	MEDICAL ASSISTANCE BULLETIN **COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE**	
	SUBJECT Revised Billing Instructions for Medicare Part B Claims that Do Not Cross Over to Medical Assistance	**BY** **Robert S. Zimmerman, Jr., M.P.H.** Deputy Secretary for Medical Assistance Programs
NUMBER:	99-98-11	
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EFFECTIVE DATE:	September 14, 1998	

PURPOSE:

The purpose of this bulletin is to provide you with updated instructions to be used when billing the Office of Medical Assistance Programs (OMAP) 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 using the federal claim form HCFA-1500 and the "Physicians Invoice and Medical Services Supplies Invoice and Claim Adjustment" (MA 319 series).

BACKGROUND/DISCUSSION:

As part of the Federal Balanced Budget Reconciliation Act of 1997, Congress clarified that states are permitted to cap their payments for Medicare deductible and coinsurance amounts related to services provided to qualified Medicare beneficiaries (QMBs) at the state's Medicaid fees. Following the enactment of these clarifying amendments, the Department published a notice in the August 23, 1997, Pennsylvania Bulletin, stating that Pennsylvania would change its payment methods to limit payment of cost-sharing amounts for Medicare claims to the applicable MA fee or payment rate.

PROCEDURE:

When billing OMAP directly for Medicare Part B claims that have not been crossed over, please follow the instructions listed below:

1. **Type of Service DC and Procedure Code W1868, are no longer valid for claims (invoice/claim adjustments) submitted on or after January 1, 1998.**

2. If you have billed a Medicare intermediary using a revenue code for Medicare Part B services not covered by MA, bill the revenue code. If there is no equivalent MA type of service, bill the Medicare Type of Service.

3. If you have billed a Medicare carrier for Medicare Part B services not covered by MA, bill the Medicare Procedure Code. If there is no equivalent MA Type of Service, bill the Medicare Type of Service.

4. When billing for payment of the Medicare deductible and/or coinsurance for services covered by MA, please bill the appropriate MA Type of Service and Procedure Code combination.

5. When billing for psychiatric services for which Medicare Part B has applied a reduction, enter the Medicare Approved Amount (the reduced amount, not the Psychiatric Approved Amount) in Block 29 O of the MA 319 invoice.

IMPORTANT

When using the 7/95 version of the MA 319 invoice series or the HCFA-1500, only one claim line per invoice is allowed. Invoices will reject if more than one claim line is completed. When using the 10/98 version of the MA 319 invoice series, more than one claim line may be completed.

NOTE:

Providers may begin using the 10/98 version of the MA 319 invoice series and submit them to the Department with a receipt date of September 18, 1998 or later.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free inquiry line for your provider type.

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