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-165
May 2009

TO: All Providers Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

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

This letter transmits Parts 1 through 7 of the Administrative and Billing Instructions (Subchapter 5) for all provider manuals. All seven parts of Subchapter 5 have been revised to reflect changes due to the implementation of NewMMIS. The seven parts of Subchapter 5 provide general administrative and billing instructions on specific topics as listed below.

- Part 1: Eligibility
- Part 2: Prior Authorization
- Part 3: Billing MassHealth
- Part 4: Required Forms and Documentation
- Part 5: Claim Status and Payment
- Part 6: Claim Status and Correction
- Part 7: Other Insurance

All revisions are effective upon the implementation of NewMMIS on May 26, 2009.

Please note the following.

- The former Part 6 of Subchapter 5 (Error Codes and Explanations) has been eliminated. Error codes and explanations are now posted as a separate document on the MassHealth Web site at www.mass.gov/masshealth.
- The former Parts 7 (Claim Status and Correction) and 8 (Other Insurance) have been renumbered as Parts 6 and 7, respectively.
- Part 7 of Subchapter 5 introduces the TPL Exception Form and the TPL Claim Bundled/Unbundled Form. Providers must use the TPL Exception Form when a dependent has insurance through an absent parent and the provider has billed the other insurer and has not received payment or a response within 30 days. Providers must use the TPL Claim Bundled/Unbundled Form to report payments and HIPAA adjustment/group reason codes where Medicare or commercial insurance has bundled payment for services. Samples of these forms are attached to this transmittal letter.

Parts 1 through 7 of Subchapter 5 are available in your MassHealth provider manual, and you can access the provider manuals from the MassHealth Web site at www.mass.gov/masshealthpubs. Click on Provider Library, then on MassHealth Provider Manuals.

It is important for providers to understand that while all parts of Subchapter 5 provide general instructions on various administrative functions within MassHealth, detailed billing information is provided in the UB-04 Billing Guide and the CMS-1500 Billing Guide. Detailed technical specifications for electronic claims submission are available in the MassHealth companion guides. Both the billing guides and the companion guides are available on the MassHealth Web site at www.mass.gov/masshealth. For billing guides, click on MassHealth Regulations and Other Publications, and then on MassHealth Billing Guides for Paper Claim Submitters. For companion guides, click on MassHealth Regulations and Other Publications, and then on MassHealth Companion Guides.

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, 5.3-1, 5.3-2, 5.4-1, 5.4-2, 5.5-1 through 5.5-4, 5.6-1 through 5.6-10, 5.7-1 through 5.7-6

OBSOLETE MATERIAL

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

All Provider Manuals

Pages v, 5.3-1, 5.3-2, and 5.5-1 through 5.5-4 transmitted by Transmittal Letter ALL-157

Pages 5.1-1, 5.1-2, 5.2-1 through 5.2-4, 5.4-1, 5.4-2, 5.6-1 through 5.6-40, 5.7-1 through 5.7-8, and 5.8-1 through 5.8-6 - transmitted by Transmittal Letter ALL-139

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TPL Exception Form

Please Note: Submit this form only with CMS-1500 paper claim forms, when a dependent has insurance through an absent parent against whom child support enforcement is being carried out by the State Title IV-D agency (Department of Revenue), and the provider has billed the other insurer but has not received payment or a response within 30 days.

Instructions on how to use this form:

1. Use this form to report HIPAA group and adjustment reason codes.
2. Use the claim(s) adjudication details provided by the insurer to fill in the form.
3. Use only Other Adjustment (OA) as the HIPAA group adjustment reason code.
4. For more details on how to use this form, refer to Part 7 of Subchapter 5 of your MassHealth provider manual.
5. Complete all fields.

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

MassHealth Provider ID/Service Location: _____

NPI: _____

Member Name: _____ MassHealth Member ID: _____

Policyholder First Name: _____ Policyholder Last Name: _____

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

Carrier ID: _____ Carrier Name: _____

Line Number	Date of Service	Revenue Code	Service Code	Billed Amount	HIPAA Group/ Adjustment Reason Code		HIPAA Adjustment Reason Amount
1					OA		
2					OA		
3					OA		
4					OA		
5					OA		
6					OA		

Clear entire form.

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TPL Claim Bundled/Unbundled Form

Clear entire form.

Please Note: Submit this form with CMS-1500 and UB-04 paper claim forms, as applicable.

Instructions on how to use this form:
Use this form to report HIPAA group and adjustment reason codes. Use the claim(s) adjudication details provided by the insurer to fill in the form. For more details on how to use this form, refer to Part 7 of Subchapter 5 of your MassHealth provider manual. Complete all fields.

Group Codes Legend
PR: Patient responsibility; **CO:** Contractual obligation; **OA:** Other adjustment; **CR:** Correction or reversal to a prior decison; **PI:** Payer initiated reduction

Examples
The following are some examples of commonly used HIPAA group and adjustment reason codes. There are others that can be used per the HIPAA guidelines.
Deductible: PR 1; **Coinsurance:** PR 2; **Copay**: PR 3; **Psych Reduction:** PR 122; **Noncovered:** OA 96

Submission Date:_____ Date of Service (range if applicable):_____ - _____ MassHealth Provider ID/Service Location:_____

NPI:_____ Member Name:_____ MassHealth Member ID:_____

Policyholder First Name:_____ Policyholder Last Name:_____ Policyholder ID:_____

Policyholder Policy No.:_____ Policyholder Group No.:_____ Carrier ID:_____ Carrier Name:_____

Line #	Revenue Code	Service Code	Date of Service	Payer Paid Amt	Bundled into Line Number	HIPAA Group/ Adj Reason Code		HIPAA Adj Reason Amt	HIPAA Group/ Adj Reason Code		HIPAA Adj Reason Amt	HIPAA Group/ Adj Reason Code		HIPAA Adj Reason Amt	HIPAA Group/ AdJ Reason Code		HIPAA Adj Reason Amt	HIPAA Group/ Adj Reason Code		HIPAA Adj Reason Amt
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5. Administrative and Billing Instructions

Part 1. Eligibility 5.1-1
Part 2. Prior Authorization 5.2-1
Part 3. Billing MassHealth 5.3-1
Part 4. Required Forms and Documentation 5.4-1
Part 5. Claim Status and Payment 5.5-1
Part 6. Claim Status and Correction 5.6-1
Part 7. Other Insurance 5.7-1

Part 1. Eligibility

The MassHealth Card

The MassHealth card identifies a person as being a MassHealth member. However, it does not guarantee that the cardholder is eligible for the specific date or date range of service, or that MassHealth will pay for the services. Therefore, the provider should request to see the card and must access the eligibility verification system (EVS) to verify eligibility for a specific date or range of dates.

Examples of the MassHealth card may be found in the EVS User Guide. You can download it at www.mass.gov/masshealth/newmmis. Click on Read Updated Billing Guides, Companion Guides, and Other Publications.

Verifying Eligibility

EVS provides you with eligibility information for all MassHealth members. By verifying a member's eligibility on the day or date range of service, you may be able to reduce the risk of your claims being denied.

All providers are required to have a user ID and password to use EVS. To obtain a user ID and password, each provider must sign a MassHealth Trading Partner Agreement (TPA).

To access EVS, go to the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter.

For providers who conduct electronic eligibility verification transactions, and have Internet access, the following options are available:

- Provider Online Service Center; and
- Third-party vendor software.

All these methods can be used for eligibility verification, while some of these methods can also be used to check the status of a claim that has been fully processed by MassHealth.

Providers without Internet access can call the automated voice response (AVR) system at 1-800-554-0042 or call the eligibility operator at 1-800-841-2900. Contact information for MassHealth Customer Service appears in Appendix A of your provider manual. Active EVS codes and their respective service restriction messages are available in Appendix Y of your provider manual. You may also refer to the EVS User Guide for more information about these and other access methods. Go to www.mass.gov/masshealth/newmmis and click on Read Updated Billing Guides, Companion Guides, and Other Publications.

Trading Partner Agreements (TPAs)

To access EVS, 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 if there is a signed TPA on file. The TPA is part of the MassHealth provider enrollment packet. To navigate to the TPA document, go to www.mass.gov/masshealth. In the lower right section of the home page, under Publications, click on MassHealth Provider Forms. Select the Trading Partner Agreement from the list of forms.

Other related information is available on the MassHealth Web site in the MassHealth Provider Forms section. To navigate to the page, go to www.mass.gov/masshealth. In the lower right section of the home page, under Publications, click on MassHealth Provider Forms.

User ID and Password

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

HIPAA Compliance

EVS meets the ANSI ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response standards. Data transmissions to and from the Provider Online Service Center meet the security standards of the HIPAA security regulations. Associated companion guides for the HIPAA 270/271 transactions are available on the MassHealth Web site. To navigate to the companion guides, go to www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library.

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 from our system. The HIPAA Privacy Rule (45 CFR Part 164.500, et seq.) governs uses and disclosures of protected health information. MassHealth's Data Protection Policies and Procedures contain information on workforce compliance with state and federal confidentiality laws for reference.

Explanation of MassHealth Coverage Types

Based on eligibility requirements, MassHealth members receive benefits according to specific coverage types. EVS provides the member's coverage type as part of the eligibility verification transaction. Providers should refer to MassHealth regulations 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 at 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 for:

- non-pharmacy services;
- pharmacy services; and
- nonemergency transportation services.

Requesting Prior Authorization for Non-pharmacy Services

For non-pharmacy medical services, MassHealth strongly encourages providers to request PA using the Provider Online Service Center (POSC) at www.mass.gov/masshealth/providerservicecenter. Providers can use the POSC 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). The PA-1 form and attachments should be sent to the appropriate address listed on the PA form or in Appendix A of your MassHealth provider manual.

- PA requests for members of the Massachusetts Commission for the Blind (MCB) will be handled by the Prior Authorization unit. These PAs can also be submitted via the POSC.
- If the PA request is for a member of Community Case Management (CCM), CCM will process the request, which can be submitted via the POSC;
- If the PA request is for dental services, a third-party administrator processes the request. This request must be submitted on the ADA dental claim form, not the PA-1 form.

For any subsequent request for the same service, you must request a new PA. Subsequent requests may be submitted via the POSC. 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, 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 the Provider Online Service Center, along with the paper PA form, or on the ADA form for dental requests.

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 the POSC or as an attachment submitted with the paper PA form.

- **Orthodontics Prior Authorization Form**

  For full orthodontic treatment and treatment visits that are billed quarterly, the orthodontist must complete an orthodontics prior authorization form (DEN-2). This form may be submitted as an attachment via the POSC or as an attachment submitted with the paper PA form.

  For continuation of orthodontic services for the second year, the orthodontist 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)**

  Orthodontists must complete the PAR Index Recording Form (DEN-7) when requesting PA for full orthodontic treatment (see 130 CMR 420.428(H) in the dental regulations). This form may be submitted as an attachment via the Provider Online Service Center or as an attachment submitted with the paper PA 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 form and a request and justification for continuous skilled nursing services (PA/PDN-1). This form may be submitted as an attachment via the POSC or as an attachment submitted with the paper PA form.

  If the member is under the age of 22, PA requests must be obtained from Community Case Management (CCM). Direct your requests to the appropriate address provided 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 the member is under the age of 22, PA requests must be obtained from 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, by clicking on the MassHealth Provider Forms link. 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 notifies both the provider and the member in writing, of its decision on PA requests. The letter indicates whether the services were approved, modified, or denied. The letter also contains 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 claim when submitting it for payment. If you have submitted your PA request via the POSC, you can also find out the status of your request using the same service. 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; and
- **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.

Note: See PA notice for decision on a PA request.

- **Approve the request** – the request is authorized.
- **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 pay for the service.
- **Defer the request** – the PA is returned to the provider with a request for additional information and status of "deferred," that must be submitted before a decision can be made. If the deferral is via the POSC, the screen is titled "Additional Information."

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 by mail or faxed 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 notifies the pharmacy, the 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 is sent to the pharmacy and the provider, and the member receives a letter. The PA number is provided on the fax only if the request is approved. The pharmacy provider should not enter this number on the online transaction. A PA tracking number is assigned regardless of whether the request was approved or denied.

Requesting Prior Authorization for Non-emergency 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 their MassHealth provider manual. See the MassHealth transportation regulations for more information about MassHealth coverage for nonemergency transportation services. PT-1 forms are 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).

- **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 gather missing information.

Part 3. Billing MassHealth

Electronic Claims

Electronic submission of claims is the most efficient, cost-effective, and accurate method of submitting claims for MassHealth payment. Electronic claims, on average, contain 25% fewer errors, and are processed faster than paper claims. This method also eliminates mailing and handling times.

Pharmacy Claims

All MassHealth retail and 340B pharmacy claims must be submitted electronically via the pharmacy Online Processing System (POPS). Affiliated Computer Services (ACS) operates POPS under the general framework of standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). Pharmacy providers must work with their switch and software vendors to ensure compliance.

For information about pharmacy claims submission, visit www.mass.gov/masshealth/pharmacy, or contact the ACS Help Desk using the information found in Appendix A of your MassHealth provider manual.

Dental Claims

All claims for dental services are handled through the dental third-party administrator. For information about dental claims submission and the MassHealth dental program, visit www.masshealth-dental.net, or contact the third-party administrator at the phone number listed in Appendix A of your MassHealth provider manual.

All Other MassHealth Claims

With the exception of pharmacy and dental providers (as directed above), all other MassHealth providers interested in submitting claims electronically should contact MassHealth Customer Service or the provider's software vendor or billing intermediary.

There are several methods of electronic claim submission available, including direct billing, the use of a vendor (billing intermediary or clearinghouse) that submits claims on your behalf, and direct data entry (DDE) of claims through the Provider Online Service Center.

Direct Billing

Electronic claim files can be submitted directly to MassHealth via the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter. You must go through testing procedures before submitting claims electronically. If you are interested in submitting claims using this method, contact MassHealth Customer Service using the contact information listed in Appendix A of your MassHealth provider manual, to learn more about testing procedures.

Using a Vendor

If you currently submit paper claims through a vendor, MassHealth Customer Service can assist you and your vendor in the transition to electronic billing. If you do not have a vendor but are interested in using one, or to check if your current vendor works with MassHealth, view the MassHealth approved vendor list on the MassHealth Web site.

Direct Data Entry (DDE)

You can use the the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter to submit claims to MassHealth using direct data entry. The online panels are similar to what Provider Claim Submission Software (PCSS, which is no longer used) offered and the claims submitted by this mechanism are adjudicated online real-time by MassHealth. You can see the status of the claim in the response panel within seconds of its submission.

You do not need to download any software to use this feature, and it requires only Internet to access to the Provider Online Service Center.

If you have additional questions, contact MassHealth Customer Service using the information in Appendix A of your MassHealth provider manual.

Additional Resources

More information about electronic billing is available in the MassHealth companion guides, found on the MassHealth Web site in the MassHealth Provider Library.

Paper Claims

MassHealth uses industry-standard claim forms – the CMS-1500 and UB-04. For information about which claim form to use, and for instructions to complete and submit them to MassHealth, go to www.mass.gov/masshealthpubs. Click on Provider Library, then on MassHealth Billing Guides for Paper Claim Submitters. These instructions should be used along with the MassHealth regulations. The proper completion and submission of claim forms is essential for timely and accurate claims processing and payment.

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. You can access the provider manuals 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 (e.g., Certification for Payable Abortion or 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; or
- other admission, election, or screening forms.

Obtaining Forms

You may download provider forms from the MassHealth Web site at www.mass.gov/masshealth, by clicking on the MassHealth Provider Forms link. You can also request supplies of these forms from the appropriate address listed in Appendix A of this manual.

Part 5. Claim Status and Payment

The claim status inquiry functionality in the Provider Online Service Center 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 or through direct data entry (DDE) panels.

- **Pharmacy claims** – For retail and 340B pharmacy claims, refer to the POPS Billing Guide for information about claim status (claim response formats).
- **All other claims** – MassHealth reports claim status and payment information through the 276/277 transaction and through its remittance advices (RAs).

For information about checking the status and correcting claims for retail pharmacy claims, refer to the POPS Billing Guide, the related 835 Companion Guide, and/or the 835 transaction (remittance advice displayed as a PDF file allowing you to save it on your system for future reference).

Dental providers can check claim status with the third-party administrator for dental claims.

Verifying Claim Status

The 276/277 HIPAA-compliant electronic transaction is the standard for claim-status inquiries to determine if a claim is paid, denied, or suspended. Through the 276/277 transaction, claim status can be verified 24 hours a day, seven days a week using the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter.

After MassHealth processes a claim, providers can upload a 276 batch file and download the 277 response for the status of the claim through the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter. The status is also available on the MassHealth-issued remittance advice (RA). The 276/277 transaction provides fast and accurate information about the status of a claim.

Direct Data Entry (DDE)

Providers can enter the information for a single claim on the Search for Claims panel (276). In return, they will receive a Claims Search Results response (277).

To use the DDE panels on the Provider Online Service Center, the claim submitter must be a MassHealth trading partner with a valid user ID and password. If you do not have a user ID and password, contact EDI Support (see Appendix A).

Claim Status Reporting

Claim status is reported through the 276/277 transaction and the RA issued by MassHealth.

The RA is a helpful tool when reconciling accounts, as it reports the status of a claim submitted to MassHealth. The RA is available in two forms: the 835 electronic RA, and the downloadable PDF RA, which is available online.

835 Remittance Advice

The 835 RA can be downloaded from the Provider Online Service Center by a provider who has a signed Trading Partner Agreement (TPA) on file with MassHealth. Format requirements and applicable standard codes are listed in the Implementation Guide, which can be accessed from the HIPAA section of the Washington Publishing Company (WPC) Web site. If you are not able to download this transaction from the MassHealth Web site, contact MassHealth Customer Service using the contact information listed in Appendix A of your MassHealth provider manual.

The MassHealth 835 Companion Guide provides MassHealth-specific information for the data content, codes, business rules, characteristics of the 835 transaction, technical requirements, and transmission options. The guide is available on the MassHealth Web site or by contacting MassHealth Customer Service using the contact information in Appendix A of your MassHealth provider manual.

PDF Remittance Advice

The RA in PDF format also displays information about claim status, although it appears in a format that is unique to MassHealth. You will be able to review, download, or print the PDF RA on the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter. Generally, claims appear on an RA within 30 days of receipt by MassHealth (with the exception of Medicare crossover claims that are forwarded by the Medicare intermediary).

For more information about the PDF RA, review the MassHealth Guide to the Remittance Advice for Paper Claims and Electronic Equivalents. This document is available in the Provider Library on www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library, then on MassHealth Billing Guides for Paper Claim Submitters. Both billing instructions and the guide to remittance advice are available from this page.

Payment

MassHealth offers two options for receiving payment for services provided to MassHealth members: electronic funds transfer (EFT) and paper checks. MassHealth strongly encourages providers to choose EFT for payment.

Please note that all payments, whether electronic or paper check, are issued by the Office of the Comptroller. Account reconciliation is the provider's responsibility. Although MassHealth does not reconcile provider accounts, if you have a claim-related issue, contact MassHealth Customer Service using the information provided in Appendix A of your MassHealth provider manual.

Electronic Funds Transfer (EFT)

EFT is a safe and secure payment method that allows MassHealth to directly deposit payments into a bank account designated by the provider. To receive payment through EFT, you must submit an application with an original signature to MassHealth. It will take approximately 14 business days to start receiving EFT payments after a completed application has been processed. Mail the EFT form to MassHealth Customer Service at the address listed in Appendix A of your MassHealth provider manual. More information is available on the MassHealth Web site at www.mass.gov/masshealth or the VendorWeb site, which can be accessed from https://massfinance.state.ma.us.

Paper Check

Providers who do not sign up for EFT receive payment through traditional paper checks. Paper checks are sent via U.S. mail and, therefore, may encounter time delays that the electronic methods of payment avoid. Reconciling the RA should be done with a corresponding check stub or transaction notification from the submitter's financial institution.

If you have additional questions about how to determine the status of a claim or which payment method is best for you, please contact MassHealth Customer Service using the contact information provided in Appendix A of your MassHealth provider manual.

VendorWeb

VendorWeb is the Commonwealth's online source for financial information. Once assigned a vendor code, providers can access information about payments issued to them by the Commonwealth through the VendorWeb site at https://massfinance.state.ma.us. For example, providers who receive payment via EFT can view their payment schedules online and download payment histories at their convenience.

Providers receiving payment via paper checks can find their vendor code on their checks. Vendor codes are alpha-numeric, beginning with the letters "VC" followed by a 10-digit number. Vendor codes are not related to your federal tax identification number. If you receive EFT reimbursement, but are unsure of your vendor code, contact MassHealth Customer Service.

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Part 6. Claim Status and Correction

To verify the status of a claim submitted to MassHealth for services provided to MassHealth members (with the exception of pharmacy and dental), you can use either batch HIPAA transaction sets 276/277 or the direct data entry (DDE) panel on the Provider Online Service Center. Additionally, you can view all claims (including pharmacy and dental) on your MassHealth remittance advice (RA).

For information about status inquiries and correction of retail pharmacy claims, refer to the POPS Billing Guide, the 835 Companion Guide, and the MassHealth remittance advice.

For information about status inquiries and correction of dental claims, please contact Doral Dental USA, Inc. at 1-800-207-5019.

Important Information about Processing Claims in NewMMIS

Claims are processed at the header level in NewMMIS. This means that if you send in a claim with multiple detail lines, all lines stay together as one claim during processing and are assigned an internal control number (ICN) that will be the claim identifier.

Individual lines are adjudicated on their own merit, and therefore, different detail lines submitted on the same claim could be paid, denied, or suspended. If one line on a claim suspends, the whole claim stays in a suspended status until the suspended detail line is reviewed and released for processing. Likewise for a multi-line professional claim, if some detail lines on the claim are paid and some are denied, the overall claim is assigned a paid status as payment is going out to the provider for that claim.

Claim processing varies with claim type. Correcting and rebilling claims is described by claim type in the following paragraphs.

Suspended Claims

MassHealth suspends claims for various reasons, such as medical review, review of required documentation, and pricing.

Note: It is a good idea to make a note in your records that the claim was received by MassHealth, so that it is not rebilled while in suspense.

A suspended claim appears on the RA only for information. You can track suspended claims by the internal control number (ICN), which remains the same throughout the processing cycle. Suspended claims require no action. Do not attempt to correct or rebill a suspended claim.

This suspended claim later appears on the RA as paid, pended, or denied.

Denied Claims

When a claim is listed on the RA as denied, it has reached its final disposition. To determine the reason for denial, review the error codes on the RA. For an explanation of the error codes go to www.mass.gov/masshealth. Click on Information for MassHealth Providers, then on MassHealth Claims Submission, and on Error Codes. You may also refer to the list of error codes and descriptions that appear on the last page of the RA on which the claim appeared as denied.

Correcting Claims

If a claim needs to be corrected, the method of correction depends on the status shown on the Provider Online Service Center or the most current PDF or electronic 835 RA. Review the specific sections by claim type in this document before attempting to correct claims.

For electronic claims, review the applicable MassHealth companion guide for detailed loop/segment information. For direct data entry (DDE), refer to the e-Learning tool available on the Provider Online Service Center. For paper claim submissions, please refer to the CMS-1500 Billing Guide and UB-04 Billing Guide on the MassHealth Web site.

Note: "RA" refers to both the electronic 835 remittance advice and the PDF remittance advice, unless otherwise stated.

Professional Claims

Paid Claims

MassHealth classifies a professional claim as paid in the following two situations:

- all detail lines have paid; or
- some detail lines have paid and some have denied.

If you are correcting the claim within 90 days of the oldest date of service on the denied claim detail lines, you can send in a new claim with only the corrected denied lines. If more than 90 days have passed since the oldest date of service on the denied claim detail lines, the process for correcting the denied lines depends on the data elements being corrected.

- If the member ID, provider ID, or claim type is being changed, you can send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same, you can send in a replacement claim with appropriate lines from the original claim (both paid and denied). Omit lines that have denied correctly and should not be resubmitted, add additional lines if necessary, or correct data elements on existing detail lines as appropriate. Identify the ICN of the originally paid claim as the former ICN for the replacement claim.

Note: If any of the previously paid lines required an attachment, the attachment must be submitted again with the replacement claim. Otherwise a previously paid line may be denied.

Denied Claims

MassHealth classifies a professional claim as denied only if all the detail lines on the claim have denied. If the errors on the claim that caused it to deny can be corrected, the corrected claim can be submitted again to MassHealth.

If you are correcting the claim within 90 days of the oldest date of service on the claim, you can send the corrected claim as a new claim irrespective of the data elements being changed. If more than 90 days have passed since the oldest date of service on the claim, the resubmittal process varies depending on the data elements being corrected.

- If you are changing the member ID, provider ID, or claim type, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same but the date of service, procedure code, or modifier is being changed, send in the claim as a resubmittal by identifying the ICN of the originally denied claim as the former ICN.
- If the member ID, provider ID, claim type, date of service, procedure code, and modifier are all the same, send the claim back to MassHealth as an original claim. The system finds the original denied ICN and will not reject the resubmitted claim for late filing.

Long Term Care (LTC) and Inpatient Claims

Paid Claims

MassHealth classifies an LTC or inpatient claim as paid only if all detail lines on it have paid.

If you have a paid claim and want to adjust it, you can send in appropriate detail lines on that claim as a replacement claim with additions, deletions, or corrections up to one year from the through date of service on the claim.

You cannot change the member ID, provider ID, or claim type and *must* include the former ICN on replacement claims.

If more than 90 days have passed since the oldest date of service on the claim, and if you want to change the member ID, provider ID, or claim type, you can send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.

Note: If your previously paid claim required an attachment, the attachment must be submitted again with the replacement claim. Otherwise a previously paid claim may be denied.

Denied Claims

MassHealth classifies an LTC or inpatient claim as denied in the following two situations:

- if the claim had a header level error that caused it to deny; or
- if one of the detail lines on the claim denied.

You can resubmit a denied LTC or inpatient claim by sending in appropriate detail lines of the claim. Omit lines that have denied correctly and should not be resubmitted, or add additional lines, if necessary. If you are not changing the member ID, provider ID, revenue codes or claim type, you can send in the claim as an original claim and the system will identify the former ICN. However, if any of the data elements mentioned above need to be changed, you must submit a new claim.

If you are submitting the claim after 90 days from the oldest date of service on the claim, you can send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.

Home Health Claims

Paid Claims

MassHealth classifies a home health claim as paid in the following two situations:

- all details lines have paid; or
- some detail lines have paid and some have denied.

If you are correcting the claim within 90 days of the oldest date of service on the denied claim detail lines, send in a new claim with only the corrected denied lines. If more than 90 days have passed since the oldest date of service on the denied claim detail lines, the process for correcting the denied lines depends on the data elements being corrected.

- If the member ID, provider ID, or claim type is being changed, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same, send in a replacement claim with all appropriate lines from the original claim (both paid and denied). Omit lines that have denied correctly and should not be resubmitted, add additional lines if necessary, and correct data elements on existing detail lines, as appropriate. Identify the ICN of the originally paid claim as the former ICN for the replacement claim.

Note: If any of the previously paid lines required an attachment, the attachment must be submitted again with the replacement claim. Otherwise a previously paid line may be denied.

Denied Claims

MassHealth classifies a home health claim as denied only if all the detail lines on the claim have denied. If the errors on the claim that caused it to deny can be corrected, you may correct and resubmit the claim to MassHealth.

If you correcting the claim within 90 days of the oldest date of service on the claim, you can send the corrected claim in as a new claim irrespective of the data elements being changed. If more than 90 days have passed since the oldest date of service on the claim, the resubmittal process varies depending on the data elements being corrected.

- If you are changing the member ID, provider ID, or claim type, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same but the date of service, revenue code, procedure code, or modifier is being changed, send in the claim as a resubmittal by identifying the ICN of the originally denied claim as the former ICN.
- If the member ID, provider ID, claim type, date of service, revenue code, procedure code, and modifier are all the same, then the claim can be sent back to MassHealth as an original claim. The system finds the original denied ICN and will not reject the resubmitted claim for late filing.

Outpatient Claims

Paid Claims

MassHealth classifies an outpatient claim as paid in the following two situations:

- all details lines have paid; or
- some detail lines have paid and some have denied.

If you are correcting the claim within 90 days of the oldest date of service on the denied claim lines, you can send in a new claim with only the corrected denied lines. If more than 90 days have passed since the oldest date of service on the denied claim lines, the process for correcting the denied lines depends on the data elements being corrected.

- If the member ID, provider ID, or claim type is being changed, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same, send in a replacement claim with the appropriate lines from the original claim (both paid and denied). Omit lines that have denied correctly and should not be submitted, add additional lines if necessary, and correct data elements on existing detail lines as appropriate. Identify the ICN of the originally paid claim as the former ICN for the replacement claim.

Note: If any of the previously paid lines had required an attachment, the attachment must be submitted again with the replacement claim. Otherwise a previously paid line may now be denied.

Denied Claims

MassHealth classifies an outpatient claim as denied only if all the detail lines on the claim have denied. The errors on the claim that caused it to deny can be corrected and the claim can be sent back to MassHealth.

If you are correcting the claim within 90 days of the oldest date of service on the claim, you can send the corrected claim in as a new claim irrespective of the data elements being changed. If more than 90 days have passed since the oldest date of service on the claim, the resubmittal process varies depending on the data elements being corrected.

- If the member ID, provider ID, or claim type is being changed, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same but the date of service, revenue code, procedure code, or modifier is being corrected, send in the claim as a resubmittal by identifying the ICN of the originally denied claim as the former ICN.
- If the member ID, provider ID, claim type, date of service, revenue code, procedure code, and modifier are all the same, then the claim can be sent back to MassHealth as an original claim. The system finds the original denied ICN and will not reject the resubmitted claim for late filing.

Requesting a 90-Day Waiver

You may request a 90-day waiver when the submission date of the claim is beyond 90 days from the service date or the date on an explanation of benefits (EOB) from another insurer and you meet one or more of the following conditions:

- you are changing the member ID number;
- you are changing the pay-to provider number;
- you are changing the claim form/claim 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.

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

1. Prepare a new paper claim form.
2. Attach a copy of all RAs where the claim has appeared to each claim if applicable.
3. Attach any other supporting documentation, such as copies of retroactive enrollment notices, to each claim.
4. Attach the 90-Day Waiver Request Form to each claim stating the reason for the waiver request.
5. Do not enter resubmittal or adjustment information and do not enter a former ICN.

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 payor's EOB and still within 18 months of the service date; and
- claims that can be resubmitted according to the instructions in this document.

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.

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 payors.

MassHealth adjudicates claims on a claim level basis, so the whole claim must be voided. If one or more lines need to be removed from the claim, send in a replacement claim as explained in the Paid Claim sections for each claim type.

You may void claims either electronically or via paper.

Electronically

Send in an 837 transaction with a frequency code of 8 and identify the former ICN in the appropriate field. Refer to the appropriate 837 Implementation Guide and MassHealth Companion Guide for more information.

Paper Voids

Circle the claims to be voided on a printout of the PDF RA and attach a signed letter or a completed Void Request Form (available at www.mass.gov/masshealthpubs) authorizing the void transactions. Mail the void request to the appropriate address listed in Appendix A of your MassHealth provider manual.

Institutional claims may also be voided by completing a UB-04 claim form and using a frequency code of "8" as part of the Type of Bill to indicate that the claim is to be voided.

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

Requesting a Final Deadline Appeal

MassHealth denies any claim received more than 12 months after the date of service (up to 18 months for those involving a third-party insurer) for exceeding the final billing deadline. It may, however, be submitted for consideration as a final deadline appeal when the criteria below are met.

A claim submitted after 36 months from the oldest date of service cannot be appealed and will appear on the remittance advice as denied.

Criteria for Filing a Final Deadline Appeal

The provider must meet all of the following criteria:

- The claim must have service dates over 12 months or 18 months when another insurer is involved.
- The claim must have appeared as denied on a remittance advice for "Final Deadline Exceeded," with the error code 853 or 855.
- The appeal must be filed within 30 days of the date on the remittance advice with error 853 or 855 that first denied the claim for this reason.
- MassHealth must have denied or underpaid the claim as a result of a MassHealth error.
- 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 a final deadline appeal:

- a cover letter with a statement that describes the MassHealth error that resulted in the denial or underpayment of the claim;
- a copy of each remittance advice on which the claim has appeared, including the one on which the claim was denied for "Final Deadline Exceeded;"
- any other documentation supporting your claim; and
- a legible and accurately completed paper claim form.

Requests for final deadline 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 remittance advices, you have questions about your MassHealth claims, you may contact MassHealth Customer Service at 1-800-841-2900 or send an e-mail to providersupport@mahealth.net.

To inquire about a claim by telephone, 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 remittance advice that pertains to the claims in question; and
- any other attachments that were required for the original submission, if necessary.

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Part 7. Other Insurance

This part contains instructions for submitting claims for services provided to members who have other health insurance or Medicare, in addition to MassHealth. For paper billing, providers must submit the CMS-1500 or UB-04 for all TPL claims including Medicare.

To determine if a member has other insurance, you must, among other things, follow the instructions for the Eligibility Verification System (EVS) in Part 1 of these administrative and billing instructions. MassHealth regulation 130 CMR 450.316 requires providers to make "diligent efforts" to identify and obtain payment from all other liable parties, including insurers. "Diligent efforts" is defined as making every effort to identify and obtain payment from all other liable parties, and include, but are not limited to

- determining the existence of health insurance by asking the member if he or she has other insurance and by using insurance databases available to the provider; and
- verifying the member's other health insurance coverage currently known to MassHealth through EVS on each date of service and at the time of billing.

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

Member Has Other Health Insurance

If the member has other insurance, submit the claim to the other insurance carrier, following the other insurer's billing instructions, before submitting the claim to MassHealth. Please check your billing guide for possible exceptions. If the claim is denied for reasons other than a correctable error, or is partially paid by the other insurance carrier, you may submit the claim to MassHealth. You may not submit the claim to MassHealth if the claim is denied for noncompliance with any one of the insurer's billing and authorization requirements. For general information about submitting the claim to MassHealth, see Part 3 of these administrative and billing instructions.

Updating Other Insurance Information

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

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

MassHealth Members Enrolled in Medicare

Crossover Claims

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

When Service Is Not Covered by Medicare

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

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

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

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

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

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

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

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

Claim Submission Resource

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

Electronic Claims Submission

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

For Electronic Claims

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

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

Paper Claims Submission

To submit paper clams, follow the instructions below.

1. Submit all TPL attachments with the appropriate claim form (CMS-1500 or UB-04). Attach the original or a copy of the other insurance carrier's notice of final disposition, EOB, notice of rejection, or some other explanation on the carrier's letterhead, to the claim form. The dates of service, provider name, and patient's name on the notice of disposition must correspond to the information on the MassHealth claim.

2. If notices of final disposition for more than one insurer are attached to the MassHealth claim, you must write the appropriate MassHealth-assigned carrier code on each EOB. If there is one insurer, enter the carrier code in Field 11C on the CMS-1500 form. Enter the carrier code on the UB-04 form in Field 51A-C. MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual, and at www.masshealth.gov.

3. When submitting Medicare EOMBs, add the carrier code 0084000 to each EOMB for institutional claims, and carrier code 0085000 to each EOMB for professional claims.

4. If the carrier's notice of final disposition, or EOB, notice of rejection, or some other explanation on the carrier's letterhead does not itemize payment for each service provided, the provider needs itemized payment and the corresponding coinsurance, copay, and deductible amount for each line on the claim form being submitted. The provider should use the **TPL Claim Bundle/Unbundled Form** and attach a copy of the EOB.

5. If the carrier notice of final disposition and EOB were paid globally, for items that should be separated to bill to MassHealth on the UB-04 and CMS-1500, the provider should itemize (estimated?) payment for each service provided for each line on the claim form submitted by invoice. The provider should use the **TPL Claim Bundle/Unbundled Form** and attach a copy of the EOB.

6. When there is no EOB for that time period being billed, home health agencies must use the TPL Exception Form for Home Health Agencies, and nursing facilities and all inpatient hospitals must use the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals. Submit the TPL Exception Form, and keep on file the required supporting documentation, for example, a cover letter from the carrier stating that the service was not covered. TPL Exception Form instructions are listed on the form.

7. a. For services billed to MassHealth on the UB-04 claim form, enter in Item 54 the total amount received toward the payment of services on this claim from third party payers other than MassHealth, and attach a copy of the EOB from each of the other payers to the claim form.

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

Crossover Claims

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

Electronic Claims Submission

You may submit the claim to MassHealth electronically, following the COB requirements for the 837 transactions or DDE, through the POSC if 60 days have passed since you received Medicare payment, or the member has other insurance in addition to Medicare and MassHealth, and the claim has not appeared on a MassHealth crossover remittance advice.

Paper Claims Submission

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

1. Submit a separate, legible photocopy of the EOMB for each Medicare claim along with a legible copy of the original CMS-1500 or UB-04 submitted to Medicare.

2. On the EOMB, circle the Medicare payment information that you are submitting to MassHealth.

Patient Pay Amount

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

Adjusting a Medicare/MassHealth Crossover Claim

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

Electronic Claims Submission

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

Paper Claims Submission

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

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

For Medicare Part A Services

- Submit a legible copy of the original Medicare Part A claim form (UB-04).

- Submit a legible copy of the MassHealth crossover remittance advice on which the claim was originally paid. Circle all applicable member information.

- If the member also has other insurance, attach a copy of the EOB from the other insurer.

- Send the claims to the appropriate address listed in Appendix A of your Masshealth provider manual.

For Medicare Part B Services

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

Resolving a Medicare/MassHealth Crossover Claim

Suspended Claims

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

Preventive Pediatric Care and Prenatal Care Services

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

Dependent Has Insurance Through an Absent Parent

If a dependent has insurance through an absent parent, against whom child support enforcement is being carried out by the State Title IV-D agency (Department of Revenue), services may be billed by the provider to MassHealth as the primary insurer when the patient has additional insurance (TPL) and the provider has billed the other insurer and has not received payment or a response after 30 days. Providers must submit the appropriate claim form along with the TPL Exception Form.