PROFESSIONAL SERVICE PROVIDERS MAY ELECTRONICALLY SUBMIT MEDICARE and Medicare Advantage Plan DENIED CLAIMS TO Fee-For-Service Medicaid

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The Louisiana Department of Health (LDH) and Molina made changes to the Fee-for-Service claims processing logic to allow professional service providers to electronically submit Medicare claims including Medicare Advantage Plan claims to FFS Medicaid as primary payer for consideration of payment.

With some exceptions listed at the end of this notice, this change is in place for Medicare Part B claims - only.

LDH and Molina expect this change to be very beneficial for professional service providers who service Medicare/Medicaid recipients. These changes will allow providers to submit Medicare denied claims electronically to Medicaid as a Medicaid primary claim. This allows claims to process more quickly and expedite payments. It will eliminate the need to drop claims to paper and attach the Medicare EOB; thus, reducing staff time eliminating mailing costs to send the denied claims to Medicaid.

A new Medicaid TPL Carrier Code, MOL001, has been created for the electronic submission of Medicare denied claims. Professional Service Providers must enter this six-digit carrier code and must enter the HIPAA Adjustment Reason Code(s) indicating the reason for the Medicare denial (i.e. 96 –not covered; etc.). This data must be included in the electronic claim transaction.

Providers should review the Companion Guides for 837P (Appendix B) Electronic Claims found on the Louisiana Medicaid web site, www.lamedicaid.com, directory link HIPAA Information Center, sub-link 5010v of the Electronic Transactions, for data specifications and information.

When the electronic claim comes through the system, the Medicare HIPAA denial codes will be 'edited' to determine if the system can 'bypass' the Medicare edits and process the claim as a Medicaid primary claim or if the claim should be denied based on the Medicare denial reason.

Providers may still see some FFS claim denials for electronically submitted claims.

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- There are some Medicare denials that cannot be processed by Medicaid and will be denied by Medicaid. These types of denials include, but are not limited to, denials such as CARC 50 (These are non-covered services because they are not deemed a 'medical necessary' by the payer); and CARC 16 (Claim/service lacks information or has submission/billing errors which are needed for adjudication).
- There are some Medicare/Medicaid recipients who do not have a category of Medicaid coverage that will allow the claims to process and be paid as Medicaid primary claims, and those will also be denied.

Claims accepted will be edited through Medicaid claims processing editing. In addition to existing Fee-For-Service error codes, providers that receive denials on these claims may see the following new error codes:

- Edit 825 – Resubmit Corrected Claim or Additional Info to Medicare
- Edit 829 – Injury/Illness is Responsibility of Another Liable Party

Providers may see edit 275 (Medicare eligible) if the claims are not submitted correctly or do not contain the required data.

Providers who choose to continue to submit these claims as paper claims should continue to follow the procedure in place for paper claims; the new carrier code and HIPAA denial codes should not be placed on the paper claim form.

MEDICARE/ denied claims that cannot be accepted through this process include:

- Non-emergency ambulance and emergency ambulance claims for recipients enrolled with a Healthy Louisiana Plan.
- Medicare denied claims must be submitted to the appropriate Healthy Louisiana Plan.

NOTE: These changes are not related to PAID Medicare (traditional or Medicare Advantage claims even if the allowable went to patient responsibility and no payment was made).