**Connecticut Department of Social Services**
**Medical Assistance Program**
www.ctdssmap.com

**Provider Bulletin 2022-87**
**November 2022**

**TO: All Providers Billing Outpatient Crossover Claims, Except FQHC**

**RE: Outpatient Crossover Claims – New Web Claim Submission Panel**

Providers were notified of upcoming changes to outpatient crossover claim requirements when submitted via the ASC X12N 837 Health Care Claim transaction in PB 21-95. In the near future, providers submitting Medicare crossover claims *will be required* to submit Medicare data at the claim detail level.

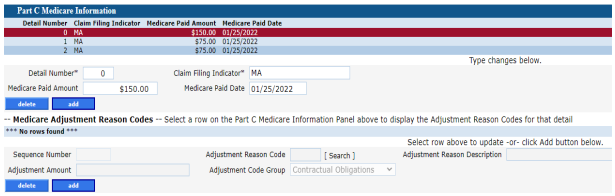
Providers that are not compliant with this requirement will experience claim denials for dates of service submitted on and after the effective date of this change. The final effective date will be communicated in a future provider bulletin.

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.

**New Web Claim Submission Panel**
Please note that, effective October 26, 2022, providers submitting outpatient crossover claims via the www.ctdssmap.com Web claim submission tool will be able to submit Medicare data at the claim detail level via new panels.

The Web claims submission help text guide will be updated to include this new panel. Information on use of the new panel is also included below.

*New Part C Medicare Information and Medicare Adjustment Reason Codes Panel*




Claim Inquiry

When performing a claim inquiry on claims that processed with only header level information available, the appropriate data will show in the new Part C Medicare Information panel with detail 0.

New Claim

To submit a new claim with data on the new Part C Medicare Information Panel, you must ensure that:

- the Claim Filing Ind only contains MA or MB,
- if the Other Payer Payment is at the HEADER, that there is ONE segment ONLY with 'Detail Number' = 0 with its corresponding CARCs (Adjustment Reason Codes),
- if the Other Payer Payment is at the HEADER and DETAIL, that there is more than ONE segment with 'Detail Number' = 0, 1, 2, 3 etc. (1, 2, 3 refers to the Claim's detail #),
- if the Other Payer Payment is at the DETAIL, that you enter the Claim's detail information first (one at the time), then enter its corresponding Other Payer Payment, and

- if claim has more than 1 detail, and with Other Payer Payment at the detail, you repeat the 3rd bullet until all details and their corresponding Other Payer Payment are entered.

Copy an Existing Claim

Follow the Web claim submission procedures to copy an existing claim. When copying a claim, ensure that:

- the same instructions as entering data on a new claim are followed, and
- when using the copy function on claims that processed with only header level information, you enter any detail Medicare payment and CARC information.

Resubmit a Claim

Follow the Web claim submission procedures to resubmit a claim. When resubmitting a claim, ensure that:

- the same instructions as entering data on a new claim are followed, and
- when using the resubmit function on claims that processed with only header level information, you enter any detail Medicare payment and CARC information.

Void a Claim

Follow the Web claim submission procedures to void a claim. When voiding a claim, ensure that:

- if you plan to re-submit the voided claim, the same instructions as entering data on a new claim are followed,
- if the user voids the claim on claims that processed with only header level information available, continue to process the Medicare amounts at the header, and
- note that C Crossover claims can only be voided.

**ASC X12N 837 I Health Care Claim Submission Requirements**

As a reminder, 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.