



MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE

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SUBJECT

Billing Instructions - Services Covered Only By Medicare

BY

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PURPOSE:

The purpose of this bulletin is to instruct providers how to bill medical assistance for the Medicare deductible and/or coinsurance for services covered only by Medicare and not covered by medical assistance.

SCOPE:

This bulletin is applicable to all providers enrolled in the Medical Assistance Program who are Medicare participating and who bill medical assistance for recipient deductibles and coinsurances.

BACKGROUND/DISCUSSION:

The Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) mandated state Medicaid Programs to expand coverage to include Medicaid payments for the premium, deductible, and coinsurance for Medicare beneficiaries whose incomes are less than 100% of the poverty level and whose resources are no more than twice the SSI limitation. This coverage provides payment for the deductible and/or coinsurance for all Medicare covered services, even if the services are not covered under the current State Medical Assistance Program.

Providers were notified of this expanded program benefit by way of Medical Assistance Bulletin 99-89-02. Bulletin 99-89-02 described how to identify those recipients, by category and program status code, who are eligible for this cost-sharing benefit.

PROCEDURE:

To bill medical assistance for the Medicare cost sharing amounts, i.e. deductible and coinsurance, providers must:

- 1.) bill Medicare first;
- 2.) receive the Explanation of Medicare Benefits (EOMB) showing the Medicare approved amount and, if applicable, the deductible and/or coinsurance amounts due;

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Bureau of Hospital and Outpatient Programs
P.O. Box 8024
Harrisburg, Pennsylvania 17105

OR CALL THE APPROPRIATE
TOLL-FREE NUMBER FOR
YOUR PROVIDER TYPE.

3.) complete the appropriate medical assistance invoice, following the billing instructions found in the provider handbook;

4.) use TYPE OF SERVICE - DC (Deductible-Coinsurance) when billing for a procedure covered by Medicare but not currently listed in the Medical Assistance Program Fee Schedule; and

5.) use the same procedure code used to bill Medicare for a procedure described in #4 above.

The Department will establish an allowable fee for those services or procedures not found on the Medical Assistance Program Fee Schedule, based on the currently approved rate-setting method. NOTE: Medical assistance will make payment towards the deductible and/or coinsurance only when the amount paid by Medicare is less than the fee established by the Department.

These services are subject to the Department's copayment regulation.

NOTE: Federal regulations state that a medical assistance provider must accept the medical assistance payment as payment in full. This means the provider may not bill the patient for any difference between the provider's charges and the total payment received from Medicare and Medicaid.