

Block 29A: (Procedure Name) – Complete this Block with the description of the service rendered, e.g., physical therapy or occupational therapy.

Blocks 29B and 29C: (Service Begin & Service End) – Complete both Blocks "B" and "C" on the MA 319 using the "From and Thru" dates on the Medicare Remittance Advice.

Blocks 29H and 29I: (Type of Service & Procedure Code) – **W1868 is a new Procedure Code that is to be used only for Medicare Part B deductible and coinsurance amounts for services rendered on or after January 1, 1996, which were processed by an intermediary.** When billing for payment of the Medicare deductible and/or coinsurance amounts for outpatient services, always use **W1868** as the Procedure Code, and DC as the Type of Service. **DO NOT USE THIS PROCEDURE CODE FOR DATES OF SERVICE PRIOR TO JANUARY 1, 1996.**

3. **Previously Submitted Claims**

Some providers already submitted and were paid by MA for the deductible and/or coinsurance on claims for Part B services which were processed by an intermediary. These providers separated the one claim line from the Medicare Remittance Advice into several claim lines, billing MA using compensable MA codes. In this process, providers also separated the Medicare Part B deductible and/or coinsurance amounts.

Providers who have submitted partial claims to MA are instructed to bill only for those claim lines **not already paid by MA.** Providers are to use Procedure Code **W1868,** Type of Service **DC**, completing one claim line per invoice, adjusting the Medicare Part B deductible and/or coinsurance amounts accordingly.

II. MEDICARE PART B CLAIMS PROCESSED BY A CARRIER THAT DO NOT AUTOMATICALLY CROSS OVER TO MA.

In most cases, providers do not have to do anything in order to be paid the Medicare Part B deductible and/or coinsurance amounts. Medicare Part B claims for Qualified Medicare Beneficiaries (QMBs) submitted to XACT Medicare Services or MetraHealth should automatically cross over to the Department for payment.

EXCEPTIONS – The following claims will NOT automatically cross over to MA for processing. In these instances, the provider must bill directly to MA for the Medicare Part B deductible and/or coinsurance:

- Claims that were denied by the Medicare carrier;
- Claims that have been adjusted by the Medicare carrier;
- Claims that have been forwarded to another supplemental insurer by the Medicare carrier; and
- Claims for Non-Qualified Medicare Beneficiaries (Non-QMBs).

Non-QMBs are identified as the following:

Category/Program Status Code B-00, TA-66, TJ-66 and any Category with Program Status Codes 21 or 22 – These claims may be submitted directly to MA by the provider if payment from Medicare is less than the MA fee.

Category TA and TJ with a Program Status Code of 65 – These recipients are not eligible for MA and MA is not obligated to pay any Medicare Part B deductible and/or coinsurance for these recipients.

Billing Instructions:

IMPORTANT: When submitting hardcopy invoices for Medicare Part B services, using either the HCFA 1500 or the MA 319, only one claim line is allowed per invoice. Claims will be rejected if more than one claim line is submitted.

1. **HCFA-1500 Invoice**

   When submitting HCFA-1500 invoices, please follow the instructions outlined in MA Bulletin 99-94-15. Pay particular attention to the instructions for Block 19.

2. **MA 319 Invoices**

   When submitting MA 319 invoices, follow the instructions outlined in the Billing Information Section of your provider handbook. Pay particular attention to the instructions for Blocks 40 and 41.

PLEASE NOTE:

1. Claims that meet the criteria outlined in this Bulletin, with dates of service exceeding the 365 day time limits, must be submitted through the Exceptions Unit at P.O. Box 8044, Harrisburg, Pennsylvania 17105.

2. Anytime you are adjusting a claim previously paid by MA, always submit it as a claim adjustment.

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.