Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter AIH-44
April 2009

TO: Acute Inpatient Hospitals Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: *Acute Inpatient Hospital Manual* (New Appendix D)

This letter transmits a new Appendix D for the *Acute Inpatient Hospital Manual*. Appendix D contains instructions for submitting 837I transactions and paper claims (after the implementation of NewMMIS) for members who have Medicare or other insurance benefits where services were deemed to be noncovered because the patient does not have benefits available (benefits exhausted), or does not qualify for a new benefit period.

Appendix D contains specific MassHealth instructions for billing claims for these situations, which are not described in the HIPAA implementation guide for the 837I transaction. It also provides instructions for using the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals to submit paper claims using the new instructions.

When the initial claim has been adjudicated by Medicare, the adjudication details provided by Medicare must be documented on the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals. This form must be attached to the claim to report HIPAA group and adjustment reason codes (ARCs). This form is available on the MassHealth Web site at www.mass.gov/masshealth, and is fillable online. A copy of the form is attached to this transmittal letter. Requests for paper copies of this form must be submitted in writing and faxed to 617-988-8973 or mailed to the following address.

MassHealth
ATTN: Forms Distribution
P.O. Box 9118
Hingham, MA 02043

This transmittal letter supersedes the billing instructions in Acute Inpatient Hospital Bulletin 126, dated November 2003, which is available on the MassHealth Web site at www.mass.gov/masshealth. Previously, providers were instructed to use condition codes to indicate the reason the insurer did not cover the service. After the implementation of NewMMIS, condition codes will no longer be used, but will be replaced by HIPAA adjustment reason codes (ARCs).

The instructions in Appendix D are effective upon implementation of NewMMIS on May 26, 2009.

If you have any questions about this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Acute Inpatient Hospital Manual

Pages vi and D-1 through D-4

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Acute Inpatient Hospital Manual

Page vi – transmitted by Transmittal Letter AIH-41

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

TPL Exception Form for Nursing Facilities and All Inpatient Hospitals

Please Note: Submit this form only with UB-04 paper claim forms.

Instructions on how to use this form:

1. Use this form to report HIPAA group and adjustment reason codes.
2. Use the claim(s) adjudication details provided by the insurer to fill in the form.
3. Use only Other Adjustment (OA) as the HIPAA group adjustment reason code.
4. For more details on how to use this form, refer to the appropriate appendix of your MassHealth provider manual.
5. Complete all fields.

Submission Date: _____ Date of Service (range if applicable): _____ - _____

MassHealth Provider ID/Service Location: _____

NPI: _____

Member Name: _____ MassHealth Member ID: _____

Policyholder First Name: _____ Policyholder Last Name: _____

Policyholder ID: _____ Policyholder No.: _____ Policyholder Group No.: _____

Carrier ID: _____ Carrier Name: _____

HIPAA Group Adjustment Reason Code	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Amount (total charges)	HIPAA Remarks (applies only to nursing homes)
OA			

Supplemental Instructions for Claims with Other Insurance

This appendix contains billing instructions for submitting 837I transactions and paper claims for members who have Medicare and/or commercial insurance, and whose services were deemed by the payer to be noncovered because the patient does not have benefits available (benefits exhausted), or does not qualify for a new benefit period.

This appendix contains specific MassHealth billing instructions that are not described in the HIPAA Implementation Guide for the 837I transaction, in the 837I Companion Guide, or in the billing guides for the UB-04.

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. MassHealth will continue to process Medicare Part B crossovers sent by Medicare.

Note: Providers must retain the original EOB (EOB, notice of the noncoverage, or the remittance advice) in their records for auditing purposes.

Billing Instructions for 837I Transactions

Providers must submit an initial claim to the other insurer (Medicare or commercial insurance) for a claim determination. When the initial claim has been adjudicated by the insurer, enter the adjudication details provided by that insurer on the other payer loops (2320 and 2330) in the 837I transaction. The provider must fill in the other payer loops in the 837I transaction as described in the following table.

Loop	Segment	Value Description
2330B	NM109 (Other Payer Name)	MassHealth-assigned carrier code. For Medicare, the carrier code is 0084000 (Part A). **Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual, or at www.mass.gov/masshealth.
2320	SBR09 (Claim Filing Indicator)	"MA" when the other payer is Medicare
2320	AMT (Amount)	Should not be populated with any insurance payment, coinsurance, or deductible.
2320	CAS01 (Claim Adjustment Group Code)	OA (other adjustments)
2320	CAS02 (Claim Adjustment Reason Code)	See Claim Adjustment Reason Code Crosswalk Table on page D-3. The table cross walks the previously used condition codes to the current HIPAA adjustment reason codes. Providers must bill using the correct HIPAA ARC to ensure that claims process correctly.

Loop	Segment	Value Description
2320	CAS03 (Monetary Amount)	Billed amount
2330B	DTP03 (Date, Time, or Period)	Date of discharge or end date of service

Providers must fill in the other payer loops in the 837I transaction as described in the following table to report Medicare Part B prior payments.

Loop	Segment	Value Description
2320	SBR09 (Claim Filing Indicator)	MB
2320	AMT01 (Allowed Amount Qualifier)	B6
2320	AMT02 (Allowed Amt = 0)	0
2320	AMT01 (Paid Amount Qualifier)	C4
2320	AMT02 (Medicare Prior Payment Amount)	Medicare prior payment amount
2330B	NM109 (Medicare Part B)	0085000

Billing Instructions for Paper Claims

Providers must submit an initial claim to Medicare for a claim determination. When the initial claim has been adjudicated by Medicare, the adjudication details provided by Medicare should be documented on the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals. This form must be attached to the claim to report HIPAA group and adjustment reason codes (ARCs). This form is available on the MassHealth Web site at www.mass.gov/masshealth.

Note: Providers submitting paper claims must refer to the Billing Guide for the UB-04. Otherwise, claims may be processed incorrectly.

Billing Instructions for Both Paper and 837I Transactions

The ARCs given in the following table may be used for both paper and 837I transactions to indicate the reason that the insurer is not covering the service. MassHealth allows providers to use ARCs to report noncovered or benefits-exhausted services only in the circumstances described in the table.

Claim Adjustment Reason Code Crosswalk Table			
Prior Condition Code	**Replace with HIPAA Adjustment Reason Code**	**Applies to Medicare?**	**Applies to Commercial Insurers?**
Y9 - Valid EOB / Utilization review notice. Patient does not have benefits available or does not qualify for a new benefit period.	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	Yes	No

Questions

If you have any questions about the information in this appendix, please refer to Appendix A of your MassHealth provider manual for the appropriate contact information.

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