Submission Guidance for Fee for Service (FFS) Claims with Third Party Liability (Medicare or Other Insurance)

All Medicaid claims submissions should accurately reflect payments received from all other insurers (Medicare or other insurances) to allow correct calculation of Medicaid reimbursement. The Explanation of Benefits (EOB) and other documentation supporting Medicare and third-party insurance reimbursement amounts must be kept for audit or inspection by the New York State Department of Health (Department), Office of the Medicaid Inspector General (OMIG), the Office of the State Comptroller (OSC), the New York State Office of the Attorney General or other state or federal agencies, for the period required by federal or state statute, regulation, policy or contract.

Additionally, for any claim submitted to Medicaid with a zero-fill reimbursement from Medicare or other third-party insurer, the provider must retain evidence that the claim was denied by the other insurer **BEFORE** seeking reimbursement from Medicaid. The exception to this policy would be for items or services that are statutorily not covered by the Medicare program – providers may bill Medicaid directly without receiving a denial from Medicare. Providers are responsible for retaining the statutory exemption from Medicare for audit or inspection.

The Department has been reviewing zero-filled claim submissions and collecting information from providers for analysis of claims. This assessment is meant to assist providers with proper claims submission and appropriate use of zero-fill. The following information is a summary of the primary issues found during our review.

Submission of electronic claims without the claim adjustment reason code(s) (CARC)

Providers are reminded that Medicaid claims with third party liability should be submitted with the appropriate CARC from the primary insurance. Medicaid uses the CARC in claims processing to ensure proper payment. Lack of CARC may lead to incorrect or over payments that may be recouped during audit.

Submission of Medicaid claims on paper where a zero payment was received by the primary insurer

At this time, CARCs cannot be submitted on a Medicaid paper claim submission. Many of these paper submissions would have paid appropriately if submitted electronically with the proper CARC from the primary insurance EOB, including claims that the primary insurance applied their allowed amount to the deductible/copay/coinsurance. To ensure proper payment, it is best to bill electronically with the supplied CARC.

Submission of zero-filled claims outside of the member's primary insurers eligibility period

Third party insurance eligibility should be checked for at the time of service. Medicaid claims should not be summitted with zero-fill reimbursement outside of the primary insurance coverage timeframe. This may cause delays in claims processing in the future as the Department continues to examine claims for appropriateness.

Provider not enrolled with the primary insurance

If a provider is not enrolled with the primary insurance, they are still required to bill the primary insurance prior to billing Medicaid. The denial from the primary insurer is necessary as supporting

documentation for audit purposes. If a CARC is provided, it should be included on the electronic claim's submission.

As a reminder, Medicaid is the payor of last resort. Going forward the Department will continue to monitor zero-fill claims with the intent of pending claims, starting with the above criteria, and request supporting documentation for payment. Claims may be denied if the documentation does not support the use of zero-fill. The Department is continuing to explore the use of CARC and zero-fill to ensure that claims are submitted properly and reimbursed appropriately.

Questions and Additional Information:

- General questions regarding claims submission should be directed to the eMedNY Call Center at (800) 343-9000.
- Questions regarding specific medical pended claims should be directed to the Bureau of Medical Review, Pended Claims Unit at (800) 342-3005 (option 3).
- Questions regarding specific dental pended claims should be directed to the Bureau of Dental Review, Pended Claims Unit at (800) 342-3005 (option 2).

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