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 ALL-139
April 2006

TO: All Providers Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: All Provider Manuals (Revised Administrative and Billing Instructions)

MassHealth is in the process of updating the provider billing instructions, which we have renamed administrative and billing instructions. The administrative and billing instructions are divided into several parts and appear as Subchapter 5 in your provider manual. This letter transmits the first set of revised parts of the administrative and billing instructions. They include

Part 1. Eligibility
Part 2. Prior Authorization
Part 4. Required Forms and Documentation
Part 6. Error Codes and Explanations
Part 7. Claim Status and Claim Correction
Part 8. Other Insurance

The revised parts of the administrative and billing instructions attached to this letter reflect a slightly different organization than that of the previous billing instructions. In some cases, the titles and location of the information are different. The material covered in these instructions remains largely the same, although it has been updated to reflect current terminology and procedures that have been previously announced through bulletins and other written issuances from MassHealth. MassHealth will publish additional revised parts of the administrative and billing instructions in the coming weeks.

The administrative and billing instructions, along with all other sections of the provider manuals are available on the Web. Go to www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library, then on MassHealth Provider Manuals.

If you have any questions about the information in 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.)

All Provider Manuals

Pages v, 5.1-1, 5.1-2, 5.2-1 through 5.2-4, 5.4-1, 5.4-2, 5.6-1 through 5.6-42, 5.7-1 through 5.7-8, and 5.8-1 through 5.8-6

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages v, 5.2-1 through 5.2-10, 5.4-1 through 5.4-4, 5.7-1, and 5.7-2 — transmitted by Transmittal Letter ALL-100

Pages 5.1-1 through 5.1-14, 5.6-1 through 5.6-18, and 5.9-15 through 5.9-22 — transmitted by Transmittal Letter ALL-37

Pages 5.8-1 through 5.8-8 — transmitted by Transmittal Letter ALL-27

Pages 5.9-1 through 5.9-14, 5.9-23 through 5.9-32, and 5.9-45 through 4.9-60 — transmitted by Transmittal Letter ALL-31

Pages 5.9-33 through 5.9-44 — transmitted by Transmittal Letter ALL-47

5. Billing Instructions

Part 1. Eligibility 5.1-1

Part 2. Prior Authorization 5.2-1

Part 3. Submitting Claims 5.3-1

Part 4. Required Forms and Documentation 5.4-1

Part 5. Remittance Advice 5.5-1

Part 6. Error Codes and Explanations 5.6-1

Part 7. Claim Status and Claim Correction 5.7-1

Part 8. Other Insurance 5.8-1

Part 1. Eligibility

The MassHealth Card

The MassHealth card identifies a person as being a MassHealth member. Possession of a MassHealth card, however, does not guarantee that the cardholder is eligible on the date of service, or that MassHealth will pay for services. Therefore, the provider should request to see the card and must access the Recipient Eligibility Verification System (REVS) to verify eligibility for a specific service and date. Examples of the MassHealth card may be found in the *REVS User Guide* at www.massrevs.eds.com.

Verifying Eligibility

The Recipient Eligibility Verification System (REVS) provides you with eligibility information for all MassHealth members. By verifying a member's eligibility on the day of service, you may be able to reduce the risk of your claims being denied. Contact information for the REVS HelpDesk appears in Appendix A of this provider manual.

To access REVS, go to www.massrevs.eds.com. All providers are required to have a user ID and password to use REVS. To obtain a user ID and password, each provider must sign a MassHealth Trading Partner Agreement (TPA). All REVS access methods can be used for eligibility verification. Some of these methods can also be used to check the status of a claim that has been fully processed by MassHealth. Listed below are some of the methods available for accessing REVS, with a more detailed description of each method.

For providers with high-speed Internet access who conduct eligibility-verification transactions, the following options are available:

- WebREVS (Internet site, recommended option)
- PC software (high-speed ISP or dial-up modem connection)

Appendix Y of this manual lists the active REVS codes and their respective service restriction messages. You may also refer to the *REVS User Guide* located in the REVS section on www.mass.gov/masshealth for more information about these and other access methods.

Trading Partner Agreements (TPA)

To access REVS, an authorized MassHealth provider must first have submitted a signed TPA. The primary contact for the Health Insurance Portability and Accountability Act (HIPAA) at your organization should be able to tell you whether you have a signed TPA on file. A TPA is part of the MassHealth Provider Enrollment packet. The TPA and other related information are available on the MassHealth Web site at www.mass.gov/masshealth under the link for MassHealth Provider Forms.

User ID and Password

You must also have a valid user ID and password to access REVS. To determine if you have a valid user ID and password, call the REVS HelpDesk after submitting the signed TPA referred to in the preceding section. Details about the user ID and password may be found in the *REVS User Guide*.

HIPAA Compliance

REVS meets the ANSI ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response standards. Data transmissions to and from these systems meet the security standards of the HIPAA Security Regulations. Associated companion guides for the HIPAA 270/271 transaction can be found at www.massrevs.eds.com.

Security and Privacy

Your current MassHealth provider agreement in combination with the TPA requires you to make every effort to secure and protect information transmitted to and received from our system. The HIPAA Privacy Rule establishes the base line for the MassHealth privacy policy. Stricter local laws take precedence over the HIPAA base line.

Explanation of MassHealth Coverage Types

Based on eligibility requirements, MassHealth members receive benefits according to specific coverage types. REVS provides the member's coverage type as part of the eligibility verification transaction. Providers should refer to the specific MassHealth regulation at 130 CMR 450.105 for a list of covered services by coverage type and for other information and requirements about each coverage type. Provider regulations are available on our Web site at www.mass.gov/masshealth in the Provider Library.

Part 2. Prior Authorization

MassHealth requires providers to obtain prior authorization (PA) for certain services. See the MassHealth program regulations for the proposed service to determine when PA is required. In addition to program regulations, PA requirements may appear in Subchapter 6 of certain provider manuals, provider bulletins, or in other written issuances from MassHealth. MassHealth posts its publications in the Provider Library on the MassHealth Web site. Go to www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library. To identify which drugs require PA, go to the MassHealth Drug List at www.mass.gov/druglist.

MassHealth reviews PA requests on the basis of medical necessity only and does not establish or waive any other prerequisites for payment, including eligibility or referral. The approval of a PA is not a guarantee of payment. You must still verify the member's eligibility, other insurance, and any other restrictions before providing service. If PA is required for a service that you want to provide, follow these guidelines when submitting your request to MassHealth.

The following information and instructions about PA are separated into information for non-pharmacy services, pharmacy services (see page 5.2-4), and nonemergency transportation services (see page 5.2-4).

Requesting Prior Authorization for Non-pharmacy Services

For non-pharmacy medical services, MassHealth strongly encourages providers to request PA using the Web-based Automated Prior Authorization System (APAS) at www.masshealth-apas.com. Providers can use APAS to submit PA requests and all attachments electronically and to review the status of PA requests.

Providers may also request PA for non-pharmacy services using the paper Prior Authorization Request form (PA-1). PA-1 forms and attachments should be sent to the appropriate address listed in Appendix A of your MassHealth provider manual.

If the PA request is for a Massachusetts Commission for the Blind (MCB) member, then MCB will process the request. A PA request submitted to MCB can also be submitted via APAS.

If the PA request is for a Community Case Management (CCM) member, then CCM will process the request, which can be submitted via APAS.

For any subsequent request for the same service, you must request a new PA. Subsequent requests may be submitted via APAS. If you choose to complete a paper PA request, mail it along with a copy of the initial request and any required supporting documentation to the appropriate address listed in Appendix A of your MassHealth provider manual.

For address and telephone information for non-pharmacy PA services, including APAS, refer to Appendix A of your MassHealth provider manual.

Other Required Prior Authorization Forms

PA requests for certain services require additional forms that must accompany the request. These supplemental forms (attachments) may be submitted via APAS or along with the paper PA-1 form.

Dental Services

- **Supplemental Dental Prior Authorization Form**

  The Supplemental Dental Prior Authorization Form (DEN-1) is a two-sided form on which the provider charts the current status of the member's teeth. This form must accompany the PA request for all dental services except orthodontics. This form may be submitted as an attachment via APAS or as an attachment submitted with the PA-1 form.

- **Orthodontics Prior Authorization Form**

  In addition to the PA request form for full orthodontic treatment and treatment visits, which are billed quarterly, the orthodontic provider must complete a PAR Index Recording Form (DEN-7) and an Orthodontics Prior Authorization Form (DEN-2). These forms may be submitted as an attachment on APAS or as an attachment submitted with the PA-1 form.

  For continuation of orthodontic service for the second year, the orthodontic provider must submit a new PA request with updated information, and a copy of the original Orthodontic Prior Authorization Form (DEN-2). The same procedure must be used for the first half of the third year, if this treatment is necessary.

- **Peer Assessment Rating Index (PAR Index Recording Form)**

  Orthodontic providers must complete the PAR Index Recording Form (DEN-7) when requesting PA for full orthodontic treatment (see 130 CMR 420.428(H)). This form may be submitted as an attachment via APAS or as an attachment submitted with the paper Prior Authorization Request form. Refer to Appendix D of the *Dental Manual* for detailed instructions and examples of the use of the PAR Index Recording Form.

Nursing Services

- **Request and Justification for Continuous Skilled Nursing Services**

  When requesting PA for continuous skilled nursing services for members over the age of 21, the provider must complete both a PA-1 and a Request and Justification for Continuous Skilled Nursing Services (PDN-001). This form may be submitted as an attachment via APAS or as an attachment submitted with the PA-1 form.

  If the member is under the age of 22, PA requests must be obtained from Community Case Management. Direct your requests to the appropriate address in Appendix A of your MassHealth provider manual.

Therapy Services: Physical, Occupational, and Speech/Language

- **Request and Justification for Therapy Services**

  When requesting PA for therapy services, the provider must complete both a PA-1 form and a Request and Justification for Therapy Services form (THP-2).

  If member is under the age of 22, PA requests must be obtained from Community Case Management (CCM). Direct your request to the appropriate address in Appendix A of your MassHealth provider manual.

Obtaining Forms

You may download PA forms from www.mass.gov/masshealth under the link for Provider Forms. You may also request supplies of all PA forms from the appropriate address listed in Appendix A of your MassHealth provider manual.

Notice of Prior Authorization Decision for Non-pharmacy Services

MassHealth will notify both the provider and the member in writing of its decision on the PA request. The letter will indicate whether the services were approved, modified, or denied. The letter will also contain the PA number assigned to the request, even if the request was denied. If the service was approved or modified, you must include the PA number on the MassHealth claim when submitting it for payment. If you submit your PA request via APAS, you can also find out the status of your request using APAS. MassHealth responds to PA requests that contain all required information within the time periods specified in 130 CMR 450.303(A):

- **Nursing** – within 14 calendar days from the date the PA Unit receives the request
- **DME** – within 15 calendar days from the date the PA Unit receives the request
- **For all other services** – within 21 days from the date the PA Unit receives the request.

Prior Authorization Decisions for Non-Pharmacy Services

MassHealth may make any of the following decisions on a PA request:

- **Approve the request** – the request is authorized. Note: When used on APAS, the term “accepted” simply means that MassHealth has processed the online PA. The provider must read the PA notice to determine the decision on the request.
- **Modify the request** – the authorization is for a service or item that is different in quantity or nature than that which was originally requested.

- **Deny the request** – the request is denied and MassHealth will not cover the service.
- **Defer the request** – the PA is returned to the provider with a request for additional information that must be submitted before a decision can be made

Requesting Prior Authorization for Pharmacy Services

For pharmacy services, MassHealth encourages providers to request PA using a drug-specific PA form, if applicable, or the MassHealth Drug Prior Authorization Request form. All PA forms for pharmacy services, along with the MassHealth Drug List, are available on the Web at www.mass.gov/druglist. All PA requests for drugs must be submitted to the address or fax number listed on the PA form or listed in Appendix A of your MassHealth provider manual.

Notice of Prior Authorization Decision for Pharmacy Services

The Drug Utilization Review (DUR) Program will notify the pharmacy, provider, and the member in writing of its decision within 24 to 48 hours of the date the DUR Program receives the request. A fax will be sent to the pharmacy and provider, and the member will receive a letter. The fax will not show a PA number if the request was denied; it will give a PA number for an approval only. The pharmacy provider should not enter this number on the online transaction. In the letter sent to the member, a PA number will be assigned regardless of whether the request was approved or denied.

Requesting Prior Authorization for Nonemergency Transportation

For nonemergency transportation services, the provider of the medical service for which the member needs transportation must fill out the Prescription for Transportation (PT-1) form to verify that the member's need for transportation is medically necessary. The request for transportation is approved only when public and private transportation resources are not available and door-to-door transportation is medically necessary. Providers must send completed PT-1 forms to the appropriate address listed in Appendix A of your MassHealth provider manual. See the MassHealth transportation regulations for more information about MassHealth coverage for nonemergency transportation services. The PT-1 form will be processed within four business days from receipt.

Notice of Prior Authorization Decision for Transportation Services

Transportation authorization specialists may take any of the following actions on a request (PT-1):

- **Receive the request** – the request is received.
- **Authorize the request** – the request is approved and MassHealth will pay for the service,
- **Deny the request** – the request is denied and MassHealth will not pay for the service.
- **Mail back the request** – the form is incomplete and is being returned to provide missing information.

Part 4. Required Forms and Documentation

For certain services, MassHealth requires other forms and documentation. Some services require you to submit a specific attachment with your claim, while others may require you to just keep the documentation in the member's medical record. See the applicable program regulations in your MassHealth provider manual for specific report requirements. Provider manuals are available online and can be accessed from the Provider Library on the MassHealth Web site. Go to www.mass.gov/masshealth, click on MassHealth Regulations and Other Publications, then on Provider Library.

Types of Attachments

The following types of attachments may be required for your claims.

General Report or Supplier's Invoice

- You must submit a general written report or a discharge summary when the service code description stipulates "with report only," individual consideration (I.C.), or when you use a service code for an unlisted procedure. Consult the applicable program regulations in your MassHealth provider manual for additional information.
- If the I.C. service is a laboratory or radiology service, and all the required information is entered on the claim form in the space for description, you do not need to attach additional documentation.
- Claims for medical supplies, medications, or injectables provided outside a pharmacy may require a supplier's invoice as the attachment.

Operative Report

- For surgery service codes designated I.C., you must submit operative notes in addition to the claim.

MassHealth Forms

- When applicable, you may also be required to submit other attachments, including but not limited to a Certification for Payable Abortion or a Sterilization Consent Form. The forms may be downloaded from the Provider Library at www.mass.gov/masshealth.

Other Forms

You may be required to complete and submit certain other forms before providing a service. Refer to other sections of your MassHealth provider manual for additional required forms and reports that are specific to the services you provide. These forms may include:

- prior authorization and supplemental authorization forms
- medical necessity forms
- other admission, election or screening forms

Obtaining Forms

You may download these forms from the MassHealth Web site. Go to www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library. You can also request supplies of these forms from the appropriate address listed in Appendix A of this manual.

Claim Attachment Forms for Electronic Submissions

Claims requiring an attachment may be submitted electronically. Once a claim requiring an attachment is submitted, it is suspended for review. During this suspension, MassHealth mails a Claim Attachment Form (CAF) to you. You must return the CAF with the appropriate attachment to the address indicated on the CAF. It is not necessary to submit a paper claim. MassHealth will continue processing the claim once it receives the CAF and attachment.

For paper claim forms, attach any necessary reports or required forms to the claim form. Please do not staple in the barcode printed in the upper-left portion of the claim form.

Part 6. Error Codes and Explanations

This part defines the error codes that may appear on your paper remittance advice. Pharmacy providers may also encounter them during an online transaction. Errors identified as "MassHealth use only" do not affect the status of a claim and, in most instances, are invisible to you. If you also use the electronic 835 remittance advice transaction to reconcile your accounts, you should refer to the Crosswalk of Adjustment Reason and Remarks Codes that is available on the MassHealth Web site.

For more information about how to correct a claim, see Part 7 of the administrative and billing instructions. Provider manuals are available in the Provider Library on the MassHealth Web site. Go to www.mass.gov/masshealth, click on MassHealth Regulations and Other Publications, then on Provider Library. Pharmacy providers should refer to the NCPDP specifications, or contact their software vendor about online transactions.

Code	Description
001	The copayment review amount has been reached.
002	The claim payment amount is less than the copayment amount.
003	The pay-to provider number entered on the claim is invalid. If it is now over 90 days from the date of service, you can request a 90-day waiver.
004	The member identification number is either missing or invalid. Verify the RID number through REVS. If it is now over 90 days from the date of service, you can request a 90-day waiver.
005	The accident type code is either missing or invalid.
006	The to-date of service entered on the claim is invalid for consecutive dates of service.
007	The member identification number is either missing or invalid. Verify the RID number through REVS. If it is now over 90 days from the date of service, you can request a 90-day waiver.
008	The prior-authorization number entered on the claim is invalid.
009	The member's Medicare identification number is either missing or invalid. Verify the HIC number through REVS.
010	The member identification number is either missing or invalid. Verify the RID number through REVS.
011	The servicing provider number entered on the claim is invalid.
012	The procedure code is either missing or invalid.
013	Partial copayment applied.
014	The usual fee is either missing or invalid.
015	The other paid amount entered on the claim is invalid.
016	MassHealth use only
017	MassHealth use only
018	There was a submission error on the claim.
019	MassHealth use only
020	MassHealth use only

Code	Description
021	The action code is either missing or invalid.
022	The level-of-care code is either missing or invalid.
023	MassHealth use only
024	The patient status code entered on the claim conflicts with the type-of-bill code entered on the claim.
025	The revenue code entered on the claim conflicts with the type-of-bill code entered on the claim.
026	The patient status code is either missing or invalid.
027	The billing date is either missing or invalid.
028	The admission date is either missing or invalid.
029	The date of birth is either missing or invalid. Correct the date of birth entered on the POPS transaction.
030	The Medicare number on the Medicare/Medicaid crossover claim does not match the Medicare number listed on the MassHealth eligibility file. Verify the member's recipient identification (RID) and health insurance claim (HIC) numbers through REVS.
031	The gender code is either missing or invalid. Correct the gender code entered on the POPS transaction.
032	The other coverage code is either missing or invalid. Correct the other coverage code entered on the POPS transaction.
033	The total charge is either missing or invalid.
034	The primary payer date is either missing or invalid. Correct the primary payer date entered on the POPS transaction.
035	Medicare made full payment on the claim. Additional payment will not be made by MassHealth.
036	Medicare denied this claim; therefore, the claim must be billed on a MassHealth claim form with the Medicare EOB as an attachment.
037	MassHealth use only
038	The place-of-service code is either missing or invalid.
039	MassHealth use only
040	MassHealth use only
041	The first or last name is either missing or invalid. Correct the first or last name entered on the POPS transaction.
042	The compound drug code is either missing or invalid.
043	The patient-paid amount entered on the claim is invalid.
044	The NDC is either missing or invalid. Correct the NDC entered on the POPS transaction.
045	The procedure code entered on the claim does not have a determined rate on file.

Code	Description
046	MassHealth use only
047	MassHealth use only
048	A HCPCS procedure code is required for dates of service on or after 04/01/91.
049	The procedure code modifier entered on the claim is not covered by MassHealth.
050	The procedure code modifier entered on the claim is invalid.
051	The procedure code modifier entered on the claim cannot be billed with the service code entered on the claim.
052	The admit-from code is either missing or invalid.
053	The procedure code modifier entered on the claim is not covered by MassHealth.
054	The dates of service, patient status, and covered days entered on the claim conflict.
055	The number of days is either missing or invalid.
056	The prescription number is either missing or invalid. Correct the prescription number entered on the POPS transaction.
057	The member is restricted to a primary pharmacy. The number of days' supply entered on the POPS transaction exceeds the maximum number allowed.
058	A less costly method of service or treatment is available.
059	MassHealth use only
060	This service is not payable by MassHealth.
061	A report containing a higher level of detail must be submitted.
062	The procedure code entered on the claim is incorrect for this service.
063	The procedure code modifier entered on the claim is incorrect for this service.
064	The date filled is either missing or invalid. Correct the filled date entered on the POPS transaction.
065	This service is a component of a primary procedure for which payment has been made. This component will not be paid separately.
066	The days' supply is either missing or invalid. Correct the days' supply entered on the POPS transaction.
067	Payment for this service has been made to another physician.
068	The date filled conflicts with the claim media. Submit this claim as a POPS transaction.
069	MassHealth use only
070	The provider did not accept Medicare assignment. MassHealth will not pay for services when assignment is not accepted.
071	The provider does not have access to the POPS system.
072	From and to dates of service are not allowed for this service. Enter a single date of service on the claim or bill another service code.

Code	Description
073	MassHealth use only
074	The drug certification code entered on the claim is invalid.
075	MassHealth use only
076	MassHealth use only
077	The date filled is before the effective dates on the NDC standard package size record.
078	A CLIA certification number is not on file. Contact MassHealth Provider Enrollment and Credentialing.
079	The date of service entered on the claim is before the effective date of CLIA certification.
080	The date of service entered on the claim is after the expiration date of CLIA certification.
081	The CLIA certification information on file does not allow for payment for this service.
082	The date of accident is either missing or invalid.
083	MassHealth use only
084	MassHealth use only
085	MassHealth use only
086	The member's Senior Pharmacy Program benefits have been exhausted.
087	MassHealth use only
088	The value code entered on the claim conflicts with the patient status code entered on the claim.
089	The type of admission entered on the claim is invalid.
096	This claim is a duplicate of a previously paid claim.
097	MassHealth use only
098	A claim for the extraction of this tooth was previously paid.
099	The procedure code entered on the claim is incorrect for this service.
100	This claim is a potential duplicate of a claim previously paid for similar services.
101	This claim is a potential duplicate of a claim previously paid for similar services.
102	This is a duplicate TCN. Pharmacy providers use this information to reverse a previously paid claim.
103	This claim is a duplicate of a previously paid claim.
104	The total number of allowed visits for this procedure has been exceeded.
105	The combination of this procedure and at least one other, submitted either on the same claim form or on a previous claim form, for the same member, on the same date of service, to the same provider is not allowed.
106	Payment of an office visit and surgical procedure for the same member, on the same date of service, to the same provider is not allowed. A claim for one of these services has been previously paid.
107	This claim is a potential duplicate of a claim previously paid for similar services.

Code	Description
108	This claim is a potential duplicate of a claim previously paid for similar services (applicable to long term care claims.)
109	Payment of multiple visits for the same member, on the same date of service, to the same provider is not allowed. A claim for a visit on this date of service has been previously paid.
110	The combination of this procedure and at least one other, submitted either on the same claim form or on a previous claim form, for the same member, on the same date of service, to the same provider is not allowed.
111	This claim is a duplicate of a claim previously paid for medical services for the same date of service.
112	This claim is a duplicate of a claim previously paid as a Medicare/MassHealth crossover claim for the same date of service.
113	This claim is a duplicate of a claim previously paid for the same date of service.
114	This service is a component of a comprehensive procedure for which payment has been made. This component will not be paid separately.
115	This component of a comprehensive service has already been paid.
116	The combination of this procedure and at least one other comprehensive and bundling procedure submitted either on the same claim form or on a previous claim form, for the same member, on the same date of service, to the same provider is not allowed.
119	This claim requires review.
120	The Certification for Payable Abortion form requires review.
121	The Hysterectomy Information form requires review.
122	The Sterilization Consent form requires review.
123	This claim requires review.
124	The NDC requires review.
125	This void transaction requires review.
126	This claim requires medical review.
127	The procedure code entered on the claim is not covered by MassHealth.
128	The NDC is not covered by MassHealth.
129	The provider specialty information on file does not permit payment for the procedure code entered on the claim.
130	The provider specialty information on file does not permit payment for this procedure.
131	The diagnosis code is missing. The procedure code entered on the claim requires that a diagnosis code be entered on the claim.
132	The procedure requires review of a report.
134	The shoe prescription form attachment was not submitted with the claim.
135	The procedure code modifier is missing. The procedure code entered on the claim requires a procedure code modifier.

Code	Description
136	The procedure code modifier entered on the claim does not match the procedure code modifier on the prior authorization.
137	The NDC was not covered by MassHealth on the date of service.
138	The drug is not covered; however, a prior-authorization number is present that may allow coverage in this instance.
139	The NDC cannot be billed by this pharmacy.
141	The from and through dates of service entered on the claim span both a contractual and non-contractual period. The claim must be split-billed.
142	The from and through dates of service entered on the claim span months. The claim must be split-billed.
143	The from date of service entered on the claim must precede the to date of service entered on the claim.
144	From and through dates of service are not allowed. Enter a single date of service on the claim.
145	MassHealth use only
146	MassHealth use only
147	MassHealth use only
148	The patient status code is either missing or invalid.
149	The member for whom you are billing is not enrolled in hospice care.
150	MassHealth use only
151	The ProDUR therapeutic duplication indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. The same provider number and different prescriber numbers exist among the previous and current claims.
152	The ProDUR therapeutic duplication indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. The same provider number and different prescriber numbers exist among the previous and current claims.
153	The units of service entered on the claim exceed the amount remaining under the prior-authorization number entered on the claim.
154	The prior-authorization number entered on the claim has been voided.
155	The procedure code modifier entered on the claim is invalid for this provider.
156	The place-of-service code entered on the claim conflicts with the procedure code entered on the claim.
157	The procedure code modifier is missing. The procedure code entered on the claim requires a procedure code modifier when the place-of-service code entered on the claim indicates an inpatient or outpatient hospital setting.
158	The member identification number entered on the claim is not the member identification number listed under the prior-authorization number entered on the claim.
159	The provider number entered on the claim is not the provider number listed under the prior-authorization number entered on the claim.

Code	Description
161	The former TCN entered on the adjustment claim is incorrect.
162	The former TCN entered on the adjustment claim is incorrect. It corresponds to a previously denied claim.
163	The amount paid by MassHealth on the voided claim does not match the amount paid by MassHealth on the original claim.
164	This returned-check transaction requires review.
165	This voided returned-check transaction requires review.
166	The former TCN entered on the adjustment claim is invalid.
167	This claim is a potential duplicate. An adjustment claim referencing the same former TCN is currently in process.
168	This claim is a potential duplicate. A resubmittal claim referencing the same former TCN is currently in process.
169	The amount of the returned check transaction exceeds the amount paid by MassHealth on the original claim.
170	The month or year of service entered on the adjustment claim does not match the month or year of service entered on the original claim.
171	The former TCN entered on the adjustment claim conflicts with the procedure code entered on the adjustment claim. The former TCN corresponds to an original claim that was not an EPSDT assessment or it corresponds to an original claim that was an EPSDT assessment.
172	The former TCN entered on the resubmittal claim is incorrect. It corresponds to a previously paid claim.
173	The ProDUR drug-to-drug interaction code is severity 1. The same provider number and different prescriber numbers exist among the previous and current claims.
174	The ProDUR drug-to-drug interaction code is severity 2. The same provider number and different prescriber numbers exist among the previous and current claims.
175	The ProDUR drug-to-drug interaction code is severity 1. Different provider numbers and different prescriber numbers exist among the previous and current claims.
176	The ProDUR drug-to-drug interaction code is severity 2. Different provider numbers and different prescriber numbers exist among the previous and current claims.
178	The procedure code entered on the claim is not covered for this provider.
180	The provider-specific rate is not on file for the date of service entered on the claim.
181	The provider-specific case-mix rate is not on file for the dates of service entered on the claim.
182	MassHealth use only
183	The provider-specific case-mix rate is not on file for the dates of service entered on the claim.
184	This claim was paid at $0.00 in accordance with MassHealth policy.
185	The report is missing. The procedure code entered on the claim requires review of a report.
186	This claim requires review.

Code	Description
187	The procedure code entered on the claim is not covered for members enrolled in this coverage type. The member is enrolled in category of assistance 04 (EAEDC).
188	The procedure code entered on the claim is not covered for members enrolled in this coverage type.
189	The ProDUR therapeutic overlap conflict code is severity 1. The same provider number and different prescriber numbers exist among the previous and current claims.
190	The ProDUR therapeutic overlap conflict code is severity 2. The same provider number and different prescriber numbers exist among the previous and current claims.
191	The quantity is either missing or invalid. Correct the drug quantity entered on the POPS transaction.
192	The Certification of Medical Necessity form requires review.
193	The Certification of Medical Necessity is missing. The procedure code entered on the claim requires that Certification of medical Necessity form.
194	The ProDUR therapeutic overlap conflict code is severity 1. Different provider numbers and different prescriber numbers exist among the previous and current claims.
195	The ProDUR therapeutic overlap conflict code conflict code is severity 2. Different provider numbers and different prescriber numbers exist among the previous and current claims.
196	The ProDUR drug to age conflict code is severity 1. The NDC being billed is contraindicated for the member's age.
197	The compound drug information is either missing or invalid.
198	This claim requires review.
199	This compound drug claim requires review.
200	The former TCN on the adjustment claim is missing.
201	The ProDUR therapeutic duplication indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. Different provider numbers exist among the previous and current claims.
202	The prior-authorization number entered on the claim is not on file.
203	The member identification number entered on the claim is not on file. Verify the RID number through REVS.
204	The member identification number entered on the claim is not on file. Verify the RID number through REVS.
205	MassHealth use only
206	The referring provider number entered on the claim is not on file.
207	MassHealth use only
208	The ProDUR drug-to-drug interaction code is severity 1. The same provider number and the same prescriber number exist among the previous and current claims.
209	The prescriber number entered on the claim is missing or invalid.

Code	Description
210	This claim requires review. The procedure code entered on the claim normally requires a letter of second opinion, but an emergency is indicated.
211	The ProDUR drug-to-drug interaction code is severity 3. The same provider number exists among the previous and current claims.
212	The ProDUR drug-to-drug conflict code is severity 4. The same provider number exists among the previous and current claims.
213	The ProDUR drug-to-drug conflict code is severity 5. The same provider number exists among the previous and current claims.
214	MassHealth use only
215	The from date of service entered on the claim must precede the to date of service entered on the claim.
216	The ProDUR therapeutic duplication indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. The same provider number and the same prescriber number exist among the previous and current claims.
217	MassHealth use only
218	MassHealth use only
219	The former TCN entered on the adjustment claim is incorrect. It corresponds to a previously adjusted or voided claim.
220	The former TCN entered on the adjustment claim is incorrect. It corresponds to a previously denied claim.
221	This returned-money or void transaction cannot be processed. It corresponds to a previously adjusted or voided claim.
222	This returned-money or void transaction cannot be processed. It corresponds to a previously denied claim.
223	This returned-money or void transaction cannot be processed. The amount on this and the matching claim are not equal.
224	This claim awaits an archive run due to the date of service entered on the claim.
225	This claim was received for processing before the billing date entered on the claim.
226	The procedure code modifier entered on the claim requires review.
227	This claim was received for processing before the date of service entered on the claim.
228	The billing date entered on the claim must be on or after the date of service entered on the claim.
229	The procedure code entered on the claim is not on file.
230	MassHealth use only
231	MassHealth use only
232	The pay-to provider number entered on the claim is not on file.
233	The servicing provider number entered on the claim is not on file.

Code	Description
234	The servicing provider number is missing.
235	This claim requires review.
236	This claim requires review.
237	The member has Medicare coverage on the date of service entered on the claim. Submit this claim to Medicare.
238	MassHealth use only
239	The NDC entered on the claim is not on file.
240	The NDC entered on the POPS transaction is not on file.
241	The ProDUR therapeutic overlap conflict code is severity 2. The same provider number and same prescriber number exist among the previous and current claims.
242	MassHealth use only.
243	MassHealth use only
244	The member identification number entered on the claim is ineligible on the date of service entered on the claim. Verify the RID number through REVS.
245	The member identification number entered on the claim is ineligible on the date of service entered on the claim. Verify the RID number through REVS.
246	The member identification number entered on the claim is ineligible on the date of service entered on the claim. Verify the RID number through REVS.
247	The member has MCO coverage on the date of service entered on the claim. Submit this claim to the MCO.
248	The ProDUR therapeutic overlap conflict code is severity 4. The same provider number exists among the previous and current claims.
249	The ProDUR therapeutic overlap conflict code is severity 5. The same provider number exists among the previous and current claims.
250	The ProDUR early refill conflict code indicates that the member may be noncompliant with the prescription because of the timeliness of the refill, which is more than 40 days early.
251	The pay-to provider number entered on the claim is ineligible on the date of service entered on the claim.
252	This type of claim form may not be used by this provider.
253	The procedure code entered on the claim is not covered by MassHealth for members of this gender.
254	The procedure code entered on the claim is not covered by MassHealth for members of this age.
255	The procedure code entered on the claim requires prior authorization.
256	The procedure code entered on the claim is not the procedure code listed under the prior-authorization number entered on the claim.
257	The procedure code entered on the claim is incorrect for this service.

Code	Description
258	The procedure code entered on the claim requires that a prior-authorization number be entered on the claim.
259	The procedure code entered on the claim cannot be billed on this type of claim form.
260	The procedure code and/or revenue code entered on the claim requires that a prior-authorization number be entered on the claim.
261	The ProDUR early refill conflict code indicates that the member may be noncompliant with the prescription as determined by the timeliness of the refill, which is from 20 to 40 days early.
262	This claim requires review.
263	A ProDUR conflict code exists.
264	The ProDUR early refill conflict code indicates that the member may be noncompliant with the prescription dispensed as determined by the timeliness of the refill, which is from eight to 10 days early.
265	MassHealth use only
266	The from and to dates of service entered on the claim span the conversion to HCPCS procedure codes. MMPCS codes must be used for services before April 1, 1991. HCPCS procedure codes must be used for services on and after April 1, 1991. This claim must be split-billed.
267	The from and to dates of service entered on the claim span state fiscal years. This claim must be split-billed.
268	MassHealth use only
269	MassHealth use only
270	MassHealth use only
271	MassHealth use only
272	MassHealth use only
273	The ProDUR drug-to-drug conflict code is severity 1. Different provider numbers and the same prescriber number exist among the previous and current claims.
274	The ProDUR drug-to-drug conflict code is severity 2. Different provider numbers and the same prescriber number exist among the previous and current claims.
275	The procedure code entered on the claim cannot be billed on this type of claim form.
276	This claim requires review.
277	The procedure code entered on the claim is not covered by MassHealth on the date of service entered on the claim for members enrolled in this coverage type.
278	The procedure code entered on the claim is not covered by MassHealth on the date of service entered on the claim.
279	The date of service entered on the claim conflicts with the payment methodology on file for the procedure code entered on the claim.
280	The amount paid by Medicare for this claim exceeds the amount allowed by MassHealth for the service; therefore, no additional payment will be made by MassHealth.

Code	Description
281	This claim requires review.
282	This claim requires review.
283	MassHealth use only
284	The combination of this procedure and at least one other, submitted either on the same claim form, or on a previous claim form, for the same member, on the same date of service is not allowed. This procedure is paid only when performed independently of other surgical procedures.
285	This claim is a potential duplicate of a claim previously paid for similar services. The servicing provider number entered on the claim is the same for both the primary and assistant surgeons.
286	The procedure code modifier is missing. The combination of this procedure and at least one other submitted either on the same claim form, or on a previous claim form, for the same member, on the same date of service requires that a multiple-surgery procedure code modifier be entered on this claim.
287	The former TCN entered on the adjustment claim is incorrect. It corresponds to a claim previously paid at zero dollars.
288	The combination of this procedure and at least one other, submitted either on the same claim form, or on a previous claim form, for the same member, on the same date of service is not allowed. This procedure is paid only when performed independently of other procedures.
289	MassHealth use only
290	This claim requires review.
291	The maximum frequency limitation for the procedure code entered on the claim, for this member, has been exceeded.
292	The number of units entered on the claim exceeds the total cumulative number of units allowed for the procedure code entered on the claim.
293	MassHealth use only
294	This claim requires review.
295	The ProDUR drug-to-drug conflict code is severity 3. Different provider numbers exist among the previous and current claims.
296	This claim was received for processing more than 90 days after the date of service entered on the claim. You can request a 90-day waiver.
297	The ProDUR drug-to-drug conflict code is severity 4. Different provider numbers exist among the previous and current claims.
298	The ProDUR drug-to-drug conflict code is severity 5. Different provider numbers exist among the previous and current claims.
299	The ProDUR therapeutic duplication conflict code indicates that the prescription being dispensed is a duplicate of a previously dispensed (active) prescription. Different provider numbers and the same prescriber numbers exist among the previous and current claims.
300	The ProDUR therapeutic overlap conflict code is severity 1. Different provider numbers and the same prescriber number exist among the previous and current claims.

Code	Description
301	The value code entered on the claim conflicts with the number of covered days entered on the claim. A standard payment amount per discharge (SPAD) claim cannot exceed 20 covered days.
302	The value code entered on the claim conflicts with the noncovered days entered on the claim.
303	MassHealth use only
304	This claim requires review.
305	The ProDUR therapeutic overlap conflict code is severity 2. Different provider numbers and the same prescriber number exist among the previous and current claims.
306	The ProDUR therapeutic overlap conflict code is severity 3. Different provider numbers exist among the previous and current claims.
307	The ProDUR therapeutic overlap conflict code is severity 4. Different provider numbers exist among the previous and current claims.
308	This service is not covered by MassHealth for members of this age.
309	MassHealth use only
310	The principal surgical procedure code entered on the claim is invalid.
311	The principal surgical procedure code entered on the claim is not on file.
312	The principal surgical procedure code entered on the claim is not covered by MassHealth for members of this gender.
313	The principal surgical procedure code entered on the claim is not covered by MassHealth for members of this age.
314	The principal surgical procedure code entered on the claim is not covered by MassHealth.
315	MassHealth use only
316	The principal surgical procedure code entered on the claim requires review.
317	The principal surgical procedure code entered on the claim was not covered by MassHealth on the from and through dates of service entered on the claim.
318	The ProDUR therapeutic overlap conflict code is severity 5. Different provider numbers exist among the previous and current claims.
319	The principal surgical procedure code is missing.
320	The second surgical procedure code entered on the claim is invalid.
321	The second surgical procedure code entered on the claim is not on file.
322	The second surgical procedure code entered on the claim is not covered by MassHealth for members of this gender.
323	The second surgical procedure code entered on the claim is not covered by MassHealth for members of this age.
324	The second surgical procedure code entered on the claim is not covered by MassHealth.
325	MassHealth use only

Code	Description
326	The second surgical procedure code entered on the claim requires review.
327	The second surgical procedure code entered on the claim was not covered by MassHealth on the from and through dates of service entered on the claim.
328	MassHealth use only
329	The second surgical procedure code is missing.
330	The third surgical procedure code entered on the claim is invalid.
331	The third surgical procedure code entered on the claim is not on file.
332	The third surgical procedure code entered on the claim is not covered by MassHealth for members of this gender.
333	The third surgical procedure code entered on the claim is not covered by MassHealth for members of this age.
334	MassHealth use only
335	MassHealth use only
336	The third surgical procedure code entered on the claim requires review.
337	The third surgical procedure code entered on the claim was not covered by MassHealth on the from and through dates of service entered on the claim.
338	MassHealth use only
339	The third surgical procedure code is missing.
340	The eligibility clarification code is either missing or invalid. Correct the eligibility clarification code entered on the POPS transaction.
341	The principal surgical procedure date is either missing or invalid. Surgical dates must be in MM/DD format.
342	The second surgical procedure date is either missing or invalid. Surgical dates must be in MM/DD format.
343	The third surgical procedure date is either missing or invalid. Surgical dates must be in MM/DD format.
344	The principal surgical procedure date entered on the claim conflicts with the from and through dates of service entered on the claim.
345	The second surgical procedure date entered on the claim conflicts with the from and through dates of service entered on the claim.
346	The third surgical procedure date entered on the claim conflicts with the from and through dates of service entered on the claim.
347	The gender code is either missing or invalid. Correct the gender code entered on the POPS transaction.
348	The gross amount due is either missing or invalid. Correct the gross amount due entered on the POPS transaction.
349	MassHealth use only

Code	Description
350	Documentation is missing. The procedure code entered on the claim requires supporting documentation.
351	The Sterilization Consent form is missing. The procedure code entered on the claim requires a Sterilization Consent form.
352	The Sterilization Consent form is incomplete.
353	The Sterilization Consent form is not completed in accordance with state and federal regulations.
354	This claim is illegible.
355	The report is illegible.
356	MassHealth use only
357	MassHealth use only
358	This claim requires review.
359	This claim requires review.
360	A request for additional information was made, the additional information was not received.
361	This service is a component of a comprehensive procedure for which payment has been made. This incidental procedure will not be paid separately.
362	The authorized signature is missing on the Claim Correction form.
363	The authorized signature is missing.
364	A usual and customary fee must be entered on the claim for each procedure or revenue code entered on the claim.
365	Two Claim Correction forms were completed, but the returned information is incorrect.
366	MassHealth use only
367	The Hysterectomy Information form is not completed in accordance with state and federal regulations.
368	The Hysterectomy Information form is missing. The procedure code entered on the claim requires a Hysterectomy Information form.
369	The Hysterectomy Information form is incomplete.
370	The Hysterectomy Information form is not acceptable, according to current MassHealth regulations.
371	The Sterilization Consent form is not acceptable, according to current MassHealth regulations.
372	MassHealth use only
373	The member has Medicare supplemental insurance coverage on the date of service entered on the claim. Submit this claim to the supplemental insurer.
374	The member's Medicare identification number entered on the claim conflicts with the member's Medicare identification number on the member eligibility file. Verify the HIC number through REVS.

Code	Description
375	The Medicare deductible amount is not numeric. Verify the deductible amount reported by Medicare.
376	The Medicare coinsurance amount is not numeric. Verify the coinsurance amount reported by Medicare.
377	The Medicare type of service code entered on the claim is invalid.
378	MassHealth use only
379	MassHealth use only
380	MassHealth use only
381	The Medicare pay-to-provider number is invalid.
382	MassHealth use only
383	MassHealth use only
384	MassHealth use only
385	The Medicare provider number entered on the claim is not on the MassHealth provider file. Contact MassHealth Customer Services Provider Enrollment.
386	The NDC entered on the claim is not on file on the date filled.
387	This claim requires review.
388	This claim requires review.
389	This claim requires review.
390	The number of noncovered days entered on the claim is invalid.
391	MassHealth use only
392	This claim requires review.
393	This claim requires review.
394	This claim requires review.
395	This claim requires review.
396	This claim requires review.
397	This claim requires review.
398	This claim requires review.
399	The diagnosis code entered on the claim is invalid on the date of service entered on the claim.
400	The diagnosis code is either missing or invalid.
401	The diagnosis code entered on the claim is not on file.
402	The diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
403	The diagnosis code entered on the claim is not covered by MassHealth for members of this age.

Code	Description
404	The diagnosis code entered on the claim is not covered by MassHealth.
405	MassHealth use only
406	MassHealth use only
407	The diagnosis code entered on the claim conflicts with the procedure code entered on the claim.
408	The diagnosis code entered on the claim must be more specific.
409	The ProDUR therapeutic overlap conflict code is severity 1. The same provider number and the same prescriber number exist among the previous and current claims.
410	The primary diagnosis code is either missing or invalid.
411	The primary diagnosis code entered on the claim is not on file.
412	The primary diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
413	The primary diagnosis code entered on the claim is not covered by MassHealth for members of this age.
414	The primary diagnosis code entered on the claim is not covered by MassHealth.
415	MassHealth use only
416	The primary diagnosis code entered on the claim requires review.
417	The primary diagnosis code entered on the claim is invalid on the date of service entered on the claim.
418	MassHealth use only
420	The second diagnosis code entered on the claim is invalid.
421	The second diagnosis code entered on the claim is not on file.
422	The second diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
423	The second diagnosis code entered on the claim is not covered by MassHealth for members of this age.
424	MassHealth use only
425	MassHealth use only
426	The second diagnosis code entered on the claim requires review.
427	The second diagnosis code entered on the claim is invalid on the date of service entered on the claim.
428	MassHealth use only
429	The ProDUR therapeutic overlap conflict code is severity 1. The same provider number and the same prescriber number exist among the previous and current claims.
430	The third diagnosis code entered on the claim is invalid.
431	The third diagnosis code entered on the claim is not on file.

Code	Description
432	The third diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
433	The third diagnosis code entered on the claim is not covered by MassHealth for members of this age.
434	MassHealth use only
435	MassHealth use only
436	The third diagnosis code entered on the claim requires review.
437	The third diagnosis code entered on the claim is invalid on the date of service entered on the claim.
438	MassHealth use only
440	The fourth diagnosis code entered on the claim is invalid.
441	The fourth diagnosis code entered on the claim is not on file.
442	The fourth diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
443	The fourth diagnosis code entered on the claim is not covered by MassHealth for members of this age.
444	MassHealth use only
445	MassHealth use only
446	The fourth diagnosis code entered on the claim requires review.
447	The fourth diagnosis code entered on the claim is invalid on the date of service entered on the claim.
448	MassHealth use only
449	The level-of-service code is either missing or invalid.
450	The fifth diagnosis code entered on the claim is invalid.
451	The fifth diagnosis code entered on the claim is not on file.
452	The fifth diagnosis code entered on the claim is not covered by MassHealth for members of this gender.
453	The fifth diagnosis code entered on the claim is not covered by MassHealth for members of this age.
454	MassHealth use only
455	MassHealth use only
456	This fifth diagnosis code entered on the claim requires review.
457	The fifth diagnosis code entered on the claim is invalid on the date of service entered on the claim.
458	MassHealth use only

Code	Description
459	The revenue code entered on the claim is not the revenue code listed under the prior-authorization number entered on the claim.
460	The revenue code units are missing.
461	The HCPCS laboratory procedure code is missing. The revenue code entered on the claim requires a HCPCS laboratory procedure code be entered on the claim.
462	The procedure code entered on the claim is not required.
463	The revenue code entered on the claim conflicts with the procedure code entered on the claim.
464	The units of service are missing.
465	MassHealth use only
466	MassHealth use only
467	The revenue code entered on the claim is incorrect for the service entered on the claim.
468	The revenue code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
469	The revenue code entered on the claim was not covered by MassHealth for this coverage type on the date of service entered on the claim.
470	The revenue code entered on the claim was not covered by MassHealth for this coverage type on the date of service entered on the claim.
471	The revenue code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
472	The revenue code entered on the claim was not covered by MassHealth for this coverage type on the date of service entered on the claim.
473	The revenue code entered on the claim was not covered by MassHealth for this coverage type on the date of service entered on the claim.
474	Revenue codes 360-369 entered on the claim are not covered by MassHealth on the same date of service entered on the claim when billed with revenue codes 490-499.
475	The revenue code entered on the claim is not on file for the date of service entered on the claim.
476	The revenue code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
477	The revenue code pricing entered on the claim requires review.
478	The revenue code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
479	The revenue code entered on the claim does not have a rate on file.
480	The revenue code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
481	Enter the procedure code description on the claim when billing an unlisted procedure code.
482	Pharmacy claims must be billed through POPS.

Code	Description
483	The claim must be billed as mental health/substance abuse only. Bill the MassHealth Behavioral Health Partnership.
484	The member's coverage type is buy in/subsidy only.
485	MassHealth use only
486	The procedure code entered on the claim is not covered for members enrolled in this coverage type. The member is enrolled in MassHealth Basic.
487	The procedure code entered on the claim is not covered for the member's coverage type.
488	The procedure code entered on the claim is not covered for members enrolled in this coverage type. The member is enrolled in MassHealth Limited.
489	The procedure code entered on the claim is not covered for members enrolled in this coverage type. The member is enrolled in MassHealth Family Assistance.
490	The EOB requires review.
491	The EOB requires review.
492	The EONMB requires review.
493	The Utilization Review letter is incomplete.
494	The services entered on the claim contain a combination of Medicare Parts A and B charges. This claim must be split-billed according to crossover claim guidelines.
495	The EOB requires review.
496	The documentation requires review.
497	The EOB requires review.
498	The EOB requires review.
499	The EOB requires review.
500	MassHealth use only
501	MassHealth use only
502	The prescription origin is either invalid or conflicts with other prescription information. Correct the prescription origin entered on the POPS transaction.
503	The EOB requires review.
504	This adjustment claim requires review.
505	MassHealth use only
506	The first TPL carrier code entered on the claim is invalid.
507	MassHealth use only
508	MassHealth use only
509	The former TCN entered on the resubmittal claim is invalid. Correct the former TCN entered on the resubmittal claim.
510	MassHealth use only

Code	Description
511	This claim requires review.
512	The former TCN entered on the resubmittal claim is invalid.
513	The former TCN entered on the resubmittal claim is invalid. The original claim submission was received for processing more than 90 days after the billing deadline. You may request a 90-day waiver.
514	MassHealth use only
515	The resubmittal entry entered on the claim requires a former TCN be entered on the claim.
516	The member has other health insurance.
517	Attachment carrier code conflict.
518	MassHealth use only
519	This returned-money or void transaction requires review.
520	This claim has been denied after medical review.
521	The from date of service is either missing or invalid.
522	The member identification number entered on the claim is ineligible on the date of service entered on the claim. Verify the RID number through REVS.
523	The member identification number entered on the claim is not on the eligibility file. Verify the RID number/eligibility through REVS.
524	This claim requires review.
525	MassHealth use only
526	MassHealth use only
527	MassHealth use only
528	The EOB is missing. The claim requires that an EOB is attached or the claim may be billed electronically using the COB transaction.
529	MassHealth use only
530	The NDC entered on the POPS transaction is incomplete. Correct the NDC entered on the POPS transaction.
531	The supplier's invoice is missing. The procedure code entered on the claim requires a supplier's invoice.
532	The acquisition cost is missing.
533	The interim bills are not payable by MassHealth.
534	The discharge bills are not payable by MassHealth.
535	MassHealth use only
536	The managed care referral number entered on the claim does not match the member's PCC entered on the claim, or the managed care referral number entered on the claim is invalid.
537	The managed care referral number is missing.

Code	Description
538	The time of admission entered on the claim indicates that the referral number entered on the claim is invalid when the urgent-care referral number is entered on the claim.
539	The mental-health or substance-abuse treatment service entered on the claim must be billed to the Massachusetts Behavioral Health Partnership.
540	The mental-health/substance-abuse services entered on the claim must be billed to the Massachusetts Behavioral Health Partnership. This claim contains both medical and mental-health/substance-abuse services.
541	MassHealth use only
542	The procedure code entered on the claim requires that the place of service indicates the emergency department when the after-hours or no-callback referral number is entered on the claim.
543	This claim requires review. The procedure code entered on the claim requires that an indication of an emergency and place of service indicating the emergency department be entered on the claim.
544	The member has MCO coverage, and therefore, is required to have this service provided by the member's PCC.
545	MassHealth use only
546	MassHealth use only
547	The member has MCO coverage, and therefore, is required to have this service provided by th member's PCC.
548	The member has MCO coverage, was seen in the emergency department, and a screening was provided. Additional inappropriate emergency-department screening services that were provided conflict with the MCO guidelines.
549	The same prescriber and pharmacy DEA numbers are invalid. Correct the prescriber and pharmacy DEA numbers entered on the POPS transaction.
550	The NDC entered on the POPS transaction is not covered by MassHealth for members of this age.
551	The NDC entered on the POPS transaction is not the NDC listed under the prior-authorization number entered on the claim.
552	The days' supply entered on the POPS transaction exceeds the amount allowed by the NDC.
553	The date filled entered on the POPS transaction must be on or after the date the prescription was written.
554	The refill date entered on the POPS transaction is more than six months after the date the prescription was written.
555	The location code entered on the POPS transaction conflicts with the place-of-service requirements of the NDC.
556	The member's gender entered on the POPS transaction conflicts with the gender requirements of the NDC.
557	MassHealth use only

Code	Description
558	The date the prescription was written is either missing or invalid. Correct the date the prescription was written entered on the POPS transaction.
559	The authorized number of refills entered on the POPS transaction exceeds the amount allowed.
560	The member is in a Medical Services Control program that restricts a member to a specific provider for the dispensing of drugs.
561	The prescriber DEA number is either missing or invalid. Correct the prescriber DEA number entered on the POPS transaction.
562	The type of prescription is either missing or invalid. Correct the type of prescription entered on the POPS transaction.
563	The authorized number of refills is either missing or invalid. Correct the authorized number of refills entered on the POPS transaction.
564	The authorized number of refills is either missing or invalid. Correct the authorized number of refills entered on the POPS transaction.
565	The number of refills entered on the POPS transaction exceeds the amount allowed.
566	MassHealth use only
567	Prior authorization is required for the NDC. The NDC entered on the POPS transaction requires that prior authorization be obtained.
568	The prior authorization for the NDC is invalid.
569	The days' supply entered on the POPS transaction is less than the minimum amount allowed of the NDC.
570	The quantity entered on the POPS transaction is less than the minimum amount allowed of the NDC.
571	The quantity entered on the POPS transaction exceeds the amount allowed of the NDC.
572	MassHealth use only
573	The member identification number entered on the claim is ineligible for this coverage type. Verify the RID number/eligibility through REVS.
574	This provider is not authorized by MassHealth to perform the services entered on the claim.
575	The provider number entered on the claim is not on the MassHealth provider file. Contact MassHealth Provider Enrollment.
576	MassHealth use only
577	The processor control number is either missing or invalid. Correct the processor control number entered on the POPS transaction.
578	The prior-authorization number or medical certification code is either missing or invalid. Correct the prior authorization or medical certification code entered on the POPS transaction.
579	MassHealth use only
580	MassHealth use only
581	MassHealth use only

Code	Description
582	MassHealth use only
583	The ProDUR conflict code is either missing or invalid. Correct the ProDUR conflict code entered on the POPS transaction.
584	The ProDUR intervention code is either missing or invalid. Correct the ProDUR intervention code entered on the POPS transaction.
585	The ProDUR outcome code is either missing or invalid. Correct the ProDUR outcome code entered on the POPS transaction.
586	MassHealth use only
587	MassHealth use only
588	MassHealth use only
589	MassHealth use only
590	The procedure code entered on the claim exceeds the amount allowed, unless a prior-authorization number is entered on the claim.
591	The procedure code entered on the claim exceeds the amount allowed.
592	MassHealth use only
593	The procedure code entered on the claim requires review.
594	The procedure code entered on the claim conflicts with services billed on previous and current claims provided on the same date of service entered on the claim.
595	The procedure billed on the claim has been paid on previous or current claims.
596	MassHealth use only
597	The procedure code entered on the claim was previously paid for a new-patient or initial-visit. An established-patient or periodic-patient procedure code must be billed to MassHealth.
598	The procedure codes entered on the claim cannot be billed for the same member, on the same date of service entered on the claim.
599	The ProDUR override code is invalid. Correct the ProDUR override code entered on the POPS transaction.
600	The procedure code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
601	The procedure code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
602	The procedure code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
603	The procedure code entered on the claim is not on file for members enrolled in this coverage type on the date of service entered on the claim.
604	The procedure code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.

Code	Description
605	The service entered on the claim is not payable by MassHealth to municipally-based health services providers.
606	The NDC entered on the POPS transaction was not covered by MassHealth on the date of service entered on the claim.
607	The NDC entered on the POPS transaction was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
608	The NDC entered on the POPS transaction is not covered by MassHealth for members enrolled in this coverage type.
609	The NDC entered on the POPS transaction was not covered by MassHealth on the date of service for members enrolled in this coverage type.
610	The NDC entered on the POPS transaction is not covered by MassHealth for members enrolled in this coverage type.
611	The NDC entered on the POPS transaction was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
612	The NDC entered on the POPS transaction is not covered by MassHealth for members enrolled in this coverage type.
614	Prior authorization is required for anti-ulcer drugs. The NDC entered on the POPS transaction requires that prior authorization be obtained.
615	MassHealth use only
616	Prior authorization is required for Ceradase. The NDC entered on the POPS transaction requires that prior authorization be obtained.
617	Prior authorization is required for Neupogen. The NDC entered on the POPS transaction requires that prior authorization be obtained.
618	Prior authorization is required for Prolast. The NDC entered on the POPS transaction requires that prior authorization be obtained.
619	The primary diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
620	The primary diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
621	The primary diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
622	The primary diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
623	The primary diagnosis code entered on the claim is not covered by MassHealth for members in this coverage type.
624	The primary diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
625	The primary diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.

Code	Description
626	The second diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
627	The second diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
628	The second diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
629	The second diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
630	The second diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
631	The second diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
632	The second diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
633	The third diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
634	The third diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
635	The third diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
636	The third diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
637	The third diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
638	The third diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
639	The third diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
640	The fourth diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
641	The fourth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
642	The fourth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
643	The fourth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
644	The fourth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.

Code	Description
645	The fourth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
646	The fourth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
647	The fifth diagnosis code entered on the claim was not covered by MassHealth on the date of service entered on the claim.
648	The fifth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
649	The fifth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
650	The fifth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
651	The fifth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
652	The fifth diagnosis code entered on the claim was not covered by MassHealth for members enrolled in this coverage type on the date of service entered on the claim.
653	The fifth diagnosis code entered on the claim is not covered by MassHealth for members enrolled in this coverage type.
654	The procedure code modifiers entered on the claim require review.
655	The admission hour is either missing or invalid.
656	This claim requires review.
657	The 90-day waiver request has been denied.
658	MassHealth use only
659	The procedure code modifier entered on the claim does not have a rate on file for the date of service entered on the claim.
660	MassHealth use only
661	The pharmacy dispensing fee entered on the POPS transaction is not on file for the date of service entered on the claim.
662	The mileage service entered on the claim does not have a rate on file for the date of service entered on the claim.
663	MassHealth use only
664	Prior authorization is required for Pulmozym. The NDC entered on the POPS transaction requires that prior authorization be obtained.
665	MassHealth use only
666	Prior authorization is required for immunity drugs. The NDC entered on the POPS transaction requires that prior authorization be obtained.
667	The NDC entered on the POPS transaction requires prior authorization.

Code	Description
668	MassHealth use only
668	Prior authorization is required for antihistamines. The NDC entered on the POPS transaction requires that prior authorization be obtained.
669	The NDC billed on the claim requires review.
670	Prior authorization is required for immunity drugs. The NDC entered on the POPS transaction requires that prior authorization be obtained.
671	Prior authorization is required for this prescription. The NDC entered on the POPS transaction requires that prior authorization be obtained.
673	The number of MLOA days are missing.
674	The from and to dates of service entered on the claim conflict as the member is coded for in long-term care.
675	The number of MLOA and NMLOA days entered on the claim are not payable by MassHealth for this provider type.
676	The MLOA from and to dates entered on the claim in the first occurrence span months. The claim must be split-billed.
677	The MLOA to date entered on the claim in the first occurrence must be on or after the MLOA from date entered on the claim.
678	The number of MLOA days entered on the claim in the first occurrence conflicts with the from and to dates of service entered on the claim.
679	The NDC entered on the POPS transaction requires prior authorization.
680	The MLOA from and to dates entered on the claim in the first occurrence span months. The claim must be split-billed.
681	The NMLOA to date entered on the claim in the first occurrence must be on or after the NMLOA from date entered on the claim.
682	The number of NMLOA days entered on the claim in the first occurrence conflicts with the from and to dates of service entered on the claim.
683	MassHealth use only
684	The number of MLOA days in the first occurrence is either missing or invalid.
685	The MLOA from date in the first occurrence is either missing or invalid.
686	The MLOA to date in the first occurrence is either missing or invalid.
687	The number of NMLOA days in the first occurrence is either missing or invalid.
688	The NMLOA from date in the first occurrence is either missing or invalid.
689	The NMLOA to date in the first occurrence is either missing or invalid.
690	MassHealth use only
691	The number of MLOA days in the second occurrence is either missing or invalid.
692	The MLOA from date in the second occurrence is either missing or invalid.

Code	Description
693	The MLOA to date in the second occurrence is either missing or invalid.
694	The number of NMLOA days in the second occurrence is either missing or invalid.
695	The NMLOA from date in the second occurrence is either missing or invalid.
696	The NMLOA to date in the second occurrence is either missing or invalid.
697	The number of MLOA days in the third occurrence is either missing or invalid.
698	The MLOA from date in the third occurrence is either missing or invalid.
699	The MLOA to date in the third occurrence is either missing or invalid.
700	The number of NMLOA days in the third occurrence is either missing or invalid.
701	The NMLOA from date in the third occurrence is either missing or invalid.
702	The NMLOA to date in the third occurrence is either missing or invalid.
703	MassHealth use only
704	The number of consecutive MLOA days entered on the claim exceeds the amount allowed.
705	The MLOA from and to dates entered on the claim are invalid.
706	The number of NMLOA days entered on the claim exceeds the amount allowed.
707	The NMLOA from and to dates entered on the claim are invalid.
708	The MLOA and NMLOA from and to dates of service entered on the claim are invalid.
709	The MLOA from and to dates entered on the claim in the second occurrence span months. The claim must be split-billed.
710	The MLOA to date entered on the claim in the second occurrence must be on or after the MLOA from date entered on the claim.
711	The number of MLOA days entered on the claim in the second occurrence conflicts with the from and to dates of service entered on the claim.
712	The number of consecutive NMLOA days entered on the claim exceeds the amount allowed.
713	The NMLOA from and to dates entered on the claim in the second occurrence span months. The claim must be split-billed.
714	The NMLOA to date entered on the claim in the second occurrence must be on or after the NMLOA from date entered on the claim.
715	The number of NMLOA days entered on the claim in the second occurrence conflicts with the from and to dates of service entered on the claim.
716	MassHealth use only
717	The MLOA from and to dates entered on the claim in the third occurrence span months. This claim must be split-billed.
718	The MLOA to date entered on the claim in the third occurrence must be on or after the MLOA from date entered on the claim.
719	The number of MLOA days entered on the claim in the third occurrence conflicts with the from and to dates of service entered on the claim.

Code	Description
720	MassHealth use only
721	The NMLOA from and to dates entered on the claim in the third occurrence span months. This claim must be split-billed.
722	The NMLOA to date entered on the claim in the third occurrence conflicts with the NMLOA from date entered on the claim.
723	The number of NMLOA days entered on the claim in the third occurrence conflicts with the from and to dates of service entered on the claim.
724	MassHealth use only
725	The prescription clarification code is either missing or invalid. Correct the prescription clarification code entered on the POPS transaction.
726	The member is not coded for residence with this long-term-care provider on the dates of service entered on the claim.
727	The member is not coded for long-term care.
728	The level-of-care code entered on the claim is not covered by MassHealth.
729	The patient-paid amount entered on the claim is incorrect.
730	The dates of service, number of days, and patient-status codes entered on the claim conflict.
731	The MLOA from and to dates entered on the claim in the first occurrence conflict with the from and to dates of service entered on the claim.
732	The MLOA from and to dates entered on the claim in the second occurrence conflict with the from and to dates of service entered on the claim.
733	The MLOA from and to dates entered on the claim in the third occurrence conflict with the from and to dates of service entered on the claim.
734	The NMLOA from and to dates entered on the claim in the first occurrence conflict with the from and to dates of service entered on the claim.
735	The NMLOA from and to dates entered on the claim in the second occurrence conflict with the from and to dates of service entered on the claim.
736	The NMLOA from and to dates entered on the claim in the third occurrence conflict with the from and to dates of service entered on the claim.
737	MassHealth use only
738	The member is not coded for residence with this long-term-care provider.
739	The member is not coded for long-term care.
740	The management minutes code is either missing or invalid.
741	The member is not coded for this casemix code. The casemix code refers to the level of functioning for the member.
742	The member is not coded for this casemix code. The casemix code refers to the level of functioning for the member.
743	MassHealth use only

Code	Description
744	MassHealth use only
745	MassHealth use only
747	The usual charge is either missing or invalid. Correct the usual charge entered on the POPS transaction.
748	The total charge is missing.
749	The total charge is required.
750	A referring provider number is required for chiropractor services.
751	The diagnosis code entered on the claim requires review.
752	The HID targeted-drug supply entered on the POPS transaction has reached the emergency amount allowed.
753	The from date of service entered on the claim must be on or after the admission date entered on the claim.
754	The Certification for Payable Abortion form requires review.
755	Certification for Payable Abortion form missing. The procedure code entered on the claim requires a Certification for Payable Abortion form.
756	The Certification for Payable Abortion form is incomplete.
757	The Certification for Payable Abortion form is not completed in accordance with state and federal regulations.
758	The Medical Necessity form is incomplete.
759	MassHealth use only
760	The MLOA and/or NMLOA entered on the claim is invalid for long-term-care contractual providers.
761	Long-term-care contractual providers are not casemix providers.
765	The pay-to provider number entered on the claim is not a group provider number.
766	The member is restricted to a case-management program.
767	The servicing provider entered on the claim is not a member of the group practice as indicated by the pay-to provider number entered on the claim.
768	MassHealth use only
769	The number of days entered on the claim conflicts with the units of service entered on the claim.
770	The days or units entered on the claim exceed the amount allowed for the procedure code entered on the claim.
771	The prior-authorization number entered on the claim was denied.
772	The procedure code modifier entered on the claim is invalid for the procedure code entered on the claim.
773	This claim requires review.

Code	Description
774	The anesthesia units entered on the claim exceed the amount allowed for the procedure code entered on the claim.
775	The procedure code entered on the claim requires review.
776	The percentage-of-charge rate entered on the claim is not on file.
777	The date of service entered on the claim must precede the expiration date of the prior-authorization number entered.
778	The prior-authorization number entered on the claim is not on file.
779	The primary diagnosis code entered on the claim is not valid as a primary diagnosis code.
780	Second Surgical Opinion letter missing. The procedure code entered on the claim requires a Second Surgical Opinion letter.
781	The Second Surgical Opinion letter does not meet State regulations.
782	The incentive days entered on the claim conflict with the incentive days on file.
783	The incentive rate entered on the claim conflicts with the incentive rate on file.
784	MassHealth use only
785	MassHealth use only
786	MassHealth use only
787	MassHealth use only
788	MassHealth use only
789	MassHealth use only
790	MassHealth use only
791	MassHealth use only
792	MassHealth use only
793	MassHealth use only
794	MassHealth use only
795	MassHealth use only
796	MassHealth use only
797	MassHealth use only
798	MassHealth use only
799	MassHealth use only
800	MassHealth use only
801	The location code is either missing or invalid. Correct the location code entered on the POPS transaction.
802	The Medical Necessity form requires review.
803	MassHealth use only

Code	Description
804	The number of miles is missing.
805	MassHealth use only
806	MassHealth use only
807	The time of service is either missing or invalid.
808	The number of minutes of waiting time is missing.
809	The number of minutes of waiting time entered on the claim is not payable by MassHealth if the number of miles entered on the claim is less than 40.
810	The servicing provider entered on the claim is ineligible on the date of service entered on the claim.
811	The servicing provider entered on the claim requires review.
812	The diagnosis code entered on the claim requires review.
813	The procedure code entered on the claim requires review.
814	The procedure code entered on the claim is not covered by MassHealth for surgical assistant services.
815	MassHealth use only
816	The immunization status box must be checked on this MassHealth claim form.
817	The clinical evaluation box must be checked on this MassHealth claim form.
818	The clinical evaluation box indicates a need for further diagnosis or treatment, but the results boxes are blank or the results boxes are complete, but the clinical evaluation box does not indicate a need for further diagnosis or treatment.
819	The referral information is missing.
820	The assessment status box must be checked on this MassHealth claim form.
821	The assessment status entry entered on the claim indicates every test or screening required under the EPSDT protocol was performed, but the procedure code modifier is for an incomplete assessment or the assessment status box indicates that every test or screening was not performed, but the procedure code modifier is for an initial or complete assessment.
822	This claim requires review.
823	This claim must indicate whether any test results are still unknown after 30 days.
824	This claim indicates that test results are unknown after 30 days, but the claim was billed less than 30 days from the date of service entered on the claim.
825	The patient status-code indicator entered on the claim is invalid.
826	The member entered on the claim does not have MCO coverage.
827	There is a conflict between the HMO provider and member.
828	The premium amount is either missing or invalid.

Code	Description
831	One of the following conditions exists. (1) The claim with one or more possible Medicare Part B-covered items was paid with an override. The pharmacy should submit the claim to Medicare and rebill within 90 days, if override Other Coverage 4 was used. (2) The claim with one or more possible Medicare Part B-covered items was paid as the primary insurance, since the payment amount is not over $5.
832	MassHealth use only
833	MassHealth use only
834	MassHealth use only
835	The member has Medicare Part D benefits, which limits MassHealth benefits.
836	One of the following conditions exists. (1) The submitted copayment amount (gross amount due) for the Medicare Part D copayment exceeds the $5 limit. (2) Patients in long-term-care are not subject to a copayment. The claim was submitted for a member enrolled in long term care.
837	This claim was denied because it exceeded the 36-month deadline from the date of service entered on the claim.
840	The member has Medicare Part D eligibility and one of the following conditions exists. (1) The MassHealth wrap provisions have been exceeded (that is, the member has already received two or more fills for a given drug). (2) The claim for services during the Medicare Part D wrap period was denied because the limits were exceeded for the first claim (that is, the supply is greater than 30 days). (3) The claim for services during the Medicare Part D wrap period was denied because limits were exceeded for the second claim (that is, the supply is greater than three days).
841	MassHealth use only
842	MassHealth use only
845	This claim requires review.
847	This claim must be submitted on paper to MassHealth.
849	The TPL procedure code entered on the claim is not on file on the date of service entered on the claim.
850	The procedure code modifier entered on the claim requires a servicing provider number be entered on the claim.
851	The procedure code entered on the claim does not have a rate on file.
852	The anesthesia units are not on file on the date of service entered on the claim.
853	The premium type entered on the claim conflicts with the premium type on file.
854	The premium type entered on the claim is not on file.
855	The premium type entered on the claim is invalid.
856	Services must be billed on a daily basis.
857	Services must be billed on a monthly basis.
858	The MCO payment method must be included in the support table.

Code	Description
859	MassHealth use only
860	This claim requires review.
861	The admission date entered on the claim must be on or after the application date entered on the claim.
862	The 837 replacement claim was submitted without a void transaction.
871	The procedure code entered on the claim requires a quadrant designation be entered on the claim.
872	The procedure code entered on the claim conflicts with the tooth number entered on the claim.
873	The tooth number is either missing or invalid.
874	The tooth-surface code is either missing or invalid.
875	The procedure code entered on the claim requires a tooth number be entered on the claim.
876	The procedure code entered on the claim requires a tooth-surface code be entered on the claim.
877	The tooth number entered on the claim conflicts with the tooth-surface code entered on the claim.
878	The tooth number or tooth-surface code entered on the claim is not covered by MassHealth for the procedure code entered on the claim.
879	The procedure code entered on the claim conflicts with the quadrant designation entered on the claim.
880	The tooth number entered on the claim is invalid for the procedure code entered on the claim.
881	The tooth-surface code entered on the claim is invalid for the procedure code entered on the claim.
884	This claim has been denied for medical necessity.
885	This claim is either considered a duplicate or is a submission error.
886	The medical records are missing. The procedure code entered on the claim requires the medical records.
887	The medical record is incomplete.
888	The final billing deadline has been exceeded.
889	The fiscal year for the date of service entered on the claim is closed.
890	Invalid procedure code for Line A.
891	The EPSDT-assessment procedure code must be billed on line A of this claim form.
892	The procedure code entered on the claim requires a modifier when billed with the place-of-service code entered on the claim.
893	The procedure code entered on the claim requires that the name and provider number of the referring provider be entered on the claim.
894	MassHealth use only
895	The procedure code entered on the claim does not have a rate on file.

Code	Description
896	The health plan coverage is under review.
897	The explanation of benefits (EOB) attachment requires further review for the billing deadline.
898	This claim requires review.
899	The date of service entered on the claim must be on or after the MMIS claims processing date entered on the claim.
900	The pay-to provider number entered on the claim is a billing agency.
901	The NDC file must indicate a standard package size for this item.
902	The provider must have the appropriate specialty code on file to be paid by MassHealth for this drug entered on the POPS transaction.
903	The authorized drug quantity for the NDC on the prior-authorization record has been exhausted.
904	The authorized drug quantity for the NDC on the prior-authorization record has been partially exhausted.
905	No refills are authorized for Schedule II drugs.
906	The prescription type entered on the POPS transaction conflicts with DEA service restrictions entered on the POPS transaction.
907	The prescription type entered on the POPS transaction conflicts with the days supply entered on the POPS transaction.
908	MassHealth use only
909	The NDC file must include a MAC price for this NDC.
910	A temporary recipient identification (RID) number is assigned to this member.
911	The authorized units for the procedure code on the prior-authorization record have been partially exhausted.
912	The number of units entered on the claim conflicts with the number of units authorized on the prior-authorization record.
913	The claim requires review.
914	The prior-authorization transaction entered on the claim requires review.
915	The prior-authorization transaction entered on the claim has been deleted.
916	MassHealth use only
917	MassHealth use only
918	MassHealth use only
919	This claim requires prepayment review.
920	MassHealth use only
921	A temporary recipient identification (RID) number is assigned to this member.
922	This claim requires prepayment review.

Code	Description
923	The claim has been denied after prepayment review by MassHealth.
924	The procedure code entered on the claim must be billed on a MassHealth claim form.
925	The prior-authorization number is missing.
926	MassHealth use only
927	The waiting time entered on the claim is not payable by MassHealth if the round-trip mileage entered on the claim is less than 40.
928	The transportation service entered on the claim requires review.
929	The emergency ambulance services waiting time entered on the claim must exceed 60 minutes.
930	The value code (spend down rate) entered on the claim is invalid.
931	The value code (spend down rate) entered on the claim must be a numeric value.
932	The value code (spend down rate) is invalid for the rate on file.
933	MassHealth use only
934	The NDC entered on the POPS transaction is not on file for the date of service entered on the claim.
935	MassHealth use only
936	The type of bill is either missing or invalid.
937	The number of covered days entered on the claim conflicts with the service units entered on the claim.
938	A revenue code entered on the claim is not on file for the date of service entered on the claim.
939	The provider rate is either missing or invalid.
940	One or more of the revenue codes entered on the claim are not covered by MassHealth.
941	The member's age on the date of service entered on the claim conflicts with the age requirements of the revenue code entered on the claim.
942	The member's gender conflicts with the gender requirements of the revenue code entered on the claim.
943	The revenue code is either missing or invalid.
944	The revenue code entered on the claim conflicts with the rate identification on file.
945	The Second Surgical Opinion letter requires review.
946	The claim tranaction control number is invalid.
947	The claim assignment indicator is invalid.
948	The claim does not indicate if the Medicare payment was Part A or B.
949	The service units entered on the claim must be a numeric value.
950	The EOB does not match the information on file.
951	The Medicare type of service code must be entered in item 24C of the HCFA-1500 claim form.

Code	Description
952	The amount billed to Medicare entered on the claim must be a numeric value.
953	The amount Medicare allowed entered on the claim must be a numeric value.
954	The amount Medicare paid entered on the claim must be a numeric value.
955	The amount billed to Medicare entered on the claim must be a numeric value.
956	The amount Medicare allowed entered on the claim must be a numeric value.
957	The amount Medicare paid entered on the claim must be a numeric value.
958	The Medicare amounts billed, allowed, and paid entered on the claim conflict.
959	The Medicare amounts billed, allowed, and paid entered on the claim conflict.
960	A copy of the original Medicare claim must be submitted with the Medicare EOMB.
961	MassHealth use only
962	The Medicare EOB must be submitted.
963	The rate identification code entered on the claim conflicts with the admission date entered on the claim.
964	The rate identification code entered on the claim conflicts with the treatment authorization code entered on the claim.
965	MassHealth use only
966	The dates of service entered on the claim must be within the approval range.
967	MassHealth use only
968	This claim has already been reversed.
969	The preoperative days were denied during preadmission screening.
970	The preadmission screening number is missing.
971	The preadmission screening number entered on the claim is either invalid or not on file.
972	The preadmission screening number entered on the claim conflicts with the preadmission screening record.
973	MassPRO has determined that the principal procedure code entered on the claim must be performed in another setting.
974	The member identification number entered on the claim conflicts with the member identification number on the preadmission screening record. Verify the RID number through REVS.
975	The admission date entered on the claim conflicts with the admission date on the preadmission screening record.
976	The pay-to provider number entered on the claim conflicts with the provider number on the preadmission screening record.
977	The admission date entered on the claim was denied during utilization review.
978	MassHealth use only

Code	Description
979	The preadmission screening number entered on the claim is inactive on the dates of service entered on the claim.
980	MassHealth use only
981	The EOB requires TPL review.
982	The EOB does not match the information on the claim.
983	The member is enrolled in an MCO plan and the service provided is covered by the MCO.
984	This medical service entered on the claim is covered by the CommonHealth program, which is the member's MCO plan.
985	The service entered on the claim is not covered by the member's CommonHealth program.
986	The out-of-state medical services entered on the claim are not covered by the CommonHealth program, except in the case of emergency.
987	The out-of-state medical services entered on the claim are not covered by the CommonHealth program, except in the case of emergency.
988	This adjustment claim requires review.
989	Because this member has changed benefit programs, your adjustment request has been denied. In order to process your claim correctly, the original paid claim must be voided and a new claim submitted for processing under the new benefit program.
990	The from and through dates of service entered on the claim conflict with member eligibility dates. Verify the RID number/eligibility through REVS.
991	MassHealth use only
992	MassHealth use only
993	The date of service entered on the claim must be on or after the date MassHealth became responsible for MCB claims.
994	The member is a Qualified Medicare Beneficiary and is covered for Medicare coinsurance and deductible claims only.
995	The claim to be reversed has been denied. Please confirm the TCN entered on the claim and other relevant data before attempting another reversal.
996	The type of service is either missing or invalid. This claim is for Medicare Part A.
997	The claim to be reversed cannot be located on the system. Please confirm the TCN entered on the claim and other relevant data before attempting another reversal.
998	Because this member's aid category has changed, your adjustment request has been denied. In order to process your claim correctly, the original paid claim must be voided and a new claim submitted for processing under the new benefit program.
999	This adjustment claim is unknown and does not match the former TCN.

This page is reserved.

Part 7. Claim Status and Claim Correction

The status of nonpharmacy claims processed by MassHealth can be shown through the Recipient Eligibility Verification System (REVS) or on a paper remittance advice (RA). The fastest way to check claim status is through REVS.

The Claim Status subsystem within REVS allows you to verify the status of a claim submitted to MassHealth for services provided. This is conducted through the HIPAA transaction sets 276/277. Please refer to the appropriate REVS user guide on the Web at www.massrevs.eds.com for more information. Contact information for the REVS HelpDesk is found in Appendix A of your MassHealth provider manual.

For information about checking the status and correcting claims for retail pharmacy claims, refer to the *POPS Billing Guide*.

Correcting Claims

If a claim needs to be corrected, the method depends upon the status shown in REVS or the most current paper RA or electronic 835 RA. Review the following instructions before attempting to correct claims. Separate instructions are given for how to correct electronic claims and paper claims.

Please Note: References to "RA" refer to both the electronic 835 remittance advice transaction and the actual paper remittance advice, unless otherwise stated.

Suspended Claims

A suspended claim appears on an RA for information only. Claims are suspended for various reasons, such as for medical review or review of required documentation. Note in your records that the claim was received by MassHealth, so that it is not rebilled. You can track suspended claims by the transaction control number (TCN), since it will remain the same throughout the processing cycle. The claim will appear on a later RA as either paid, pending, or denied. Suspended claims require no action. Do not attempt to correct or rebill a suspended claim.

Denied Claims

Rebilling Denied Claims

When a claim is listed on the RA as denied, it has reached its final disposition. Review the error code(s) on the RA to determine the reason for denial. Refer to Part 6 of these administrative and billing instructions for an explanation of the error codes.

If the reason for the denial is correctable, follow one of the procedures described below.

- If the corrected claim will be received for processing within 90 days from the date of service, or from the date on an explanation of benefits (EOB) from another insurer, enter the corrected or new information on a new claim form, or follow the corresponding electronic claim specifications, and complete all required items. A clear, readable photocopy of the original paper claim form may be submitted. Send the claim and any required attachments to MassHealth as a new claim.

- If the corrected claim will be received for processing after 90 days from the date of service, or from the date on an EOB, but within 12 months from the date of service (18 months when an EOB is attached to the claim), you can submit it as a "new" claim unless one or more of the following conditions are present:
  - you are correcting the provider number;
  - you are correcting the member number;
  - you are correcting the date of service; or
  - you are correcting the service code and/or modifier.

Resubmitting a Corrected Claim

If you are correcting the date of service or the service code and/or modifier, follow the resubmittal procedures below.

For Electronic Claims

For instructions on how to address and correct claims submitted electronically using the void and replace transaction, review the applicable MassHealth companion guide for detailed loop/segment information.

For Paper Claims

Follow the instructions below. **Please Note:** A denied claim requiring a correction to the pay-to-provider Number, the member identification number (RID), or the invoice type cannot be resubmitted. If the corrected claim will be received by MassHealth within 90 days from the date of service, send it back as an original claim. If the corrected claim will be received by MassHealth more than 90 days after the to date of service or the EOB date, you may request a 90-day waiver (see page 5.7-4).

1. Resubmit only one claim line per claim form. Use a new claim form and enter the corrected or new information, or use a legible photocopy of the original claim and cross out all other claim lines.

   Exception: Inpatient hospital claims billed on the UB-92 must be resubmitted as an entire claim. (Outpatient claims are resubmitted one line per claim form.)

2. Enter an “X” in the Resubmittal box at the bottom of the claim.

   Exception: For claims submitted on the UB-92, enter "R" in Item 37 on Line A.

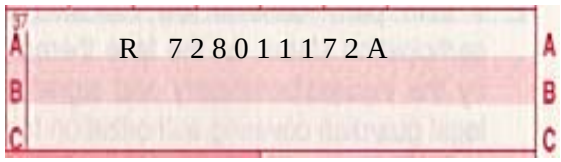
   Exception: For dental claims submitted on the ADA Claim Form, enter "R" in Field 35, Remarks.

3. Enter the 10-character TCN of the denied claim in the Former Transaction Control Number field at the bottom of the claim. The TCN is found on the RA where the claim was originally denied.

   Example: The following is an example of how to complete resubmittal information on a claim.

   Exception: For claims resubmitted on the UB-92, enter the original TCN from the denied claim following the “R” in Item 37 on Line A.

   Example: The following is an example is how to complete resubmittal information on a UB-92.



   Exception: For dental claims filed on the ADA Claim Form, use the Remarks section of the form. Enter the original TCN following “R” in Field 35. Justify all information to the left, and begin text immediately following the word “Remarks.”

   For all claims, including those submitted on the UB92 and the ADA Claim Form, that have been submitted several times, always enter the TCN of the original submission.

4. Attach any documentation that was included with your original submission and any additional documentation that may now be required to correct the claim.

5. Mail the completed form along with any required supporting documentation to the appropriate address listed in Appendix A of your MassHealth provider manual.

Requesting a 90-Day Waiver

You may request a 90-day waiver when you have exceeded 90 days from the service date or the date on an EOB from another insurer, the claim has never been listed on an RA in a paid status, and you meet one or more of the following conditions:

- you are correcting the member ID number;
- you are correcting the pay to provider number;
- you are changing the invoice (claim form) type; or
- you are billing the claim for the first time, and meet the criteria outlined in MassHealth regulations at 130 CMR 450.309 through 450.314. This includes retroactive member eligibility or provider eligibility.

If your claim meets the requirements for requesting a 90-day waiver, follow the steps below.

1. Prepare a new paper claim form. (All 90-day-waiver requests must be submitted on paper.)
2. Attach a copy of any RA where the claim has appeared, if applicable.
3. Attach any other supporting documentation, such as copies of self-pay notices.
4. Attach a cover letter stating the reason for the waiver request.
5. Do not enter resubmittal or adjustment information and do not enter a former TCN.
6. Mail the information to the address for 90-day waivers listed in Appendix A of your MassHealth provider manual.

The following circumstances do ***not*** require a 90-day waiver:

- claims that will be received within 90 days from the date on a third-party payer's EOB; or
- claims that can be resubmitted according to the instructions beginning on page 5.7-1, or claims that can be adjusted according to the instructions beginning below.

Paid Claims

Adjusting Claims

To correct or add information to a previously paid claim, submit an adjustment. An incorrect pay-to provider number or member ID number cannot be corrected by an adjustment. To correct these items, request a void according to the instructions for overpayments beginning on page 5.7-4 and submit a new claim using the correct pay to provider number or member ID. If necessary, request a 90-day waiver when submitting the corrected claim.

For Electronic Claims

Electronic claims may be adjusted by submitting void and replacement transactions. Consult the Provider Library at www.mass.gov/masshealth for the applicable MassHealth companion guide that details loop/segment information.

For Paper Claims

To correct information on paid *paper* claims, follow the adjustment procedures below.

1. Adjust only one claim line per claim form. Use a new claim form and enter the corrected or new information, or use a legible photocopy of the original claim and cross out all other claim lines.

   Exception: Inpatient hospital claims billed on the UB92 must be adjusted as an entire claim. (Outpatient claims are adjusted one line per claim form.)

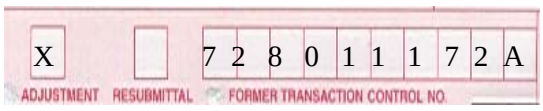
2. Enter an "X" in the Adjustment box at the bottom of the claim.

   Exception: For claims billed on the UB92, enter "A" in Item 37 on Line A.

   Exception: For dental claims submitted on the ADA Claim Form, enter “A” in Field 35, Remarks.

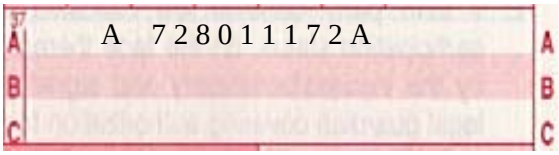
3. Enter the 10-character TCN of the paid claim in the Former Transaction Control Number field at the bottom of the claim. The TCN is found on the most recent RA where the claim appeared as paid or adjusted.

   Example: The following is an example of how to complete adjustment information on a claim.



Exception: For claims adjusted on the UB-92, enter the TCN from the most recent RA showing the claim as "PAID" or "CRADJ" (adjusted) following the "A" in Item 37 on line A.

Example: The following is an example of how to complete adjustment information on a UB-92.



Exception: For dental claims filed on the ADA 2002 or 2004 Claim Form, use the Remarks section of the form. Enter the TCN from the most recent RA showing the claim as "PAID" or "CRADJ" (adjusted) following the "A" for adjustment in Field 35. Justify all information to the left, and begin text immediately following the word "Remarks."

4. Do not subtract the original payment from your usual charge, and do not enter it in the Other Paid Amount column. (The claims processing system will perform the necessary calculation.)

5. Attach only documentation that was required with the original submission, if applicable.

6. Mail the completed form along with any required supporting documentation to the appropriate address listed in Appendix A of your MassHealth provider manual.

Voiding Claims

If you receive an overpayment that cannot be corrected by adjusting the claim, you must request that the payment be voided. If all payments on a particular RA need to be refunded to MassHealth, do not return the original check received from the State Comptroller's office. Instead, deposit the check and follow the void procedures outlined below.

Void requests are applicable when the full payment must be returned. The following are some common reasons for requesting a void:

- Payment was made to the wrong provider.
- Payment was made for the wrong member.
- Payment was made for overstated services.
- Payment for services was made in full by other third-party payers.

For Electronic Claims

For electronic claims, you can either:

- identify the claim(s) to be voided on a printout of the electronic 835 RA and attach a signed letter authorizing the void transaction(s); or
- fill out the Void Request form that is available for download from our Web site at www.mass.gov/masshealthpubs. No letter is necessary with this option. Send the RA printout and the Void Request form or signed letter to the appropriate address listed in Appendix A of this provider manual.

For Paper Claims

For paper claims, circle the claim line(s) to be voided on a photocopy of the RA and send the photocopy, as well as a signed letter or Void Request Form authorizing the void transaction(s), to the appropriate address listed in Appendix A of your MassHealth provider manual.

After the void request has been processed, the void transaction(s) will appear on a RA. The total amount originally paid will appear as a negative amount owed to MassHealth and will be deducted from subsequent payments until the full amount is recouped by MassHealth.

Requesting an Administrative Appeal

A claim received more than 12 months after the date of service (up to 18 months for those involving a third-party insurer and not more than 36 months when Medicare is the primary payer) will be denied. It may, however, be submitted for consideration as an administrative appeal when the criteria below are met. Note that a claim submitted after 36 months from the date of service cannot be appealed.

Criteria for Filing an Administrative Appeal

The provider must meet all of the following criteria.

- The claim must have received error code 888 (“The final billing deadline has been exceeded”) and the appeal must be filed within 30 days of the date on that RA.
- The claim must, as a result of a MassHealth error, have been denied or underpaid.
- You must have exhausted all available correction procedures outlined in these administrative and billing instructions, before the final deadline.
- You must have originally submitted the claim in a timely manner.

Accompanying Documentation

You must submit the following documentation with each claim for which you are requesting an administrative appeal:

- a statement that describes the MassHealth error that resulted in the denial or underpayment of the claim;
- a copy of each RA on which the claim has appeared, including the one on which the claim was denied with error code 888;
- any other documentation supporting your claim; and
- a legible and accurately completed paper claim form.

Requests for administrative appeals should be sent to the appropriate address listed in Appendix A of your MassHealth provider manual.

Assistance

If, after reviewing these administrative and billing instructions and applicable RAs, you still have questions about your MassHealth claims, you should contact MassHealth Customer Service. This department is available to respond to your written and telephone inquiries about claims that have not been processed correctly.

To inquire by telephone about a claim, call the MassHealth Customer Service number listed in Appendix A of your MassHealth provider manual.

- To inquire in writing about a claim, submit a cover letter describing the history of the claim, along with the following documentation to the appropriate address listed in Appendix A of your MassHealth provider manual:
  - a copy of the original claim;
  - a copy of each RA that pertains to the claim(s) in question; and
  - any other attachments that were required for the original submission, if necessary.

Part 8. 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. To determine if a member has other insurance, you must, among other things, follow the instructions for the Recipient Eligibility Verification System (REVS) in Part 1 of these administrative and billing instructions. MassHealth regulations at 130 CMR 450.316 require 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 possible 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 REVS 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. 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. For general information about submitting the claim to MassHealth, see Part 3 of these administrative and billing instructions.

If REVS indicates that the member is enrolled with a MassHealth managed care organization (MCO), you must obtain authorization from the MCO for any services that are covered by the MCO before providing services. Unauthorized services that are denied by the MCO will not be paid by MassHealth.

For Electronic Claims

Submit the claim according to the HIPAA 837 Coordination of Benefits (COB) requirements. Include all applicable information about the other insurance in the transaction, including payments, noncovered charges, copayments, and deductibles, 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 on Provider Library.

For Paper Claims

Follow the instructions below.

1. Attach to the claim form a photocopy of the other insurance carrier's notice of final disposition. The dates of service, provider name, and patient's name on the notice of disposition must correspond to the information on the MassHealth claim form.

2. If the carrier's notice of final disposition, explanation of benefits (EOB), notice of rejection, or some other explanation on the carrier's letterhead does not itemize payment for each service provided or reduces payment by a nonitemized deductible amount, estimate the portion of the total benefit amount that was paid for each service on that notice.

3. Enter in the Other Paid Amount field of the MassHealth claim form the amount that was paid by the other insurance carrier for each service. The other paid amount must include the contractual adjustment from the commercial carrier. The total for all the lines in the Other Paid Amount fields must equal the total benefit amount on the notice of final disposition, including the contractual amount.

   Exception: For services billed on the UB92 claim form to MassHealth, enter the total amount paid by the other insurance in Item 54.

   Exception: For dental services billed on the ADA Claim Form, check the Yes box in Field 4 of the ADA Claim Form. Ensure that the payments on the EOB are itemized. If payment is not itemized by the insurer, annotate the EOB to reflect the estimated portion of the total benefit amount that was paid for each service on that notice. Enter the total amount paid in Field 35 (Remarks) of the ADA Claim Form. This amount must equal to total amount shown on the EOB.

Updating Other Insurance Information

If you are aware that the information shown on REVS about a member's health insurance has changed, send appropriate documentation to MassHealth verifying the coverage change to ensure 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.

When submitting documentation to MassHealth to verify a change in a member's health insurance coverage, complete and submit a Third Party Liability Indicator (TPLI) form to the address listed in Appendix A of your provider manual. This form is available on the Web at www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library, then on MassHealth Provider Forms. Also see Appendix A of your MassHealth provider manual for information about requesting supplies of this form.

Send the TPLI form with appropriate documentation, as stated above, showing the correct information, a cover letter explaining the discrepancy, and any other supporting documentation. Include the 10-character MassHealth member ID number. Until you receive notification from MassHealth that the

member's file has been updated, you must continue to attach a copy of the EOB to all claims submitted for this member.

MassHealth Members Enrolled in Medicare Parts A and B

If the member has Medicare Part A or B, submit the claim to Medicare. If the intermediary is a Massachusetts Medicare fiscal intermediary, and Medicare makes a payment or applies the charge to the deductible, any remaining amounts are automatically forwarded to MassHealth for processing through the crossover claim system. If the intermediary is not a Massachusetts Medicare fiscal intermediary, see Resolving a Medicare/MassHealth Crossover Claim beginning on page 5.8-4 of these instructions. Be sure to enter the 10-character MassHealth member identification number on the Medicare claim in order for the claim to crossover automatically to MassHealth. Your Medicare provider number must also be on file with MassHealth for the claims to crossover automatically to MassHealth.

Crossover Claims

After Medicare has made a payment or applied the charge to the deductible, MassHealth processes its portion of the claim as a crossover claim. For MassHealth-covered services, MassHealth pays the lower of the member deductible and/or coinsurance or the difference between the Medicare payment and the MassHealth allowable amount. The total payment from Medicare and MassHealth will be no greater than the MassHealth-allowable amount. You will receive an Explanation of Medicare Benefits (EOMB) from Medicare and a Medicare/MassHealth crossover remittance advice from MassHealth, indicating the disposition of the claim processed by each agency.

When Service Is Not Covered by Medicare

If the service is not covered by Medicare, the claim will not cross over to MassHealth. However, you may submit a MassHealth claim for your charges after you have received an EOMB indicating that the claim was denied by Medicare. Submit an 837 Coordination of Benefits (COB) electronic claim, or attach a photocopy of the EOMB to the MassHealth paper claim form. For information about completing the appropriate MassHealth paper claim form, see Part 3 of these 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, MassHealth will accept the most recent letter stating that benefits are exhausted, an explanation of benefits (EOB) with the benefits exhausted remark code, or the Medicare notice of noncoverage. MassHealth accepts screen prints of the Common Working Files (CWF) with a cover sheet and drop-down version of the electronic Medicare EOB. Due to variations in the electronic Medicare EOB, MassHealth must review electronic formats to verify that each CWF printout has all necessary information. For those providers whose CWF has not yet been approved, please send claims with a CWF printout to the address listed in the Third Party Liability section of Appendix A.

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

Member Has Medicare and Another 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 carriers.

2. Once you have received an EOB from both carriers, you may submit the claim to MassHealth. MassHealth will not pay for the service unless the service is covered by Medicare, but 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. See Resolving a Medicare/MassHealth Crossover Claim.

3. 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. 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 Part 3 of the administrative and billing instructions. Attach a photocopy of the EOMB indicating that the claim was denied by Medicare and a photocopy of the EOB from the other insurance company to the MassHealth claim form.

Resolving 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.

Submitting Crossover Claims Directly to MassHealth

You may submit a crossover claim directly to MassHealth when:

- 60 days have passed since you received Medicare payment;
- you have received notice that Medicare applied the charge to the deductible, and the claim has not appeared on a MassHealth crossover remittance advice; or
- the member has other insurance in addition to Medicare and MassHealth.

Electronic Claims

You may submit the claim to MassHealth electronically following the requirements for COB billing for the 837 transaction.

Paper Claims

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

1. Submit a separate, legible photocopy of the EOMB for each Medicare claim.
2. On the EOMB, circle the Medicare payment information that you are submitting to MassHealth.
3. Print the 10-character MassHealth member identification (ID) number in the lower-right corner of the EOMB.
4. Your unique Medicare pay-to provider number must be on your MassHealth provider file in order for your claims to process, either electronically or on paper. The Medicare pay-to provider number should not be cut off, crossed out, or written over with a different Medicare provider number. If your Medicare provider number is not on the MassHealth provider file, the claims will not appear on a MassHealth crossover remittance advice. In order to update your Medicare/MassHealth provider file, contact MassHealth Customer Services Enrollment and Credentialing at the appropriate address listed in Appendix A of the MassHealth Provider Manual.

For Medicare B Services

- Attach a legible copy of the original Medicare 1500 claim form or a facsimile of the claim form if you submit claims to the Medicare intermediary electronically. Be sure the Medicare Type of Service (TOS) code is entered in Item 24C of the Medicare 1500 form.
- If the member also has other insurance, attach a copy of the EOB from the other insurer.
- If the claim is for an abortion, sterilization, or hysterectomy, attach the appropriate MassHealth form.
- Send this information to the appropriate address listed in Appendix A of your MassHealth provider manual.

For Medicare Part A Services

Submit only a copy of the Medicare remittance advice. Print the member ID in the lower right corner of the remittance advice. If other insurance is also present, attach a copy of the EOB from the other insurer, and circle the appropriate information on both.

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

The claim adjustment may be submitted to MassHealth electronically following the requirements for COB billing and for the 837 adjust/void transaction.

Paper Claims

To submit crossover claim adjustments on paper, follow the steps below.

1. Submit a legible copy of the original EOMB.
2. Submit a legible copy of the adjusted EOMB, if applicable. Circle all the applicable information on each of the EOMBs, and enter the 10-character MassHealth member identification number on in the lower-right corner of each EOMB.

For Medicare Part B Services

- Submit a legible copy of the original Medicare Part B claim form (HCFA 1500 or HCFA 1490.)
- Submit a legible copy of the MassHealth crossover remittance advice on which the claim was originally paid, if applicable. Circle all applicable member information.
- Mail the completed form along with any required supporting documentation, including the reason for the adjustment, to the appropriate address listed in Appendix A of your MassHealth provider manual.
- If your claim has been adjusted by Medicare, but MassHealth has not yet made an initial payment, follow steps (1) through (2) only and send to the appropriate address listed in Appendix A of your MassHealth provider manual.

For Medicare Part A Services

Submit a legible copy of the original Medicare remittance advice, the adjusted Medicare remittance advice, if applicable, and a copy of the MassHealth remittance advice, if applicable.