

## MassHealth 5010 Key Concepts

### July 22, 2011

The key concepts listed below provide a current high level overview of some of the changes that will be implemented on January 1, 2012, to support the CMS 5010 mandate. It is not an all-inclusive list of the 5010 changes that will impact providers. This list will be updated as necessary to convey key concepts of interest to the provider community.

Further details of all the specific changes will be communicated in MassHealth's paper billing instructions and the 5010 companion guides. Providers may also refer to our Web site at [www.mass.gov/masshealth/5010](http://www.mass.gov/masshealth/5010) for information about MassHealth's implementation of the 5010 standards.

TRANSACTION	KEY CHANGES
Global Concepts	<p>Claim balancing: Direct data entry (DDE) claims submitted to MassHealth must now balance at both the service line and the claim level. This means that the total claim charge amount must balance to the sum of all service line charge amounts. Paper claims are not impacted by this change.</p> <p>Copy A claim feature: DDE users will have the ability to copy a claim that was previously submitted in the 4010 format to support a new claim submission.</p> <p>Deleted 4010 data elements: 4010 deleted data elements will no longer be displayed on the Provider Online Service Center (POSC) panels. Claims previously submitted in the 4010 format will be displayed in the 5010 format. The new 5010 data fields that do not apply to the 4010 claims will be left blank when displayed.</p> <p>New 5010 data elements: The relevant new data elements required for 5010 will be used and displayed throughout the application as required.</p> <p>TA1/999: The 997 Acknowledgement has been eliminated. It is being replaced with the 999 Acknowledgement. MassHealth will no longer support the 997 Acknowledgement as of January 1, 2012.</p>
COB	<p>Check/remittance date: The claim check or remittance date is critical for coordination of benefits (COB) claims adjudication. Currently it can be submitted at the claim level and the service line level. HIPAA 5010 restricts its submission to either the claim level or the service line level. MassHealth would recommend submitting the check/remittance date at claim level for hospital inpatient and long term care claims and submitting check/remittance date at the service line level for outpatient and professional claims:</p> <p>Exception billing: Total noncovered amount must be submitted in lieu of providing the prior payer amount and any adjustment segments previously submitted in exception billing. This will streamline the exception billing process.</p> <p>Payer allowed amount: Currently, payer allowed amount is an important criterion in claim type determination. This field has been removed in HIPAA 5010. With HIPAA 5010, payer paid amount and patient responsibility amount will be used to determine the claim type.</p>

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	<p>Payer paid amount balancing: Payer paid amount on all claims submitted to MassHealth must balance at both the service line and the claim level. When payer information is present at the service line, the total claim payer paid amount must balance to the sum of all the service line payer paid amounts less the claim level adjustment reason codes.</p> <p>For claim types B (professional Part B crossover), C (outpatient Part B crossover), M (physician), H (home health and community health), and O (hospital outpatient), the provider billed amount on the service line should balance to the sum of service line payer paid amount and service line adjustment reason code amounts</p>
837P	<p>Anesthesia units: Anesthesia services billed with procedure codes that do not have a specific time period defined in the description of the code, must be reported using minutes. Anesthesia services reported in units will no longer be accepted. Details about this change can be found in Physician Bulletin 91 at <a href="http://www.mass.gov/masshealth/5010">www.mass.gov/masshealth/5010</a>.</p> <p>Billing provider address: A P.O. box can no longer be submitted on a claim under the billing provider address. A street address must be provided. Electronic billers may place P.O. box information in the pay to address loop. Paper providers must provide a doing business as (DBA) address.</p> <p>Compound drugs: Where applicable, all ingredients that make up a compound prescription must be identified on the claim and have the same prescription number, or, the same linkage number if provided without a prescription.</p> <p>Diagnosis codes: All MassHealth providers are required to enter an ICD-9 diagnosis code on all claim submissions. This includes those provider types that previously did not require a diagnosis code. All paper claims must contain diagnosis information as well.</p> <p>Healthcare diagnosis codes: Providers will now be able to submit up to 12 diagnosis codes per claim with a maximum of four per service line. This change does not impact paper claim submissions.</p> <p>National provider identifier (NPI)/Atypical provider identifier: Providers that should have an NPI must report their NPI on all claim submissions. Atypical providers must indicate G2 instead of 1D as a qualifier, as defined by MassHealth.</p> <p>Nine-digit zip code: The billing provider name and address must include the nine-digit zip code on claim submissions.</p> <p>Pharmacy/National drug code (NDC) data: As applicable, professional claims must include additional drug information and qualifiers such as NDC code, quantity, composite unit of measure, and prescription date. MassHealth will edit to support the new data requirements.</p> <p>Prior authorization (PA): If any service on a claim requires a PA, you must now enter it at the header level for the entire claim. You should enter it at the service line only when the PA is different from the one entered at the header level.</p>

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	<p>Referrals: If any service on a claim requires a referral, you must now enter it at the header level for the entire claim. You should enter it at the service line only when the referral is different from the one entered at the header level.</p> <p>Taxonomy codes: PXC (health care provider taxonomy code) has replaced the generic value of ZZ (mutually defined) to identify taxonomy. Submit this only if you need to use a taxonomy code and/or when directed by MassHealth.</p> <p>Transportation pick-up/drop-off codes: New pick-up and drop-off codes must be submitted when billing for ambulance or nonemergency transportation services.</p>
8371	<p>Billing provider address: A P.O. box can no longer be submitted on a claim under the billing provider address: a street address must be provided. Electronic billers may place P.O. box information in the pay-to address loop. Paper providers must provide a DBA address.</p> <p>Compound drugs: Where applicable, all ingredients that make up a compound prescription must be identified on the claim and have the same prescription number, or, the same linkage number if provided without a prescription.</p> <p>Diagnosis codes: All MassHealth providers are required to enter an ICD-9 diagnosis code on all claim submissions. This includes those provider types that previously did not require a diagnosis code. All paper claims must contain diagnosis information as well.</p> <p>Nine-digit zip code: The billing provider name and address must include the nine-digit zip code on claim submissions.</p> <p>NPI/Atypical provider identifier: Providers that should have an NPI must report their NPI on all claim submissions. Atypical providers must indicate G2 instead of 1D as a qualifier, as defined by MassHealth.</p> <p>Patient paid amount: The 2300/AMT segment with F5 qualifier (patient paid amount) has been deleted. Nursing facility providers must now submit the FC value code (claim/value information) with patient paid amount as the value code amount on claim submissions.</p> <p>Patient reason for visit: Acute outpatient hospitals, chronic disease and rehabilitation outpatient hospitals, psychiatric outpatient hospitals, substance abuse outpatient hospitals, and hospital-licensed health centers are required to include the patient reason for visit on all out-patient claims in order to comply with the HIPAA Implementation Guide. All relevant outpatient UB-04 paper claims must also contain this information. MassHealth will not enforce any additional requirements to accommodate this new data element.</p> <p>Pharmacy/NDC data: As applicable, institutional claims must include additional drug information and qualifiers such as NDC code, quantity, composite unit of measure, and prescription date. MassHealth will edit to support the new data requirements.</p>

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	<p>Present on admission (POA): A POA indicator is required for the Principal, Other, and External Cause of Injury segments.</p> <p>Prior authorization (PA): If any service on a claim requires a PA, you must now enter it at the header level for the entire claim. You should enter it at the service line only when the PA is different from the one entered at the header level.</p> <p>Referrals: If any service on a claim requires a referral, you must now enter it at the header level for the entire claim. You should enter at the service line only when the referral is different from the one entered at the header level.</p> <p>Taxonomy codes: PXC (health care provider taxonomy code) has replaced the generic value of ZZ (mutually defined) to identify taxonomy. Submit this only if you need to use a taxonomy code and/or when directed by MassHealth.</p>
835	Reversals/voids: Reversed/voided claims will now appear on the 835 with a claim adjustment group code of OA. The CR adjustment group code has been eliminated.
270/271	Routine changes (additions, deletions, field lengths)
276/277	Routine changes (additions, deletions, field lengths)