Indiana Medicaid Resolutions Manual

NAME: **2500 MBR CVRD BY MEDICARE A (DTL)**

ERROR TYPE: Batch Edit, Hard Coded

HEADER/DETAIL: Detail

OVERRIDABLE: Y

ALLOW DENIAL: Y

DESCRIPTION:

Set this edit when an inpatient (non-crossover) is for Medicare Part A or Medicare Advantage Plan covered services for a member who has Medicare A or Medicare Advantage coverage on the eligibility file for the claim dates of service.

CRITERIA:

Set this edit when an inpatient (non-crossover) is for Medicare Part A or Medicare Advantage Plan covered services for a member who has Medicare A or Medicare Advantage coverage on the eligibility file for the claim dates of service.
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 ages 0-21
- Diagnosis is in EPSDT (diagnosis group 100007)
- State Psychiatric Hospital NPI's listed in CoreMMIS group 152.

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

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:** ALL **Status:** Do Not Post

Location	Region	EOB	Disposition
02	00	9999	PAY

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

Location	Region	EOB	Disposition
02	00	9999	PAY

Claim Type: I - Inpatient Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
02	00	2500	DENY
02	11	2500	SUSPEND
02	21	2500	SUSPEND
02	23	2500	SUSPEND
02	30	9999	PAY
02	32	9999	PAY
02	33	9999	PAY
02	34	9999	PAY
02	50	2500	SUSPEND
02	51	2500	SUSPEND
02	52	2500	SUSPEND
02	61	2500	SUSPEND
02	64	2500	SUSPEND
02	70	9999	PAY
02	72	9999	PAY
02	73	9999	PAY
02	74	9999	PAY
02	91	2500	SUSPEND

EOB: 2500 - THIS MEMBER IS COVERED BY MEDICARE PART A; THEREFORE, YOU MUST FIRST FILE CLAIMS WITH MEDICARE.

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 denial (EOMB) from a Medicare carrier, override the edit.
- If not a valid denial, fail this edit with EOB 2500.

It is a Valid denial if it is applicable to the claim (same services, dates of service, etc.)
Denial reason is due to: Medicare non-covered service Medicare benefits exhausted
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.
If claim has a Medicare payment amount and can be processed as an X-over, deny this claim.
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.

2501-This recipient is covered by Medicare Part A; therefore, you must first file claims with Medicare.
2507-Medicare EOMB remark code indicates that this claim was 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.
0566-Your crossover claim has not been submitted on the correct form, verify and resubmit.
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