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Division of Health Care Finance and Policy
Health Safety Net (HSN) Claim Update

Billing of Administrative and MassHealth Outlier Days

January 25, 2011

Beginning December 1, 2010, hospitals may submit claims to the HSN for Administrative and MassHealth Outlier Days. Administrative Days and MassHealth Outlier Days are defined as:

Administrative Day: a day of inpatient hospitalization on which a Patient's care needs can be provided in a setting other than an acute inpatient hospital and on which the patient is clinically ready for discharge.

MassHealth Outlier Day: outlier days as reported to the HSN must be otherwise not reimbursable by MassHealth and must meet the following criteria:

a. The Medicaid non-managed care length of stay for the hospitalization exceeds 20 cumulative acute days at that Hospital (not including days paid by a third party);

b. The Hospital continues to fulfill its discharge planning duties as required in MassHealth regulations;

c. The patient continues to need acute level care and is therefore not on Administrative Day status on any day for which an outlier payment is claimed;

d. The patient is not a patient in a Psychiatric, Substance Abuse, or Rehabilitation unit on any day for which an outlier payment is claimed;

e. The patient is 21 years of age or older.

To submit an Administrative Day or MassHealth Outlier Day claim to the HSN, providers must comply with the following requirements:

Administrative days cannot be submitted for any hospital stay prior to December 1, 2010.

Administrative days must be submitted as HSN Prime where SBR01 = P. Administrative days submitted as secondary or tertiary to HSN (SBR01 = S or T) will be paid via a PAF.

Administrative dates must fall within statement from / through dates.

MassHealth outlier days cannot be submitted for any hospital stay prior to December 21, 2010 as MassHealth non-covered outlier days pertain to admissions on or after December 1, 2010.

MassHealth outlier days must be submitted as Secondary to HSN where SBR01 = S or T. Outliers submitted as HSN Prime will be ignored.

HSN claim submissions for Administrative Days or MassHealth Outlier Days must be submitted via Occurrence Codes and Dates in the following manner:

Occurrence Span Information to Report Administrative Days to HSN at Pre-Admit Status*

To report a Residential Level of Care for Administrative Day:

Loop 2000B SBR01 = P
Loop 2300 DTP*434*RD8*20101201-20101209~
Loop 2300 DTP*435*DT*20101202~
Loop 2300 HI*BI:M4:RD8*20101201-20101201~

To report a SNF Level of Care for Administrative Day:

Loop 2000B SBR01 = P
Loop 2300 DTP*434*RD8*20101201-20101209~
Loop 2300 DTP*435*DT*20101202~
Loop 2300 HI*BI:75:RD8*20101201-20101204~

Providers should note that MassHealth rules and regulations do not allow a patient to be admitted at an AD status, except in limited circumstances as outlined in EOHHS regulations. In most cases, therefore, Administrative Days will follow an acute stay in the Hospital."

Occurrence Span Information to Report Administrative Days to HSN at Post-Discharge Status*

To report a Residential Level of Care for Administrative Day:

Loop 2000B SBR01 = P
Loop 2300 DTP*434*RD8*20101201-20101209~
Loop 2300 DTP*435*DT*20101201~
Loop 2300 HI*BI:M4:RD8*20101209-20101209~

To report a SNF Level of Care for Administrative Day:

Loop 2000B SBR01 = P
Loop 2300 DTP*434*RD8*20101201-20101209~
Loop 2300 DTP*435*DT*20101201~
Loop 2300 HI*BI:75:RD8*20101209-20101209

If it is necessary to report Administrative Days at both Pre-Admit and Post-Discharge, then an Occurrence Span for each period must be reported.

* At least one Line Item Revenue Code should correspond to the Occurrence Span Code being reported for Administrative Days in the range of 019x (Subacute care). Total days must equal the number of days reported in the Occurrence Date Span.

Occurrence Code and Date Information to Report Outlier Days after MassHealth to HSN

MassHealth segments must show payment amount, date and DHCFP Org ID for MassHealth (see DHCFP Payer Source Code List for all options):

Loop 2000B SBR01 = S or T
Loop 2300 DTP*434*RD8*20101201-20101231~
Loop 2300 DTP*435*DT*20101201~
Loop 2300 HI*BH:47:D8:20101221~
Loop 2320 AMT*C4*$$$$¢¢~
Loop 2330B DTP*573*D8*20110115~
Loop 2330B REF*2U*103~

Please note that the Occurrence Date reports the first day of the Outlier. If Occurrence Code 47 appears on a Prime Claim to HSN, it will be ignored.

In matters where a gap in HSN eligibility exists, providers must ensure this is reported via Date of Exhaust occurrence codes in the following manner:

Occurrence Information to Report a Split in Eligibility to HSN

When providers are aware that an HSN Eligibility gap is present on a claim, the gap identification is to be reported using the Date of Exhaust occurrence code of **A3**, **B3** or **C3** and the first date of the gap period reported in the corresponding occurrence date. Occurrence codes are to be reported in Loop 2300 in the HI segment where HI01-1 = BH, HI01-2 = the occurrence code, HI01-3 = D8, and HI01-4 = the first date of the HSN Eligibility gap. This additional information will flag the claim for full eligibility checking on each day of the patient's stay, thus insuring that all services are taken into consideration for payment.

When HSN is PRIME

The use of **A3** supports that HSN is the Primary Payer (where Loop 2000B SBR01 = P, also known as the Payer Responsibility Sequence Code) on the claim and the date that follows must be within the Admit-through-Discharge period reported on the claim.

Example:
*Loop 2000B SBR*P*18**PRIME*****ZZ~*
*Loop 2300 HI*BH:A3:D8:20090101~*

When HSN is SECOND

The use of **B3** supports that HSN is the Secondary Payer (where Loop 2000B SBR01 = S, also known as the Payer Responsibility Sequence Code) on the claim and the date that follows must be within the Admit-through-Discharge period reported on the claim

Example:
*Loop 2000B SBR*S*18**SECOND*****ZZ~*
*Loop 2300 HI*BH:B3:D8:20090101~*

When HSN is TERTIARY

The use of **C3** supports that HSN is the Tertiary Payer (where Loop 2000B SBR01 = T, also known as the Payer Responsibility Sequence Code) on the claim and the date that follows must be within the Admit-through-Discharge period reported on the claim

Example:
*Loop 2000B SBR*T*18**MH*****ZZ~*
*Loop 2300 HI*BH:C3:D8:20090101~*

This uniform reporting allows the provider to bill other payers and use this code for them as well under their specific billing and reimbursement guidelines.

When codes do not align

If this occurrence code does not align to the HSN Payer Responsibility Sequence Code, but should, it will be ignored and may have adverse effects on the claim processing correctly. Below is an example of an incorrectly reported split for an Admit-through-Discharge of 12/31/08 through 1/10/09 where the Primary Payer denied the claim and HSN is Secondary.

> *Example:*
> *Loop 2000B SBR*S*18**SECOND*****ZZ~*
> *Loop 2300 HI*BH:A3:D8:20090101~*

Because the occurrence code of A3 (Primary) does not align to the Payer Responsibility Sequence Code of S (Secondary) this claim may present as HSN Ineligible, thus the claim may not be flagged for payment consideration.

How to resolve Eligibility Splits on Cycle Bills

Providers will be required to submit individual claims for pertinent Outpatient eligibility periods. An example of this would include –

> Outpatient claim submitted with a Span Date of 3/1/09 through 3/31/09. Service lines pertain to eligibility dates of 3/1 through 3/8 (two service dates within) and then on 3/24 through 3/31 (two additional service dates).

In this example, providers would need to submit four (4) Outpatient claims not designated as cycle billing (From / Thru dates would equal Service Line dates) and without an additional occurrence code and date.