Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2021-95**
www.ctdssmap.com **November 2021**

TO: All Providers Billing Outpatient Crossover Claims, Except FQHC

RE: Outpatient Crossover Electronic 837I Claim Submission and Pricing Changes

The purpose of this bulletin is to notify providers of upcoming changes to outpatient crossover claim requirements when submitted via the ASC X12N 837 Health Care Claim transaction. In the near future, providers submitting Medicare crossover claims *will be required* to submit Medicare data at the claim detail level.

Providers that are not compliant with this requirement will experience claim denials for dates of service submitted on and after the effective date of this change. The final effective date will be communicated in a future provider bulletin.

The Department of Social Services (DSS) understands that providers/trading partners may need to modify their system to support these new billing requirements. Providers are strongly encouraged to begin making those changes now, and submitting claims in that format as soon as possible, to avoid claim denials in the future.

ASC X12N 837 I Health Care Claim Submission Requirements

In order to submit Medicare data at the detail level, providers must ensure that data is submitted in the loops and segments shown below.

Note that changes have been made for outpatient crossover claims only so that providers submitting at the claim detail can now also submit copay information, using the claim adjustment reason code (CARC) of 3. That change is also reflected below.

Loop	Segment	Description
2430	SVD	Line Adjudication Information
2430	CAS	Line Adjustment Information – Enter the co-insurance (claim adjustment reason code = 2), deductible (claim adjustment reason code = 1), or copay for outpatient crossovers only (claim adjustment reason code = 3) for the line item.
2430	DTP	Line Adjudication Date

As a result of these claim submission changes, providers may see slight differences in their crossover claim payments. Claim payments are generally calculated as the lower of the Medicaid calculated allowed amount (using the applicable methodology such as max fee) minus any Medicare payments or the deductible/copay/coinsurance billed. Copay will be recognized and utilized once the Medicare data is submitted at the detail level.

Chapter 11 of the Provider Manual, which can be accessed from the www.ctdssmap.com Web site by selecting Information > Publications, and then selecting the appropriate claim type from the drop down box, contains additional instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment or denied a claim.

To assist providers with understanding and correcting other insurance/Medicare related claim denials, providers may refer to Chapter 12 of the Provider Manual, also available on the www.ctdssmap.com Web site. This chapter is

revised as existing EOBs are modified and new EOBs are added.

Please note that providers submitting claims via the Web claim submission tool will be able to submit Medicare data at the claim detail level in the future. A provider bulletin will be posted when that enhancement is available to providers.