



## **Medical Assistance Administration**



# **Ambulatory Surgery Centers**

## **Billing Instructions**

**July 2000**

# **Current Procedure Terminology CPT**

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## **About this publication**

**This publication supersedes all previous billing instructions for Ambulatory Surgery Centers.**

Published by the Medical Assistance Administration  
Washington State Department of Social and Health Services  
July 2000

**Received too many billing instructions?  
Too few?  
Address incorrect?**

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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# Important Contacts

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A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

## **Applying for a provider #**

**Call:**

Provider Enrollment Unit  
(800) 562-6188 and  
Select Option #1

**or call one of the following numbers:**

(360) 725-1033  
(360) 725-1026  
(360) 725-1032

## **Where do I send my claims?**

**Hard Copy Claims:**

Division of Program Support  
PO Box 9248  
Olympia WA 98507-9248

**Magnetic Tapes/Floppy Disks:**

Division of Program Support  
Claims Control  
PO Box 45560  
Olympia, WA 98504-5560

## **How do I obtain copies of billing instructions or numbered memoranda?**

**Check out our web site at:**

<http://maa.dshs.wa.gov>

**Or write/call:**

Provider Relations Unit  
PO Box 45562  
Olympia WA 98504-5562  
(800) 562-6188

## **Who do I contact if I have questions regarding...**

**Payments, denials, general questions regarding claims processing, or Healthy Options?**

**Call:**

Provider Relations Unit (PRU)  
(800) 562-6188

**Private insurance or third party liability, other than Healthy Options?**

**Write/call:**

Division of Client Support  
Coordination of Benefits Section  
PO Box 45565  
Olympia, WA 98504-5565  
(800) 562-6136

**Electronic Billing?**

**Write/call:**

Electronic Billing Unit  
PO Box 45511  
Olympia, WA 98504-5511  
(360) 725-1267

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# Definitions

**This section defines terms and acronyms used throughout these billing instructions.**

**Ambulatory Surgery Center (ASC)** - Any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

**Categorically Needy (CNP)** - CNP programs are the federally matched Medicaid programs that provide the broadest scope of medical coverage. Persons may be eligible for:

- CNP only;
- Cash benefits under the SSI (Supplemental Security Income);
- TANF (Temporary Assistance for Needy Families);
- General Assistance – X (special); or
- General Assistance (children’s).

CNP includes full scope coverage for pregnant women and children.

**Client** – An applicant approved for, or recipient of, DSHS medical care programs.

**Code of Federal Regulations (CFR)** - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**Coinsurance-Medicare** – The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges. (WAC 388-500-0005)

**Core Provider Agreement** - A basic contract that the Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

**Current Procedural Terminology (CPT™)** – A description of medical procedures available from the American Medical Association of Chicago, Illinois.

**Deductible-Medicare** – An initial specified amount that is the responsibility of the client.

- **Part A of Medicare-Inpatient Hospital Deductible** - An initial amount of the medical care cost in each benefit period which Medicare does not pay.
- **Part B of Medicare-Physician Deductible** - An initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay. (WAC 388-500-0005)

**Department** - The state Department of Social and Health Services. (WAC 388-500-0005)

**Expedited Prior Authorization (EPA)** - The process of authorizing selected services in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

**Explanation of Benefits (EOB)** - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

**Explanation of Medicare Benefits (EOMB)** – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

**Health Care Financing Administration Common Procedure Coding System (HCPCS)** – Coding system established by the Health Care Financing Administration to define services and procedures.

**Managed Care** – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

**Maximum Allowable** - The maximum dollar amount a provider may be reimbursed by MAA for specific services, supplies, or equipment.

**Medicaid** - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

**Medical Assistance Administration (MAA)** - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

**Medical Assistance Identification (MAID) cards** – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were previously known as DSHS medical coupons.

**Medically Necessary** - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

**Medicare** - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

**Patient Identification Code (PIC)** - An alphanumeric code that is assigned to each MAA client consisting of:

- a) First and middle initials (a dash (-) must be used if the middle initial is not indicated).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- c) First five letters of the last name (and spaces if the name is fewer than five letters).
- d) Alpha character (tiebreaker).

**Primary Care Case Manager (PCCM)** – A physician, Advanced Registered Nurse Practitioner, or Physician Assistant who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small, monthly, management fee.

**Prior Authorization** – Approval required from MAA prior to providing services, for certain medical services, equipment, or supplies based on medical necessity.

**Program Support, Division of (DPS)** – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Field Services;
- Managed Care Contracts;
- Provider Relations; and
- Regulatory Improvement.

**Provider or Provider of Service** - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

**Provider Number** – A seven-digit identification number issued to providers who have signed the appropriate contract(s) with MAA.

**Remittance And Status Report (RA)** - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

**Revised Code of Washington (RCW)** - Washington State laws.

**State Unique Procedure Code(s)** – MAA procedure code(s) used for a specific service(s) where there is not a CPT, Health Care Financing Administration's Common Procedure Coding System (HCPCS), or CDT code available or appropriate.

**Third Party** - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

**Title XIX** - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

**Usual and Customary Fee** – The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed*:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same.

**Washington Administrative Code (WAC)** - Codified rules of the state of Washington.

# **Ambulatory Surgery Centers**

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## **What is the purpose of the Ambulatory Surgery Centers Program?**

The purpose of the Ambulatory Surgery Centers (ASC) Program is to reimburse providers for the facility costs of surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgery center.

## **Who should use these billing instructions?**

Ambulatory Surgery Centers that have a valid Core Provider Agreement with MAA should use these billing instructions.

# Client Eligibility

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## Eligibility

Most medical assistance clients are eligible for Ambulatory Surgery Center services **except** clients presenting Medical Assistance IDentification (MAID) cards with one of the following identifiers:

### Exceptions:

#### MAID Identifier

#### Medical Program

CNP-Emergency Medical Only

**Categorically Needy Program-Emergency Medical Only** – These clients are not eligible for Ambulatory Surgery Center services.

Emergency Hospital and Ambulance Only

**Medically Indigent Program** - These clients are not eligible for Ambulatory Surgery Center services.

LCP-MNP – Emergency Medical Only

**Limited Casualty Program – Medically Needy Program – Emergency Medical Only** – These clients are not eligible for Ambulatory Surgery Center services.

Family Planning Only

**Family Planning** – These clients may receive only sterilization services.

## Are clients enrolled in managed care eligible for Ambulatory Surgery Center services?

Clients with an identifier in the HMO column on their MAID card are enrolled in one of MAA’s Healthy Options managed care plans. The client’s managed care plan covers services provided at ambulatory surgery centers when the client’s Primary Care Provider (PCP) determines that the services are appropriate for the client’s health care needs. You must bill the plan directly.

To prevent billing denials, please check the client’s MAID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and/or plan.

Primary Care Case Management (PCCM) clients will have the identifier PCCM in the HMO column on their MAID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the HCFA-1500 claim form. (See the *Billing* section for further information.)

# Coverage

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## What is covered?

MAA covers the procedure codes listed in these billing instructions when medically necessary and not solely for cosmetic treatment or surgery.



**Note:** Authorization requirements or diagnoses may limit coverage of some procedures. When there are requirements, there is a notation below the CPT code description.

## What procedures have special limitations?

- The physician performing the surgery for procedures with special limitations must:
  - ✓ Meet the special limitation requirements; and/or
  - ✓ Obtain prior authorization through either the Limitation Extension or Expedited Prior Authorization process.

When billing MAA, the ASC must include this information on the HCFA-1500 claim form.

**Continued on next page** —————>

## Ambulatory Surgery Centers

- MAA allows the following surgeries only when the diagnosis is V10.3, 140-239.9, 757.6, 906.5-9, or 940-949.5.

CPT™ Codes	Description
11960	Insertion of tissue expander(s)
11970	Replacement of tissue expander w/permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
19160	Mastectomy, partial;
19162	with axillary lymphadenectomy
19180	Mastectomy, simple, complete
19182	Mastectomy, subcutaneous
19316	Mastopexy
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction
19342	Delayed insertion breast prosthesis
19350	Nipple/areola reconstruction
19357	Breast reconstruction w/tissue expander
19364	Breast reconstruction/free flap
19366	Breast reconstruction w/other technique
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast

- MAA allows the following surgeries only when the diagnosis is 605, 607.1, or 607.81.

CPT™ Codes	Description
54152	Circumcision, using clamp or other device; except newborn.
54161	Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn.

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- MAA covers medically necessary cataract removal when the client has one of the following:
  - ✓ Correctable visual acuity in the affected eye at 20/50 or worse as measured on the Snellen test chart; or
  - ✓ One or more of the following conditions:
    - Dislocated or subluxated lens;
    - Intraocular foreign body;
    - Ocular trauma;
    - Phacogenic glaucoma;
    - Phacogenic uveitis;
    - Phacoanaphylactic endophthalmitis; or
    - Senescent cataract.
- MAA covers prior authorized cochlear implants. To receive prior authorization through the Limitation Extension process, a provider must send or fax a request for authorization along with medical justification to:

**Division of Health Services Quality Support  
Quality Fee for Service Section  
PO Box 45506  
Olympia, WA 98504-5506  
Fax: (360) 586-2262**

The request must contain all of the following:

- 1) The name and PIC number of the client;
- 2) The provider's name and provider number;
- 3) The name of the facility where surgery will be performed;
- 4) The service being requested, including CPT procedure code;
- 5) A list of the client's diagnoses;
- 6) A complete evaluation from a multiple disciplinary cochlear implant team addressing, at a minimum, the following:
  - a) Team recommendation;
  - b) Evaluation of family expectations, compliance, motivation and exposure to all potential forms of communication;
  - c) Medical clearance for surgery-no contraindications to surgery;
  - d) Documentation that hearing is amenable to cochlear implants;
  - e) Evidence of failed hearing aids if appropriate. If not appropriate, a brief note as to why hearing aids are not appropriate in this individual case; and
  - f) Proposed post op rehabilitation program and location of rehabilitation services.



**Note:** MAA will request additional information as needed.

# Expedited Prior Authorization

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The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an “EPA” number when appropriate.

To bill MAA for services that meet the expedited prior authorization (EPA) criteria on the following pages, the provider must create a 9-digit EPA number. The first 6 digits of the EPA number must be **870000**. The last 3 digits must be the code number that qualifies the procedure for the EPA criteria. Enter the EPA number on the HCFA-1500 claim form in the *Authorization Number* field or in the *Authorization* or *Comments* field when billing electronically.

**Example:** The 9-digit EPA number for reduction mammoplasties in a client with hypertrophy of the breast that meets all of the EPA criteria would be **870000241** (870000 = first 6 digits, 241 = diagnostic condition or procedure code).

EPA numbers are not valid for:

- Services for which the documented medical condition does not meet all of the specified criteria; or
- Services that are limited by diagnosis; or
- Services not allowed in an ambulatory surgery center.

## Expedited Prior Authorization Guidelines:

- A. Medical Justification (criteria)** - All information must come from the client’s prescribing provider. MAA will not accept information obtained from the client or someone on behalf of the client (e.g. family).
- B. Documentation** - The ASC **must keep** documentation that meets the criteria in the client’s file. This documentation must be readily available for inspection by MAA staff conducting a pre-pay or post-pay audit. Keep documentation on file for six (6) years.



**Note:** Upon audit, if all specified criteria are not met, MAA has the authority to recoup any payments made. (WAC 388-087-010)

Washington State  
Expedited Prior Authorization Criteria Coding List

Code	Criteria
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**BLADDER NECK SUSPENSION**

CPT Codes: 57288 and 57289

- 201 Diagnosis of *stress urinary incontinence* with all of the following:
- 1) Documented urinary leakage severe enough to cause the client to be pad dependent; *and*
  - 2) Surgically sterile or past child bearing years; *and*
  - 3) Failed conservative treatment with one of the following: bladder training or pharmacologic therapy; *and*
  - 4) Urodynamics showing loss of ureterovesical angle or physical exam showing weak bladder neck; *and*
  - 5) Recent gynecological exam for coexistent gynecological problems correctable at time of bladder neck surgery.

**BLEPHAROPLASTIES**

CPT Codes: 15822, 15823, and 67901 – 67908

- 630 Blepharoplasty for noncosmetic reasons when **both** of the following are true:
- 1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; **and**
  - 2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

**OTHER REDUCTION MAMMOPLASTIES/MASTECTOMY FOR GYNECOMASTIA**

- 250 Reduction mammoplasty or mastectomy, not meeting expedited prior authorization criteria, but medically necessary as clearly evidenced by the information in the client’s medical record.

**REDUCTION MAMMOPLASTIES/MASTECTOMY FOR GYNECOMASTIA**

CPT Codes: 19318 and 19140

Associated ICD-9-CM Diagnosis codes: 611.1 (Hypertrophy of Breast) or 611.9 (Gynecomastia)

- 241 Diagnosis for *hypertrophy of the breast* with:
- 1) Photographs and client’s chart; **and**
  - 2) Documented medical necessity including:
    - a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia; **and**
    - b) Conservative treatment not effective; **and**
  - 3) Abnormally large breasts in relation to body size with shoulder grooves; **and**
  - 4) Within 20% of ideal body weight; **and**
  - 5) Verification of minimum removal of 500 grams of tissue from each breast.
- 242 Diagnosis for *gynecomastia*:
- 1) Pictures in client’s chart; **and**
  - 2) Persistent tenderness and pain; **and**
  - 3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

Code	Criteria
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**STRABISMUS SURGERY**

CPT Codes: 67311 – 67340

- 631** Strabismus surgery for clients 18 years of age and older when **both** of the following are true:
- 1) The client has double vision; and
  - 2) It is not done for cosmetic reasons.

**VAGINAL HYSTERECTOMY**

CPT Code: 58550

- 111** Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with *two or more* of the following conditions:
- 1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months.
  - 2) Documented hct of less than 30 or hgb less than 10.
  - 3) Documentation of failure of conservative care i.e.: d&c, laparoscopy, or hormone therapy for at least three months.
- 112** Diagnosis of **fibroids** for any *one* of the following indications in a client 30 years of age or older:
- 1) Myomata associated with uterus greater than 12 weeks or 10cm in size
  - 2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct less than 30 or hgb less than 10
  - 3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.
- 113** Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following:
- 1) Significant findings per laproscope; *and*
  - 2) Unresponsiveness to 3 months of hormone therapy or cauterization.
- 114** Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics.

# Reimbursement

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## What is included in the facility payment?

The facility payment maximum allowable includes:

- The client's use of the facility, including the operating room and recovery room;
- Nursing services, technician services, and other related services;
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment related to the care provided;
- Diagnostic or therapeutic items and services directly related to the surgical procedure;
- Administrative, recordkeeping and housekeeping items and services; **and**
- Materials and supplies for anesthesia.

### Facility fee when multiple surgical procedures are performed

- ✓ For providers performing multiple surgical procedures in a single operative session, MAA reimburses 100 percent of the department allowable of the procedure with the highest group number. For the second procedure, reimbursement is 50 percent of the department allowable. MAA does not make additional reimbursement for subsequent procedures.
- ✓ The provider must identify the:
  - Primary procedure (the procedure with the highest reimbursement rate) with modifier **5A**; **and**
  - Secondary procedure with modifier **5B**.

## What is not included in the facility payment?

The following services are not included in the facility payment:

- Physicians' professional services;
- The sale, lease, or rental of durable medical equipment to clients for use in their homes;
- Prosthetic devices (e.g., intraocular lens);
- Ambulance or other transportation services;
- Leg, arm, back, and neck braces; **and**
- Artificial legs, arms, and eyes.

# Billing

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## What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

- ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:
  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed<sup>1</sup> certification criteria.



**Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

- ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
  - DSHS certification of a client for a retroactive<sup>2</sup> period; or
  - The provider proves to MAA's satisfaction that there are other extenuating circumstances.

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<sup>1</sup> **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

<sup>2</sup> **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

- ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.



**Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

## What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

## How do I bill for services provided to Primary Care Case Management (PCCM) clients?

For the client who has chosen to obtain care with a Primary Care Case Manager (PCCM), the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. Please refer to the client's MAID card for the PCCM.

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

**Newborns of Healthy Options clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen. These services must be billed to MAA.**



**Note:** If you treat a Healthy Options client who has chosen to obtain care with a PCCM and you are not the PCP, or the client was not referred to you by the PCCM/PCP, you may not receive payment. You will need to contact the PCP to get a referral.

## How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medical Assistance, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

### Medicare Part B


Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.


When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the “XO” indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.
- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

 **Note:** Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.

 **Note:** A Medicare Remittance Notice or EOMB must be attached to each claim.

### Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)
- Medicare's payment is deducted from the amount selected above.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

- 1) The provider accepts assignment; and
- 2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

## QMB (Qualified Medicare Beneficiaries) Program Limitations:

### QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their MAID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If only Medicaid **and not Medicare** cover the service and the service is covered under the CNP or MNP program, MAA will reimburse for the service.

### QMB-Medicare Only

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.



**Note: For QMB-Medicare Only:** If Medicare does not cover the service, MAA will not reimburse the service.

## Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at <http://maa.dshs.wa.gov> or by calling the Coordination of Benefits Section at 1-800-562-6136.

## What records must be kept?

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.
  
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.
  
- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.**

## How do I bill for sterilization procedures?

- Federal regulations prohibit MAA from processing claims for sterilization procedures without a completed consent form. ASCs, surgeons, anesthesiologists, and assistant surgeons must attach a copy of the completed consent form to their claim; copies may be obtained from the physician who performs the sterilization. A sample of the consent form is on page 25. See page 23 to request the form.
- A claim for a sterilization procedure received without a consent form will be denied.
- An incomplete consent form will be returned to the provider and the claim will be denied.
- The signature and other information on the consent must be legible.
- Submit the claim and completed consent form to:

**DIVISION OF PROGRAM SUPPORT  
PO BOX 9248  
OLYMPIA WA 98507-9248**



**Note:** The DSHS 13-364x Consent Form and regulations for sterilization are the same for fee-for-service and Healthy Options providers. Healthy Options providers must send the Sterilization Consent Form, with attachments as applicable, directly to their Licensed Health Carrier for billing purposes, rather than to MAA.

### Sterilization Procedures and CPT Codes:

<u>Procedure</u>	<u>Associated CPT Codes</u>
Vasectomy	55250
Tubal Ligation	58600, 58615, 58670, 58671

(CPT procedure codes and descriptions are copyright 1999 American Medical Association.)

**Physician Signature Clarification:**

The physician identified in the *Consent to Sterilization Section* of the DSHS 13-364x Consent Form must be the same physician who completes the *Physician's Statement Section* and performs the sterilization procedure. If the physician who signed the above referenced sections of the Consent Form is not the physician performing the sterilization procedure, the client must sign and date a new Consent Form indicating the name of the physician performing the operation under the *Consent for Sterilization Section*, at the time of the procedure. Staple this modified consent form to the initial Consent Form.

**Consent Requirements:**

- Submit a completed Consent Form, DSHS 13-364x, with the claim.
- Consent must be voluntary.
- The client must be at least 18 years old when the consent form is signed.
- For clients 18 through 20 years old, modify the DSHS 13-364x Consent Form by crossing out 21 in the following three places on the form and writing in the correct age:
  - ✓ *Consent to Sterilization Section* - "**I am at least 21**"
  - ✓ *Statement of Person Obtaining Consent Section* - "**is at least 21**"
  - ✓ *Physician's Statement Section* - "**is at least 21**"
- The client must sign the consent form at least 30 days, but no more than 180 days, prior to surgery. Consent expires after 180 days.
- The physician must sign the consent form after, or not more than one week before, surgery.
- If the Medical Assistance IDentification (MAID) card shows delayed or retroactive certification, all of the above criteria must still be met.

**What about clients who have no consent form?**

For clients who are mentally incompetent or institutionalized, MAA requires a court order and a DSHS 13-364x signed by the client's legal guardian at least 30 days prior to the surgery.

For clients under 18 years of age, who have received retroactive certification, or who have received delayed certification, providers must obtain a letter of exception from MAA's Medical Director. Send your request to:

**MEDICAL ASSISTANCE ADMINISTRATION  
MEDICAL DIRECTOR  
PO BOX 45500  
OLYMPIA, WA 98504-5500**

Write or fax your request for the DSHS 13-354x Consent Form to:

**DSHS WAREHOUSE  
PO BOX 45816, OLYMPIA WA 98504-5816  
FAX (360) 664-0597**

**This is a blank page...**



CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

• CONSENT TO STERILIZATION •

I have asked for and received information about sterilization from \_\_\_\_\_ DOCTOR OR CLINIC

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a \_\_\_\_\_ The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on \_\_\_\_\_ MONTH DAY YEAR. I, \_\_\_\_\_, hereby consent of my own free will to be sterilized by \_\_\_\_\_ DOCTOR by a method called \_\_\_\_\_. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
• Representatives of the Department of Health and Human Services; or
• Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

\_\_\_\_\_, Date: \_\_\_\_\_ SIGNATURE MONTH DAY YEAR

You are requested to supply the following information, but it is not required. RACE AND ETHNICITY DESIGNATION (PLEASE CHECK):

- Checkboxes for American Indian or Alaska Native, Black (not of Hispanic origin), Hispanic, Asian or Pacific Islander, White (not of Hispanic origin)

• INTERPRETER'S STATEMENT •

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

\_\_\_\_\_, DATE INTERPRETER

• STATEMENT OF PERSON OBTAINING CONSENT •

Before \_\_\_\_\_ signed the consent form, I explained to him/her the nature of the sterilization operation

STATEMENT OF PERSON OBTAINING CONSENT (CONTINUED):

\_\_\_\_\_, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

\_\_\_\_\_, Date: \_\_\_\_\_ SIGNATURE OF PERSON OBTAINING CONSENT

\_\_\_\_\_, FACILITY ADDRESS

• PHYSICIAN'S STATEMENT •

Shortly before I performed a sterilization operation upon \_\_\_\_\_ or \_\_\_\_\_ NAME: INDIVIDUAL TO BE STERILIZED \_\_\_\_\_ DATE: STERILIZATION OPERATION \_\_\_\_\_ I explained to him/her the nature of the sterilization operation \_\_\_\_\_ SPECIFY TYPE OF OPERATION \_\_\_\_\_ the fact that

it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(INSTRUCTIONS FOR USE OF ALTERNATIVE FINAL PARAGRAPHS Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

1. At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

2. This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Checkboxes for Premature delivery (Individual's expected date of delivery: \_\_\_\_\_) and Emergency abdominal surgery (describe circumstances): \_\_\_\_\_

\_\_\_\_\_, DATE PHYSICIAN

**NOTICE: ALL BLANKS MUST BE COMPLETED EXCEPT AS INDICATED BELOW**

**Instructions to the Patient for Completing Consent to Sterilization**

1. In the first blank space, write the name of the doctor or clinic giving you the information.
2. In the second blank space, write the name of the operation.
3. In the next blank space, you must write the month, day, and year you were born.
4. Fill in the last five blanks as indicated. Be sure the doctor's name is the name of the physician who will actually perform the operation.
5. You are not required to fill out the "Race and Ethnicity" portion. It is optional.

**Interpreter's Statement**

This section of the form should be completed ONLY if interpretation into another language is required.

**Statement of Person Obtaining Consent**

1. Complete the first two blanks with the patient's name and the name of the procedure to be performed.
2. Fill in the last four blanks with your signature, date, name, and address of the facility.

**Physician's Statement**

1. Complete the first three blanks with the name of the individual to be sterilized, the date of the sterilization operation, and the specific type of operation.
2. Cross out the "alternative final paragraph" if inappropriate.
3. The performing surgeon must sign. The date given below the signature must either be the date of the sterilization or a date which follows the sterilization.
4. The performing surgeon's name must appear in the *sterilized by* blank in the CONSENT TO STERILIZATION section.













**Sample HCFA-1500 Form**

# Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

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**Q: Why do I have to mark “XO,” in box 19 on crossover claim?**

**A:** The “XO” allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

**Q: Where do I indicate the coinsurance and deductible?**

**A:** You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

**Q: What fields do I use for HCFA-1500 Medicare information?**

<b>A: <u>In Field:</u></b>	<b><u>Please Enter:</u></b>
19	an “XO”
24D	total combined coinsurance and deductible
24K	Medicare’s allowed charges
29	Medicare’s total deductible
30	Medicare’s total payment
32	Medicare’s EOMB process date, and the third-party liability amount

**Q: When I bill Medicare denied lines to MAA, why is the claim denied?**

**A:** Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate “XO.”

**Q: How do my claims reach MAA?**

**A:** After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *“This information is being sent to either a private insurer or Medicaid fiscal agent,”* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

**REMEMBER!** You must submit your claim to MAA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

# How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

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The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

**The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.**

## General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

### FIELD DESCRIPTION

**1a. Insured's I.D. No.:** Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card consisting of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).

- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

*For example:*

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

## Ambulatory Surgery Centers

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).
3. **Patient's Birthdate:** Required. Enter the birthdate of the MAA client.
4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.
5. **Patient's Address:** Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).
9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.
- 9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
- 9b. Enter the other insured's date of birth.
- 9c. Enter the other insured's employer's name or school name.

- 9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

**Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).
11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.
- 11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.
- 11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.



- |   |   |
|---|---|
| <p><b>24K. <u>Reserved for Local Use:</u></b> Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).</p> <p><b>26. <u>Your Patient's Account No.:</u></b> Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading <i>Patient Account Number</i>.</p> <p><b>27. <u>Accept Assignment:</u></b> <i>Required.</i> Check <b>yes</b>.</p> <p><b>28. <u>Total Charge:</u></b> Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.</p> <p><b>29. <u>Amount Paid:</u></b> Required. Enter the <u>Medicare Deductible</u> here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. <b>Do not include coinsurance here.</b></p> <p><b>30. <u>Balance Due:</u></b> Required. Enter the <u>Medicare Total Payment</u>. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. <b>Do not include coinsurance here.</b></p> | <p><b>32. <u>Name and Address of Facility Where Services Are Rendered:</u></b> Required. Enter Medicare Statement Date <i>and</i> any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). <b>Do not include coinsurance here.</b></p> <p><b>33. <u>Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:</u></b> Required. Enter the occupational therapy clinic or individual number assigned to you by MAA.</p> |
|---|---|

**Sample Medicare Part B/Medicaid Crossover Form**

