



**TO: Pharmacy Providers**  
**RE: Clarification of Billing Requirements for Medications Covered by Medicare Part D and Medicare Part B Including Additional Third Party Insurance**

The purpose of this bulletin is to provide the correct procedures for billing the co-insurance of medications to the Connecticut Medical Assistance Program. (Please note that the information and instruction contained within this bulletin was previously published as Provider Bulletin 2009-36.) Due to the prevalence of Medicare Advantage (MA) plans, DSS and HP have received numerous calls from pharmacy providers experiencing difficulties in processing co-pays. This is primarily an issue when a drug is covered by Medicare Part B but a MA plan chooses to allow this drug to be covered through its Medicare Part D Program.

**Billing Instructions - For MA plans that cover Part B drugs through their Part D program**

When a Medicare Part B covered medication is processed by the Medicare Advantage plan as a Medicare Part D covered service, in standard NCPDP pharmacy claim format, the co-pay portion of the claim, typically the 20% co-insurance, **cannot** be submitted to HP as a pharmacy claim. This co-pay amount must be submitted in the Professional Crossover claim format.

**Billing Instructions - For all plans that cover Part D drugs through their Part D program**

If a Medicare Part D covered medication is processed by the MA/Medicare HMO Plan/normal standalone Prescription Drug Plan as a Medicare Part D covered

service, the co-pay submitted to HP for processing must be submitted as an NCPDP D.0 co-pay only transaction (Other Coverage Code = 8). The co-pay submitted on the claim should not exceed the prescription co-pay threshold for a Medicare Part D covered medication if the individual is dually eligible. The current threshold amount for 2012 is \$6.50.

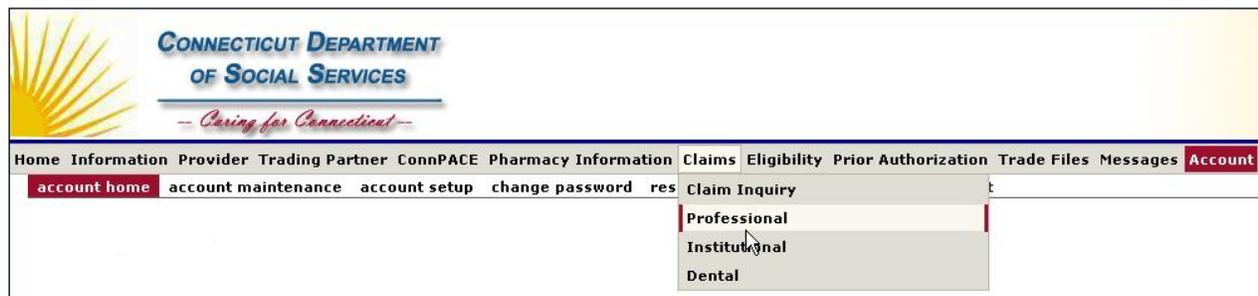
**Billing Instructions – For Medicare B covered drugs**

If the medication is processed by a Medicare HMO or a Medicare Advantage plan as a Medicare Part B covered service, the co-insurance submitted to HP for processing **must** be sent as a **Professional Crossover claim**. The claim can be submitted electronically as a crossover from Medicare; through Provider Electronic Solutions (PES) or vendor software as an 837P file; on a CMS 1500 paper claim form with a copy of the Medicare Explanation of Benefits (EOMB) attached to the claim; or **through the Connecticut Medical Assistance Program secure Web site at [www.ctdssmap.com](http://www.ctdssmap.com)**. Complete billing instructions for Web claim submissions are outlined in this bulletin. CMS 1500 paper claims should be sent to: Connecticut DSS/HP, P.O. Box 2941, Hartford, CT 06104.

**Note:** The coinsurance portion of a claim submitted to Medicare Part B is not covered by the ConnPACE program.

**Web Claim Submission Instructions**

To submit a Professional Crossover claim via the Web portal, providers should log on to their pharmacy secure Web account at [www.ctdssmap.com](http://www.ctdssmap.com). From the account Home page, click on *Professional* from the drop down menu under claims, as illustrated below:



OVER, please →



The page will populate a blank Professional claim. The first panel on the claim contains the client information:

**Professional Claim**

Billing Information		Service Information	
ICN	<input type="text"/>	From Date	<input type="text"/>
Provider ID	008000008 MCD	To Date	<input type="text"/>
AVRS ID	008000008	Admission Date	<input type="text"/>
1 Client ID*	<input type="text"/>	Total Charges	\$0.00
Last Name	<input type="text"/>	Total Paid	\$0.00
First Name, MI	<input type="text"/>	TPL Amount	\$0.00
Date of Birth	<input type="text"/>	CoPay Amount	\$0.00
2 Patient Account #	<input type="text"/>	3 Medicare Crossover	<input type="text"/>
Referring Physician	<input type="text"/> [ Search ]		
Accident Related	No <input type="button" value="v"/>		
Accident Date	<input type="text"/>		

**Accident Related Causes**

Auto Accident  Another Party Responsible  Employment Related  Other

1 – Enter the Client ID

2 – Enter a Patient Account Number

3 – Select ‘Yes’ from the dropdown menu in the Medicare Crossover field. **In order for the claim to be submitted as a Medicare crossover claim, ‘YES’ must be selected in the Medicare Crossover field.**

The Providers ID, Client Last Name, First Name, and Date of Birth will auto-populate in the corresponding fields.

The ‘From’ and ‘To’ dates of service will auto-populate from the dates entered on the claim detail panel.

The next panel is for submitting a diagnosis on the claim:

**Diagnosis**

Diag-Sequence	Diagnosis	Description
Code Set	ICD 9	
Principal	<input type="text"/>	[ Search ]
Other 1	<input type="text"/>	[ Search ]
Other 2	<input type="text"/>	[ Search ]
Other 3	<input type="text"/>	[ Search ]
Other 4	<input type="text"/>	[ Search ]
Other 5	<input type="text"/>	[ Search ]
Other 6	<input type="text"/>	[ Search ]
Other 7	<input type="text"/>	[ Search ]
Other 8	<input type="text"/>	[ Search ]

If a diagnosis was included on the primary claim, it should be included on the crossover claim. The primary diagnosis code should be entered in the Principal diagnosis field without the decimal point. Any subsequent diagnosis codes would be entered in Other 1, Other 2, etc.



The diagnosis panel is followed by the claim detail panel. The NDC submitted on the pharmacy claim must be converted to a J-code for the professional crossover claim. **Both the NDC and J-code need to be entered in the detail panel.** From [www.ctdssmap.com](http://www.ctdssmap.com) click on the “Provider” tab and select “Drug Search.” From there you can look up a J-code or find the corresponding J-code for a particular NDC and/or drug name.

- 1 – Enter the ‘From’ date of service (DOS)
- 2 – The ‘To’ DOS will auto-populate with the From DOS
- 3 – Enter the J-code that corresponds to the NDC submitted on the pharmacy claim to the Medicare Advantage Part D Plan (MAPD)
- 4 – Enter the number of J-coded units needed to equal the NDC quantity billed on the pharmacy claim the MAPD. (May be different)
- 5 – Enter the Facility Type Code
- 6 – Enter the Billed Amount submitted on the pharmacy claim to the MAPD
- 7 – Enter the NDC submitted on the pharmacy claim to the MAPD
- 8 – Enter the NDC quantity submitted on the pharmacy claim to the MAPD
- 9 – Enter the NDC Unit of Measurement from the dropdown menu code.

The MAPD payment information needs to be entered in the Medicare Fields of the Claim Detail panel:

- 10 – Enter the MAPD paid date
- 11 – Enter the sum of the MAPD paid amount and the Client’s co-payment amount
- 12 – Enter the MAPD paid amount
- 13 – Enter the client’s MAPD Co-pay amount

The Medicare Deductible amount would not be applicable for a MAPD paid claim.

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Additional Third Party Insurance (TPL) coverage besides Medicare

The next panel is for entering any Third Party Insurance coverage the client may have. **Do not** enter the client’s Medicare information in this panel:

Once all of the claim information has been entered and verified, click the ‘submit’ button. If any required fields have not been submitted, or submitted with invalid values, error messages will appear after the ‘submit’ button is clicked.

The following messages were generated:	
Message Description	Panel
❗ To Date is required.	Professional Claim
❗ From Date is required.	Professional Claim
❗ To DOS is required.	Detail
❗ From DOS is required.	Detail
❗ Procedure is required.	Detail
Medicare Deductible Amount or Medicare Coinsurance Amount is required and must be greater than 0	Detail
❗ A valid Client ID is required	Professional Claim

The status of the claim, located at the bottom of the Web page, will remain in a “not submitted yet” status:

Any noted errors need to be addressed before the claim is submitted. After the corrections are made, click the ‘submit’ button. If all required fields are submitted, the claim will process in real time. Once processed, the claim will be assigned an Internal Control Number (ICN); the claim status will be paid, denied or suspended; the paid amount, and Explanation of Benefit (EOB) codes posted to the claim will be provided. Below is an example of the claim status panel:

Detail Number	Code	Description
0	2100	CLIENT NOT FOUND ON ELIGIBILITY MANAGEMENT SYSTEM.
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
2	4714	SERVICE BILLED DOES NOT MEET AGE CRITERIA ACCORDING TO THE PROVIDER'S CONTRACT.

Please note that a claim processed in the current financial cycle will not have a paid date until after the cycle has been completed.

