North Carolina
Medicaid Special Bulletin

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Attention: All Providers

Beginning March 1, 2002, Medicaid implemented a new Medicare Part B crossover payment method effective for dates of services on or after October 1, 2001.

Physician Professional Charges
Physician professional charges are calculated based on 95 percent of the Medicare allowed amount as the Medicaid allowed amount. For each procedure, the Medicaid allowed amount is compared to the Medicare paid amount. If the Medicare paid amount is greater than the Medicaid allowed amount, the provider is paid zero by Medicaid and receives an EOB 030 – paid-in-full by Medicare. The procedure is considered paid-in-full. Providers cannot bill the recipient.

However, if the Medicaid allowed amount is greater than the Medicare paid amount, Medicaid pays the lesser of the difference between the Medicaid allowed amount and the Medicare paid amount or the coinsurance and deductible. Refer to the example below:

A	B	C	D	E	F	G	H
Procedure Billed	Medicare Billed Amount	Medicare Allowed Amount	Medicare Paid Amount	Medicare Deductible	Medicare Coinsurance	Medicaid Allowed (.95 x column C)	Medicaid Allowed – Medicare Paid (column G-D)
90780	$41.00	$40.62	$32.50	$0.00	$8.12	$38.59	$6.09
90781	$21.00	$20.84	$16.67	$0.00	$4.17	$19.80	$3.13
Total	$62.00	$61.46	$49.17	$0.00	$12.29	$58.39	$9.22

Since the difference between the Medicaid allowed amount and the Medicare paid amount shown in column H is less than the Medicare coinsurance shown in column F and the Medicare deductible amount shown in column E, Medicaid reimburses the provider $9.22. Providers cannot bill the recipient for the remaining coinsurance.

Hospital Outpatient Reimbursement
To determine the Medicaid reimbursement for outpatient hospital crossovers, Medicaid first calculates the Medicaid allowed amount based on 80 percent of the hospital's assigned ratio of cost-to-charge times the total Medicare billed amount. This amount is compared to the Medicare paid amount. If the Medicare paid amount is more than the Medicaid allowed amount, the provider is paid zero by Medicaid and will receive an EOB 030 – paid-in-full by Medicare. The claim is considered paid-in-full. Providers cannot bill the recipient. Refer to the example below:

A	B	C	D	E	F	G
Total Medicare Billed Amount	Facility-Specific RCC Rate*	Total Medicaid Allowed (.80 x column A x column B)	Medicare Allowed Amount	Medicare Paid Amount	Medicare Deductible	Medicare Coinsurance
$64.22	.65	$33.39	$80.50	$64.28	$0.00	$16.07

*This rate is specific to each facility.

Because the Medicaid allowed amount shown in column C is less than the Medicare paid amount shown in column E, this claim pays zero. Providers cannot bill the recipient for the difference.

However, if the Medicaid allowed amount is greater than the Medicare paid amount, Medicaid pays the lesser of the difference between the Medicaid allowed amount and the Medicare paid amount or the coinsurance and deductible. Refer to the example below:

A	B	C	D	E	F	G	H
Total Medicare Billed Amount	Hospital-Specific RCC Rate*	Total Medicaid Allowed (.80 x column A x column B)	Medicare Allowed	Medicare Paid Amount	Medicare Deductible	Medicare Coinsurance	Medicare Paid - Medicaid Allowed (column C-E)
$73.10	.65	$38.01	$51.79	$23.07	$0.00	$28.72	$14.94

*This rate is specific to each hospital.

In this example, the difference between the Medicare paid amount and the Medicaid allowed amount (column H) is less than the coinsurance and deductible (column G and F), so the provider is paid $14.94. Providers cannot bill the recipient for the difference.

Durable Medical Equipment, Home Infusion Therapy and Ambulatory Surgery Center Reimbursement

To determine the Medicaid reimbursement for DME services, the Medicaid allowed amount is determined by the Medicaid fee schedule rate. If the Medicare paid amount is greater than the Medicaid fee schedule rate, the claim pays zero and the provider receives an EOB 030 – paid-in-full by Medicare. Providers cannot bill the recipient for the Medicare coinsurance. Refer to the example below:

A	B	C	D	E
Procedure Code	Medicare Paid Amount	Medicaid Fee Schedule Rate	Medicare Deductible	Medicare Coinsurance
K0004	$128.21	$115.25	$0.00	$9.75

Because the Medicare paid amount shown in column B is greater than the Medicaid fee schedule rate shown in column C, the claim pays zero.

However, if the Medicaid fee schedule rate is greater than the Medicare paid amount, Medicaid pays the lesser of the difference between the Medicaid fee schedule rate and the Medicare paid amount or the coinsurance and deductible. Refer to the example below:

A	B	C	D	E	F
Procedure Code	Medicare Paid Amount	Medicaid Fee Schedule Rate	Medicare Deductible	Medicare Coinsurance	Medicaid Rate – Medicare Paid (column C-B)
E0651	$721.00	$892.66	$0.00	$144.20	$171.66

In this example, the Medicare coinsurance amount shown in column E and the Medicare deductible amount shown in column D are less than the difference between the Medicaid fee schedule rate and the Medicare paid amount (column F). Therefore, the provider is paid $144.20.

Rural Health Clinics and Federally Qualified Health Centers Core Services Reimbursement
To determine the Medicaid reimbursement for RHC and FQHC core services claims, the Medicaid fee schedule rate for the facility is compared to the Medicare paid amount. If the Medicare paid amount is greater than the Medicaid fee schedule rate for the facility, the claim pays zero and the provider receives an EOB 030 – paid-in-full by Medicare. Providers cannot bill the recipient for the Medicare coinsurance. Refer to the example below:

A	B	C	D
Facility Rate	Medicare Paid Amount	Medicare Deductible	Medicare Coinsurance
$61.75	$66.20	$0.00	$13.24

Since the Medicare paid amount shown in column B is greater than the Medicaid facility rate shown in column A, Medicaid pays the provider zero.

However, if the facility rate is greater than the Medicare paid amount, Medicaid pays the lesser of the difference between the Medicaid allowed amount and the Medicare paid amount or the coinsurance and deductible. Refer to the example below:

A	B	C	D	E
Facility Rate	Medicare Paid Amount	Medicare Deductible	Medicare Coinsurance	Medicaid Facility Rate – Medicare Paid (column A-B)
$55.75	$44.60	$0.00	$22.60	$11.15

Since the difference between the Medicaid facility rate and the Medicare paid rate in column E is less than the Medicare coinsurance and deductible in column D and C, the claim pays $11.15.

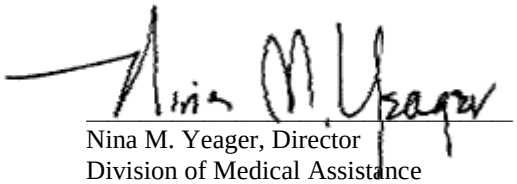
Rural Health Clinics and Federally Qualified Health Centers Noncore Services Reimbursement
RHC and FQHC noncore services charges are calculated based on 95 percent of the Medicare allowed amount as the Medicaid allowed amount. The Medicaid allowed amount is compared to the Medicare paid amount. If the Medicare paid amount is greater than the Medicaid allowed amount, the provider is paid zero by Medicaid and receives an EOB 030 – paid-in-full by Medicare. The claim is considered paid-in-full. Providers cannot bill the recipient.

However, if the Medicaid allowed amount is greater than the Medicare paid amount, Medicaid pays the lesser of the difference between the Medicaid allowed amount and the Medicare paid amount or the coinsurance and deductible. Refer to the example below:

A	B	C	D	E	F	G	H
Procedure Billed	Amount Billed	Medicare Allowed Amount	Medicare Paid Amount	Medicare Deductible	Medicare Coinsurance	Medicaid Allowed (.95x column C)	Medicaid Allowed – Medicare Paid (column G-D)
90780	$41.00	$40.62	$32.50	$0.00	$8.12	$38.59	$6.09
90781	$21.00	$20.84	$16.67	$0.00	$4.17	$19.80	$3.13
Total:	$62.00	$61.46	$49.17	$0.00	$12.29	$58.39	$9.22

Since the difference between the Medicare allowed amount and the Medicaid paid amount shown in column H is less than the Medicare coinsurance shown in column F and Medicare deductible shown in column E, Medicaid pays the provider $9.22. Providers cannot bill he recipient for the remaining coinsurance.

Dialysis Facility, Hospice, Hearing Aid, and Home Health Reimbursement
Medicaid pays zero for all dialysis facility, hospice, hearing aid, and home health Medicare/Medicaid crossover claims. Providers receive an EOB 030 – paid-in-full by Medicare. Providers cannot bill the recipient for any remaining coinsurance.



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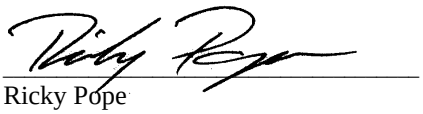

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