Indiana Medicaid Resolutions Manual

NAME: **2502 MEMBER COVERED BY MEDICARE B**

ERROR TYPE: Batch Edit, Hard Coded

HEADER/DETAIL: Detail

OVERRIDABLE: Y

ALLOW DENIAL: Y

DESCRIPTION:

Set this edit when non-crossover outpatient or medical claims for Medicare Part B or Medicare Advantage covered services for a member who has Medicare B or Medicare Advantage coverage on the eligibility file for the claim dates of service.

CRITERIA:

Set this edit when non-crossover outpatient or medical claims for Medicare Part B or Medicare Advantage covered services for a member who has Medicare B or Medicare Advantage coverage on the eligibility file for the claim dates of service.
Outpatient Claim Type:
Specific revenue codes are included with the below bypass criteria:

- Diagnosis is in Prenatal Care (diagnosis group 100010)
- Diagnosis is in Preventive pediatric care (diagnosis group 100011) for age 0-21
- If State Psychiatric Hospital NPI's listed in provider group 152.

These provider numbers can be located at Main Menu>Provider>Related Data>Open Tab>Other>Provider Category Type>Click on appropriate type.

- Specific procedure codes not covered by Medicare listed in procedure group 100025.

The codes can be located at Main Menu>Provider>Related Data>Open Tab>Other>HCPCS Procedure Group Type>Click on appropriate type.

- Rehab PT/PS 04/000 except if billed with procedure codes 92506, 92507, or 92508.

Physician Claim Type:
All procedure codes are included with the below bypass criteria:

- Diagnosis is in Prenatal Care (diagnosis group 100010)

- Diagnosis is in Preventive pediatric care (diagnosis group 100011) for age 0-21
- Diagnosis is in EPSDT (diagnosis group 100007)
- If State Psychiatric Hospital NPI's listed in provider group 152.

Global maternity procedure codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 and 59622 bypass criteria:

- Members that have an active TPL segment for coverage types BX or MA on the claim date of service
- Claim contains an attachment of a valid EOMB from Medicare indicating payment in part or full for the date of service

These provider numbers can be located at Main Menu>Provider>Related Data>Open Tab>Other>Provider Category Type>Click on appropriate type.

- Billing or Rendering provider type/specialty is 04/000 (rehab), 12/000 (school), 13/000 (public health), 16/000 (nurse), 18/000 (optometrist), 19/000 (optician), 22/000 (hearing aid dealer), 27/000 (dentist), 09/094 (CNRA), 09/095 (midwife), 11/113 (psychologist), 14/000 (podiatrist), 31/330 (ophthalmologist)
- Billing or Rendering provider type/specialty is 15/000 (chiropractor) except for procedure codes 98940, 98941, 98942
- Provider type/specialty is 11/116 (social worker) for all codes except G0410, 90785, 90791, 90192, 90801, 90846, 90849, and 90853.
- Provider type/specialty is 26/260 or 26/261 for all codes except procedure code A0420, A0422, A0427, A0429, A0430, A0431, A0433, A0436 and A0999 and is in place of service is 11, 51, 71, 72, 81, or 99
- Specific DME equipment and supply procedure codes if performed in place of service is 31, 32, 33, 34, or 54.
- Specific DME codes and billed with modifier RR, UE, or LL.
- Benefit plans PASMI(sak 15), PASMR(sak 16), MRO(sak 17), Waiver plans(sak 18-29), 1915i plans (sak 62, 63, 64)
- Vision codes V2020-V2615, hearing codes V5008-V2999, and all D-codes except D0150, D1206, D4355, D7111, D7140, D9241, and D9242.
- Specific procedure codes not covered by Medicare.

DISPOSITION:

Note: EOB 9999 with a Do Not Post status is for internal system use only. This EOB is used to avoid potential system processing abends. This EOB is not posted on the RA and the disposition may be ignored.

Claim Type: 0 - All Claim Types **Member Plan:** PKGC **Status:** Do Not Post

Location	Region	EOB	Disposition

02	00	9999	PAY

Claim Type: 0 - All Claim Types **Member Plan:** ALL **Status:** Do Not Post

Location	Region	EOB	Disposition
02	00	9999	PAY

Claim Type: M - Professional Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
02	00	2502	DENY
02	11	2502	SUSPEND
02	21	2502	SUSPEND
02	23	2502	SUSPEND
02	30	2502	PAY
02	32	2502	PAY
02	33	2502	PAY
02	34	2502	PAY
02	50	9999	SUSPEND
02	51	9999	SUSPEND
02	52	2502	SUSPEND
02	55	9999	PAY
02	61	2502	SUSPEND
02	64	2502	PAY
02	70	2502	PAY
02	72	2502	PAY
02	73	2502	PAY
02	74	2502	PAY
02	80	2502	SUSPEND
02	91	2502	SUSPEND

Claim Type: M - Professional Claims **Member Plan:** PASMR **Status:** Do Not Post

Location	Region	EOB	Disposition
02	00	9999	PAY

Claim Type: M - Professional Claims **Member Plan:** PASMI **Status:** Do Not Post

Location	Region	EOB	Disposition
02	00	9999	PAY

Claim Type: M - Professional Claims **Member Plan:** MRT **Status:** Do Not Post

Location	Region	EOB	Disposition
02	00	9999	PAY

Indiana Medicaid Resolutions Manual

Claim Type: O - Outpatient Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
02	00	2502	DENY
02	11	2502	SUSPEND
02	21	2502	SUSPEND
02	23	2502	SUSPEND
02	30	2502	PAY
02	32	2502	PAY
02	33	2502	PAY
02	34	2502	PAY
02	50	2502	SUSPEND
02	51	2502	SUSPEND
02	52	2502	SUSPEND
02	55	9999	PAY
02	61	2502	SUSPEND
02	64	2502	PAY
02	70	2502	PAY
02	72	2502	PAY
02	73	2502	PAY
02	74	2502	PAY
02	80	2502	SUSPEND
02	91	2502	SUSPEND

EOB: 2502 - THIS MEMBER IS COVERED BY MEDICARE PART B OR MEDICARE D; THEREFORE, YOU MUST FIRST FILE CLAIMS WITH MEDICARE. IF ALREADY SUBMITTED TO MEDICARE, PLEASE SUBMIT YOUR EOMB.

ARC Code	ARC Description	Effective Date	End Date
22	This care may be covered by another payer per coordination of benefits.	19950101	22991231

Remark Code	Remark Description	Effective Date	End Date
N245	Incomplete/invalid plan information for other insurance .	20040801	22991231

EOB: 9999 - PROCESSED PER POLICY.

ARC Code	ARC Description	Effective Date	End Date
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231

METHOD OF CORRECTION:

Review attachment:

- If it is a valid EOMB from a Medicare carrier, where Medicare has denied the claim, regardless of the reason for denial, the edit should be overridden for payment.
- If not a valid EOMB from Medicare, then fail this edit with EOB 2502.

It is NOT a Valid denial if the denial reason is that the provider will not take Medicare assignment. Do not override the edit in this situation.
It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. It is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code.
Or

- Global maternity procedure codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 and 59622
- Valid EOMB from a Medicare carrier, where Medicare has paid in part or full for the services then the edit should be overridden

- No valid EOMB from Medicare indicating payment in part or full for the date of service, then fail this edit with EOB 2502

Review claims notes:
When billing for services provided to members who are dually eligible for Medicare and Medicaid, mental health providers that submit claims using procedure codes with modifier HE or HO may use claim notes to indicate that the provider that performed the service is not approved to bill services to Medicare. Claims must include the following text in the claim notes: "Provider not approved to bill services to Medicare." The use of claim notes allows the claim to suspend for review of the claim note and be adjudicated appropriately.
Blanket Denial:
If the attachment indicates that the service provided is a BLANKET DENIAL, and the denial letter is present as an attachment, FORCE the claim for payment. If the provider hand writes the corresponding procedure code on the claim, this is acceptable. NOTE: This is good for one year from the denial letter.
Court Orders: If the attachment is a court order, FORCE the claim to pay.
EOB CODE:
2503 This recipient is covered by Medicare Part B or D; therefore, you must first file claims with Medicare. If already submitted to Medicare, please submit your EOMB
2507 The Medicare EOMB remark code indicates that this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.
2506 The Medicare EOMB indicates that the claim was forwarded to another insurance company. You must attach a denial notice from that insurance company, plus the Medicare EOMB for payment.
2508 Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier/insurer.
2055 The claim has been denied. Please resubmit the Medicare Replacement Plan claim as a crossover claim for reimbursement consideration.
NOTE: For dates of service prior to August 9, 2012 the Medicare Replacement Guidelines would apply

- Handled as TPL
- Medicare Replacement Plan written on claim and EOB

For dates of service after August 9, 2012 Medicare Replacement Plans are treated as Medicare excepting when there is a denial. Medicare Replacement Plan denials:
If a claim has been denied by the Medicare Replacement Plan, the explanation of benefit (EOB) or Remittance Advice (RA) must be attached to the claim with "Medicare Replacement Plan" written on the top of the attachment. Medicare-denied services must be filed on a separate claim form from paid services, and the appropriate EOB or RA must be attached for reimbursement consideration.