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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. For paper billing, providers must submit the CMS-1500 or UB-04 for all TPL claims including Medicare.

To determine if a member has other insurance, you must, among other things, follow the instructions for the Eligibility Verification System (EVS) in Part 1 of these administrative and billing instructions. MassHealth regulation 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.

For additional information about third-party-liability requirements, see 130 CMR 450.316. For more information about submitting retail pharmacy claims for members with other insurance, refer to the *POPS Billing Guide*.

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, before submitting the claim to MassHealth. Please check your billing guide for possible exceptions. 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.

Updating Other Insurance Information

If you are aware that the information shown on EVS about a member’s health insurance has changed, submit a [Third Party Liability Indicator \(TPLI\)](#) form to the address listed in Appendix A of your MassHealth provider manual. This form is available on the Web at www.mass.gov/masshealth. Click on the link for MassHealth Provider Forms on the home page. Also see Appendix A of your MassHealth provider manual for information about requesting supplies of this form. Please submit the acceptable documentation to MassHealth, verifying the coverage change, to ensure that the member’s file is updated to reflect current information. Acceptable documentation includes an EOB, a letter from an employer, or a copy of the health insurance card for any new insurance.

You must continue to attach a copy of the EOB to all claims submitted for this member, until the member’s file has been updated on EVS.

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MassHealth Members Enrolled in Medicare

Crossover Claims

After Medicare has made a payment or applied the charge to the deductible, the coordination of benefits contractor (COBC) automatically forwards claims to MassHealth that will be processed through NewMMIS. For payment methodology, please refer to 130 CMR 450.318.

When Service Is Not Covered by Medicare

If Medicare does not cover the service, claims are not automatically forwarded to MassHealth for processing by the COBC. In order to be reimbursed for these services, you may submit a MassHealth claim after you have received an explanation of Medicare benefits (EOMB) indicating that the claim was denied by Medicare. Submit an 837 transaction for a coordination of benefits (COB) electronic claim, submit a direct data entry (DDE) claim, or for paper billing, attach a photocopy of the EOMB to the appropriate claim form. For information about completing the appropriate claim form, see Subchapters 3, 5, and 6 of the administrative and billing instructions. Payment will be based on the MassHealth-allowable amount.

Note about Exhaustion of Medicare Part A Benefits: If the Medicare Part A benefits are exhausted for a MassHealth member, please submit the TPL exception form and keep the appropriate documentation on file. MassHealth will accept the most recent letter stating that benefits are exhausted, an EOMB with the benefits exhausted remark code, the Medicare notice of noncoverage, or screen prints of the common working files (CWFs), with a cover sheet and drop-down version of the electronic Medicare EOB.

Send all other claims to the appropriate address listed in Appendix A of your MassHealth provider manual.

Member Has Medicare and Other Insurance (in Addition to MassHealth)

If the member has coverage from both Medicare and another insurance company, follow the instructions below.

1. Submit the claim to the appropriate intermediaries and all carriers.
2. Once you have received an EOB from both Medicare and the other insurance company, you may submit the claim to MassHealth. MassHealth pays for covered services if the total payment you have received from both Medicare and the other insurance carrier is less than the MassHealth allowable amount.

Note: If the member has other health insurance in addition to Medicare and MassHealth, the claim will not automatically crossover to MassHealth. If the service is not covered by Medicare and the total payment you have received from the other insurance company is less than the MassHealth-allowable amount, you may submit the claim to MassHealth.

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The claim may be submitted to MassHealth electronically following the requirements for COB billing for the 837 transaction. For information about completing the MassHealth paper claim form, see the see Subchapters 3 and 5 of the administrative and billing instructions. Attach to the MassHealth claim form a photocopy of the EOMB indicating that the claim was denied by Medicare and a photocopy of the EOB from the other insurance company.

Claim Submission Resource

Providers may submit claims to MassHealth electronically using 837 transactions or DDE through the Provider Online Service Center (POSC), or on paper using the CMS-1500 or UB-04 claim forms, as applicable.

Electronic Claims Submission

Providers may submit claims to MassHealth electronically following the instructions for COB billing for the 837 transactions or DDE through the POSC.

For Electronic Claims

Submit the claim according to the HIPAA 837 COB requirements. Include all applicable information about the other insurance in the transaction, including payments, noncovered charges, and patient responsibility amounts as outlined in the MassHealth companion guides. The companion guides are available for download from the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then click on Provider Library.

To submit DDE claims through the POSC, providers should follow the same HIPAA 837 COB requirements as for electronic claims.

Paper Claims Submission

To submit paper claims, follow the instructions below.

1. Submit all TPL attachments with the appropriate claim form (CMS-1500 or UB-04). Attach the original or a copy of the other insurance carrier's notice of final disposition, EOB, notice of rejection, or some other explanation on the carrier's letterhead, to the claim form. The dates of service, provider name, and patient's name on the notice of disposition must correspond to the information on the MassHealth claim.
2. If notices of final disposition for more than one insurer are attached to the MassHealth claim, you must write the appropriate MassHealth-assigned carrier code on each EOB. If there is one insurer, enter the carrier code in Field 11C on the CMS-1500 form. Enter the carrier code on the UB-04 form in Field 51A-C. MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual, and at www.masshealth.gov.
3. When submitting Medicare EOMBs, add the carrier code 0084000 to each EOMB for institutional claims, and carrier code 0085000 to each EOMB for professional claims.

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4. If the carrier's notice of final disposition, or EOB, notice of rejection, or some other explanation on the carrier's letterhead does not itemize payment for each service provided, the provider needs itemized payment and the corresponding coinsurance, copay, and deductible amount for each line on the claim form being submitted. The provider should use the **TPL Claim Bundle/Unbundled Form** and attach a copy of the EOB.
5. If the carrier notice of final disposition and EOB were paid globally, for items that should be separated to bill to MassHealth on the UB-04 and CMS-1500, the provider should itemize (estimated?) payment for each service provided for each line on the claim form submitted by invoice. The provider should use the **TPL Claim Bundle/Unbundled Form** and attach a copy of the EOB.
6. When there is no EOB for that time period being billed, home health agencies must use the TPL Exception Form for Home Health Agencies, and nursing facilities and all inpatient hospitals must use the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals. Submit the TPL Exception Form, and keep on file the required supporting documentation, for example, a cover letter from the carrier stating that the service was not covered. TPL Exception Form instructions are listed on the form.
7. a. For services billed to MassHealth on the UB-04 claim form, enter in Item 54 the total amount received toward the payment of services on this claim from third party payers other than MassHealth, and attach a copy of the EOB from each of the other payers to the claim form.

b. For services billed to MassHealth on the CMS-1500, enter in Item 29 the total amount received toward the payment of services on this claim from third party payers other than MassHealth, and attach a copy of the EOB from each of the other payers to the claim form.

Crossover Claims

After Medicare has made a payment or applied the charge to the deductible, the COBC automatically forwards claims to MassHealth that will be processed through NewMMIS. For payment methodology, please refer to 130 CMR 450.318.

Electronic Claims Submission

You may submit the claim to MassHealth electronically, following the COB requirements for the 837 transactions or DDE, through the POSC 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.

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Paper Claims Submission

To submit crossover claims on paper, follow the steps below.

1. Submit a separate, legible photocopy of the EOMB for each Medicare claim along with a legible copy of the original CMS-1500 or UB-04 submitted to Medicare.
2. On the EOMB, circle the Medicare payment information that you are submitting to MassHealth.

Patient Pay Amount

For Medicare claims, the patient pay amount will be automatically deducted from crossover long-term-care claims.

Adjusting a Medicare/MassHealth Crossover Claim

If you are requesting an adjustment to a crossover claim that has been paid incorrectly by MassHealth, or has been adjusted by Medicare, take the following steps for resolution.

Electronic Claims Submission

The claim adjustment may be submitted to MassHealth electronically following the requirements for COB billing, and for the 837 void/replace transaction, or through DDE of the POSC.

Paper Claims Submission

If your claim has been adjusted by Medicare, follow the steps below and send to the appropriate address listed in your MassHealth provider manual.

Submit a void request for all original claim lines. Then submit a corrected claim form and the adjusted EOMB information. Circle all the applicable information on each of the EOMBs.

For Medicare Part A Services

- Submit a legible copy of the original Medicare Part A claim form (UB-04).
- Submit a legible copy of the MassHealth crossover remittance advice on which the claim was originally paid. Circle all applicable member information.
- If the member also has other insurance, attach a copy of the EOB from the other insurer.
- Send the claims to the appropriate address listed in Appendix A of your Masshealth provider manual.

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For Medicare Part B Services

- Submit a legible copy of the original Medicare Part B claim form (CMS-1500 or UB-04).
- If the member also has other insurance, attach a copy of the EOB from the other insurer.
- Send the claims to the appropriate address listed in Appendix A of your Masshealth provider manual.

Resolving a Medicare/MassHealth Crossover Claim

Suspended Claims

If a claim is suspended on a MassHealth crossover claim remittance advice, no action is required. The error code on the remittance advice will explain why the claim is suspended. This claim will appear on a later remittance advice as either paid or denied.

Preventive Pediatric Care and Prenatal Care Services

Preventive pediatric care services for members under the age of 21, and prenatal care services for members of any age, may be billed by the provider to MassHealth as the primary insurer when the patient has additional insurance (TPL) and the provider has chosen not to bill the other insurance carrier for the service.

Dependent Has Insurance Through an Absent Parent

If a 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), services may be billed by the provider to MassHealth as the primary insurer when the patient has additional insurance (TPL) and the provider has billed the other insurer and has not received payment or a response after 30 days. Providers must submit the appropriate claim form along with the TPL Exception Form.