**TO: Inpatient Hospital, Psychiatric Outpatient Hospital, Ambulatory Surgical Center Clinic, Rehabilitation Facility Clinic, and Free-standing Renal Dialysis Clinic Providers**

**RE: Outpatient Crossover Claim Pricing Changes**

Effective for dates of service on and after January 1, 2022, outpatient claims that crossover directly from Medicare or that are submitted by an inpatient hospital, psychiatric outpatient hospital, ambulatory surgical center clinic, rehabilitation facility clinic, and free-standing renal dialysis clinic provider with Medicare information at the claim detail will now be priced using the information that is submitted at the detail level.

Additionally, inpatient hospital, psychiatric outpatient hospital, ambulatory surgical center clinic, rehabilitation facility clinic, or free-standing renal dialysis clinic providers submitting Medicare information at the claim detail can now submit copay information, using claim adjustment reason code (CARC) of 3. The following shows the ASC X12N 837 I Health Care Claim loop and segment where that CARC may be submitted.

| Loop | Segment | Description |
|---|---|---|
| 2430 | CAS | Claim Adjustment – 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 claim. |

As a result of these changes, providers may see slight differences in their crossover claim payments. Claim payment is generally calculated as the lower of the Medicaid calculated allowed amount (such as max fee or provider specific rate, as applicable) minus any Medicare payments or the deductible/copay/coinsurance billed.

No claim submission changes are currently required for any providers that may not be submitting Medicare information at the detail level. However, that will be required in the future. Chapter 11 of the Provider Manual, available via the **www.ctdssmap.com** Web site by selecting Information > Publications and selecting the appropriate claim type from the drop down box, outlines the ASC X12N 837I loops and segments needed to submit the Medicare information at the detail level. Trading partners/providers are encouraged to begin to make necessary changes to support the above requirements now. Additional provider notification will be distributed with implementation timeframes and instructions on how to submit the required claim detail information.

Additionally, changes will be made to the Web claims submission panels available via a provider's Secure Web portal account when logged on via **www.ctdssmap.com** to allow providers to submit Medicare information at the claim detail. Providers will be notified when those changes are available.

Adequate time will be allotted for providers to make the changes required to submit Medicare information at the claim detail. However, upon implementation, if that information is not submitted at the claim detail, providers will experience claim denials.

To assist providers with understanding 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.

For additional other insurance/Medicare claim submission instruction reminders, providers should refer to PB 2021-73 "Other Insurance/Medicare Claim Submission Instruction Reminders".