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## ***Part 7. Other Insurance***

This part contains instructions for submitting claims for services provided to members who have other health insurance or Medicare, in addition to MassHealth.

MassHealth regulation at 130 CMR 450.316 requires providers to make “diligent efforts” to identify and obtain payment from all other liable parties, including insurers. “Diligent efforts” is defined as making every effort to identify and obtain payment from all other liable parties, and include, but are not limited to

- determining the existence of health insurance by asking the member if he or she has other insurance and by using insurance databases available to the provider; and
- verifying the member’s other health insurance coverage, currently known to MassHealth through EVS, on each date of service and at the time of billing following instructions found in Part 1 of these administrative and billing instructions

For additional information about third-party-liability requirements, see MassHealth regulations at 130 CMR 450.316 through 450.321.

### **Updating Other Insurance Information**

If you have evidence that a member’s other health insurance information differs from what appears on EVS, you must fax or mail a Third Party Liability Indicator (TPLI) form to the TPL Unit. To download this form, go to [www.mass.gov/masshealth](http://www.mass.gov/masshealth). Click on MassHealth Provider Forms and scroll down the list. In addition to the TPLI form, please submit acceptable documentation verifying the coverage change to ensure that the member’s file is updated to reflect current information. Acceptable documentation for updating member’s insurance information includes an explanation of benefits (EOB), a letter from an employer or health insurance carrier, or a copy of the health insurance card for any new insurance.

Contact information for the TPL Unit is at the bottom of the [TPLI form](#). This information can also be found in [Appendix A](#) of your MassHealth provider manual.

### **Member Has Other Health Insurance**

If the member has other insurance, submit the claim to the other insurance carrier, following the other insurer’s billing instructions. If the claim is denied for reasons other than a correctable error, or is partially paid by the other insurance carrier, you may submit the claim to MassHealth. You may not submit the claim to MassHealth if the claim is denied for noncompliance with any one of the insurer’s billing and authorization requirements. For general information about submitting the claim to MassHealth, see Part 3 of these administrative and billing instructions.

### **Coordination of Benefits Claim Submission**

#### **837 Transaction**

Providers may submit coordination of benefits (COB) claims to MassHealth following instructions found in the HIPAA 837 implementation guides and MassHealth companion guides. Include the other insurer’s adjudication information in the transaction as outlined in the guides.

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The MassHealth companion guides are available at [www.mass.gov/masshealth](http://www.mass.gov/masshealth). To start submitting claims electronically, contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to [providersupport@mahealth.net](mailto:providersupport@mahealth.net), or fax your inquiry to 617-988-8974.

### **Provider Online Service Center Direct Data Entry Claim**

You can use the Provider Online Service Center (POSC) at [www.mass.gov/masshealth/providerservicecenter](http://www.mass.gov/masshealth/providerservicecenter) to submit COB claims to MassHealth using direct data entry (DDE). Job aids are available on the Web to assist providers with COB claim submissions. To download job aids, go to [www.mass.gov/masshealth](http://www.mass.gov/masshealth). Click on Information for MassHealth Providers, then on MassHealth Provider Training. Click on NewMMIS Provider Training and choose a job aid from the list.

If you have more questions about DDE claim submission, contact [MassHealth Customer Service](#).

### **Medicare Crossover Claims**

After Medicare has made a payment or applied the charge to the deductible, the coordination of benefits contractor (COBC) automatically transmits claims to MassHealth for processing. A claim must contain at least one Medicare-approved service line in order for the entire claim to be automatically crossed over to MassHealth. For Medicare crossover payment methodology, please refer to 130 CMR 450.318.

Providers may submit the claim to MassHealth electronically, following the MassHealth COB requirements if 60 days have passed since you received Medicare payment, or the member has other insurance in addition to Medicare and MassHealth, and the claim has not appeared on a MassHealth crossover remittance advice.

### **When Medicare Denies Your Entire Claim**

When there are no Medicare-approved services on your claim, you may submit a MassHealth claim after you have received an explanation of Medicare benefits (EOMB) indicating that the claim was denied for reasons other than a correctable error. A valid HIPAA adjustment reason code (ARC) from Medicare must be provided with the COB information on your claim.

### **Adjusting a COB Claim**

When the primary insurer (other insurer or Medicare) voids or adjusts a claim that has been previously paid by MassHealth, providers should submit an adjustment claim to MassHealth including the revised COB information on the claim. Refer to MassHealth billing guides for instructions to submit an adjustment claim to MassHealth.

### **Preventive Pediatric Care and Prenatal Care Services**

Preventive pediatric care services may be billed by the provider to MassHealth as primary when the patient has additional insurance (as described in the EPSDT and PPHSD Billing Guidelines for MassHealth Physicians and Mid-level Providers, for members under the age of 21, and prenatal care services including routine prenatal office visits and tests, for members of any age).

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### Dependent Has Insurance through an Absent Parent

Providers may bill services to MassHealth as the primary insurer if **both** the following conditions are true.

- The dependent has insurance through an absent parent against whom child support enforcement is being carried out by the State Title IV-D agency (Department of Revenue).
- The provider has billed the other insurer and has not received payment or a response for 30 days after billing.

Providers should include the correct carrier code and noncovered amount on their claim submission.

### Supplemental Instructions

Please refer to the appendix in your MassHealth provider manual (as listed in the table below) for supplemental instructions that may be applicable to your provider type.

<b>Provider Type</b>	<b>Location</b>
All providers subject to provider preventable conditions	Appendix V of all provider manuals
Acute inpatient hospitals	Appendix D of the <i>Acute Inpatient Hospital Manual</i>
Chronic disease and rehabilitation inpatient hospitals	Appendix D of the <i>Chronic Disease and Rehabilitation Inpatient Hospital Manual</i>
Community health centers	Appendix D of the <i>Community Health Center Manual</i>
Home health agencies	Appendix D of the <i>Home Health Agency Manual</i>
Mental health centers	Appendix D of the <i>Mental Health Center Manual</i>
Nursing facilities	Appendix G of the <i>Nursing Facility Manual</i>
Psychiatric inpatient hospitals	Appendix D of the <i>Psychiatric Inpatient Hospital Manual</i>

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