Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
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Boston, MA 02111
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MassHealth
Acute Inpatient Hospital Bulletin 126
November 2003

TO: Acute Inpatient Hospitals Participating in MassHealth

FROM: Beth Waldman, Acting Commissioner

RE: **Electronic Claim Submissions for Dually Eligible Members**

Background

This bulletin transmits billing instructions for submitting 837I transactions for dually eligible members when Medicare has determined that the services are noncovered or that benefits have been exhausted. The implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 allows all coordination-of-benefits claims to be submitted electronically on the 837 transaction. The information in this bulletin contains specific MassHealth billing guidelines, which are not described in the HIPAA Implementation Guide for the 837I transaction.

Providers should continue to follow the billing instructions in Transmittal Letter AIH-38, dated June 2001, for paper-claim submissions.

Medicare Claims

Acute inpatient hospital claims for dually eligible members must be billed to Medicare for payment before being billed to MassHealth. Once Medicare indicates that the member does not have Medicare benefits available, providers may submit an 837I transaction for the noncovered services to MassHealth. The provider must populate the transaction with condition code Y9 ("Patient does not have Medicare benefits available or does not qualify for a new benefit period.") to describe the reason for noncoverage.

Providers must continue to bill Medicare for all Part B ancillary services and physician services associated with the inpatient stay before billing MassHealth for the noncovered Part A services. Any MassHealth payment of the Medicare Part B crossover claims will continue to be processed automatically as a Part B crossover submitted to MassHealth by the Medicare intermediary.

Medicare Claims (cont.)

Once Medicare approves the Part B charges, the provider may bill the Part A noncovered/exhausted charges to MassHealth, including the sum of the Medicare Part B payment(s) plus the coinsurance and deductible amount(s) in the Payer Prior Payment field in the Other Subscriber Information loop (2320-AMT02, where 2320-AMT01 = C4) of the 837I transaction.

In these circumstances, **the provider must also populate the other payer loops** (2320 and 2330) in the transaction with Medicare's information and a value of 084 as the MassHealth-assigned carrier code for Medicare in 2330B-NM109 (Other Payer Name – Other Payer Primary identifier). Do not populate any Medicare payments, coinsurance, or deductible in the other payer loops (2320 and 2330) in the transaction. Payment amounts indicated in the transaction for Medicare Part B charges would be an exception to this rule and should be populated as described above.

Monitoring

Providers **must** retain a copy of the Medicare remittance advice in the member's file. The Division may request insurance billing records for auditing purposes to ensure that, among other things, providers are using the condition codes appropriately.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.