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

MassHealth
Transmittal Letter ALL-196
October 2012

TO: All Providers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: Updates to Appendices U and V to All Provider Manuals to Reflect Changes in DPH-Designated Serious Reportable Events (SREs) and CMS-Designated Provider Preventable Conditions (PPCs)

This letter transmits the following publications, with all changes effective for dates of service on or after October 1, 2012.

- Updated Appendix V to all MassHealth provider manuals, which sets forth MassHealth billing instructions that providers must follow for reporting and billing "Provider Preventable Conditions (PPCs)"; and
- Updated Appendix U to all MassHealth provider manuals, which sets forth the list of "Serious Reportable Events (SREs)," designated by the Massachusetts Department of Public Health (DPH) that are not PPCs under MassHealth.

Overview of Changes to Appendices V and U

MassHealth has updated the lists of PPCs in Part I of Appendix V applicable to inpatient hospitals, and Part II of Appendix V applicable to outpatient hospitals and freestanding ambulatory surgery centers, effective October 1, 2012. In addition, for freestanding ambulatory surgery centers and inpatient and outpatient hospitals for which MassHealth currently applies nonpayment methods for the occurrence of serious reportable events (SREs), MassHealth has also updated the list of DPH-designated SREs that are not CMS-designated PPCs (PPCs not designated by the Centers for Medicare & Medicaid Services), in Appendix U.

All changes to the lists of PPCs that are Additional Other Provider Preventable Conditions (Additional OPPCs) in Parts I and II of Appendix V, and to the list of DPH-designated SREs that are not PPCs in Appendix U, conform with updates DPH made, effective October 1, 2012, to its list of SREs that apply to DPH-regulated hospitals and freestanding ambulatory surgery centers. Because of federal Medicaid rules on PPCs (42 CFR 447.26), MassHealth must categorize any SRE that overlaps with a federal PPC category, into its appropriate federal PPC category.

In addition, in Part I of Appendix V for inpatient hospitals, MassHealth has clarified that PPCs that are CMS-designated health care acquired conditions (HCACs) are updated and apply automatically as of the effective date of any corresponding updates to CMS's hospital acquired conditions (HACs) under Medicare. The list of CMS-designated HCACs in Part I of Appendix V now reflects updates that CMS made to its list of HACs under Medicare that took effect October 1, 2012.

There were no changes to the lists of PPCs that are National Coverage Determinations (NCDs).

Any provider that previously submitted a claim to MassHealth that is affected by these changes must resubmit the claim following applicable MassHealth billing instructions. The MassHealth billing instructions and payment methods that apply to PPCs and DPH-designated SREs that are not PPCs, respectively, have not changed.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

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 U-1, U-2, and V-1 through V-24

OBSOLETE MATERIAL

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

All Provider Manuals

Pages U-1, U-2, and V-1 through V-24 — transmitted by Transmittal Letter ALL-195

DPH-Designated Serious Reportable Events That Are Not Provider Preventable Conditions

Appendix U is applicable to the following MassHealth providers.

▪ acute inpatient and acute outpatient hospitals and hospital-licensed health centers (HLHCs)	▪ acute inpatient and acute outpatient hospitals and HLHCs billing for acute inpatient and acute outpatient hospital-based physician services
▪ privately owned chronic disease and rehabilitation inpatient and outpatient hospitals	▪ freestanding ambulatory surgery centers (FASCs)
▪ state-owned non-acute inpatient and outpatient hospitals operated by the Department of Public Health (DPH)	▪ substance abuse treatment inpatient and outpatient hospital

The following events that are designated by the Massachusetts Department of Public Health (DPH) as "Serious Reportable Events (SREs)" in accordance with 105 CMR 130.332 (or 105 CMR 140.308, as applicable) are **not** considered "Provider Preventable Conditions" (PPCs) under MassHealth. These SREs shall be subject to applicable MassHealth provisions on "Serious Reportable Events" set forth, in the case of DPH-licensed hospital providers, in the hospital's agreement with MassHealth governing payment for services, or in the case of freestanding ambulatory surgery centers, in Transmittal Letter FAS-25.

1. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
2. Any incident in which systems designated for oxygen or other gas are delivered to a patient contain no gas or the wrong gas or are contaminated by toxic substances
3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
4. Abduction of a patient/resident of any age
5. Sexual abuse/assault on a patient or staff member within or on the grounds of the health care setting

NOTE: The above list is subject to change.

This page is reserved.

This appendix describes the MassHealth billing instructions for Provider Preventable Conditions (PPCs), as they apply to providers.

This appendix is subdivided into three parts, listed below. This appendix is also available on the MassHealth website at www.mass.gov/masshealthpubs. Click on Provider Library, then on MassHealth Provider Manual Appendices.

Contents

Part 1. Billing Instructions for PPCs for Inpatient Hospitals

I. Applicable Providers

This part contains PPC billing instructions that apply to inpatient hospital providers (UB-04 or 837I claims) and acute inpatient hospital providers billing for acute inpatient hospital-based physician services (CMS-1500 or 837P), as indicated below.

A. UB-04 or 837I institutional claims	*B. CMS-1500 or 837P professional claims:*
▪ acute inpatient hospitals	▪ acute inpatient hospital claims for acute inpatient hospital-based physician services
▪ privately owned chronic disease and rehabilitation inpatient hospitals	
▪ psychiatric inpatient hospitals	
▪ state-owned non-acute inpatient hospitals operated by the Department of Mental Health (DMH)	
▪ state-owned non-acute inpatient hospitals operated by the Department of Public Health (DPH)	
▪ substance abuse treatment inpatient hospitals	

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

II. Provider Preventable Conditions

Under Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (the ACA) and federal regulations at 42 CFR 447.26, providers must report "provider preventable conditions" (PPCs) to Medicaid agencies; and Medicaid agencies are prohibited from paying providers for PPCs in violation of the federal requirements.

A Provider Preventable Condition is a condition that meets the definition of a "Health Care Acquired Condition (HCAC)" or an "Other Provider Preventable Condition (OPPC)" as defined by the Centers for Medicare & Medicare Services (CMS) in federal regulations at 42 CFR 447.26(b). "Other Provider Preventable Conditions" are further divided into two subcategories: (1) "National Coverage Determinations (NCDs);" and (2) "Additional Other Provider Preventable Conditions (Additional OPPCs)." See Section III, below, for more information on each of these PPC categories, and for the lists of PPCs that apply to the providers subject to Part 1 of this appendix.

III. Billing Instructions

Set forth below are the MassHealth billing instructions that inpatient hospital providers must follow for reporting and billing PPCs, by applicable PPC subcategory. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations, provider manuals, and their other MassHealth billing and companion guides, as necessary.

Present on Admission (POA) Indicator

All inpatient hospital claims related to a PPC must contain the appropriate Present on Admission (POA) indicator (see Table (1)). If the POA indicator is N or U with respect to a PPC, inpatient hospitals must follow the instructions for billing the PPC below.

Table (1). POA Indicator Reporting Description and PPC Payment Criteria for Inpatient Hospitals

POA Value on UB-04 or 837I	Description	Medicaid Payment Adjustments
Y	Diagnosis was present at time of inpatient admission.	Payment is made for the condition.
N	Diagnosis was **not** present at time of inpatient admission.	Applicable PPC payment adjustments will be made.
U	Documentation is insufficient to determine if the condition was present at the time of inpatient admission.	Applicable PPC payment adjustments will be made.
W	Clinically undetermined. The provider was unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment is made for condition.
Leave field blank	Effective January 1, 2011, the POA field will be left blank for codes exempt from POA reporting. **Note:** The number "1" is no longer valid on claims submitted under the 5010 format, effective January 1, 2011. Refer to CMS change request 7024 www.cms.gov/transmittals/downloads/R756OTN.pdf.	Exempt from POA reporting

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Billing Instructions for Provider Preventable Conditions by PPC Subcategory

A. Health Care Acquired Conditions (HCACs)

Applicable Providers

HCACs apply to all providers listed in Section I, above.[1] Providers must follow the HCAC billing instructions set forth below if an HCAC occurs.

HCACs are conditions occurring in an inpatient hospital setting that Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and (iv) of the SSA), *with the exception of* deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee or total hip replacement in pediatric (under 21 years) and obstetric patients. Table (2) lists the HCACs and their associated ICD-9-CM diagnosis codes.

Note: The HCACs, and associated ICD-9-CM diagnosis codes listed below, are subject to change as a result of revisions to the list of HACs and related codes made by CMS under Medicare. CMS's changes to the Medicare HAC list and related codes shall be deemed to take effect automatically as of the effective date of the CMS updates under Medicare, without the need for an amendment to Table (2), below. For the most current list of HACs and ICD-9-CM diagnosis codes, providers should refer to the CMS website at www.cms.gov.

Table (2). Health Care Acquired Conditions (HCACs)

Description of Condition	*ICD-9-CM Diagnosis Codes CC/MCC*
Foreign object retained after surgery	998.4 (CC) 998.7 (CC)
Air embolism	999.1 (MCC)
Blood incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure ulcers, stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and trauma related to a) fractures b) dislocations c) intracranial injuries d) crushing injuries e) burns f) other injuries	Codes with these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994

[1] HCACs under Medicaid rules apply to all inpatient hospitals participating as Medicaid inpatient hospital providers, and are not limited to inpatient hospitals that are subject to the Medicare Inpatient Prospective Payment System.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Description of Condition	*ICD-9-CM Diagnosis Codes CC/MCC*
Catheter-associated urinary tract infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular catheter-associated infection	999.31 (CC) 999.32 (CC) 999.33 (CC)
Manifestations of poor glycemic control that include a) diabetes ketoacidosis b) nonketototic hyperosmolar coma c) hypoglycemic coma d) secondary diabetes with ketoacidosis e) secondary diabetes with hyperosmolarity	250.10 - 250.13 (MCC) 250.20 - 250.23 (MCC) 251.0 (CC) 249.10 - 249.11 (MCC) 249.20 - 249.21 (MCC)
Surgical site infection, mediastinitis following coronary artery bypass graft (CABG)	519.2 (MCC) and one of following procedure codes 36.10 - 36.19
Surgical site infection following certain orthopedic procedures: a) spine b) neck c) shoulder d) elbow	996.67 (CC) 998.59 (CC) and one of the following procedure codes: 81.01 - 81.08, 81.23 - 81.24, 81.31 - 81.38, 81.83, or 81.85
Surgical site infection following bariatric surgery for obesity: a) laparascopic gastric bypass b) gastroenterostomy c) laparoscopic gastric restrictive surgery	Principal diagnosis code 278.01 539.01 (CC) 539.81 (CC) 998.59 (CC) and one of the following procedure codes: 44.38, 44.39, or 44.95
Surgical site infection (SSI) following Cardiac Implantable Electronic Device (CIED) procedures	Diagnosis of 996.61 or 998.59 And one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.94, 37.96, 37.98, 37.74, 37.75, 37.76, 37.77, 37.79, 37.89

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Description of Condition	*ICD-9-CM Diagnosis Codes CC/MCC*
Iatrogenic pneumothorax with venous catheterization	Diagnosis of 512.1 in combination with the associated procedure code of 38.93
Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures: a) total knee replacement b) hip replacement **Note:** This HCAC category does not apply to pediatric (under 21 years of age) or obstetric patients.	415.11 (MCC) 415.13 (MCC) 415.19 (MCC) 453.40 - 453.42 (CC) and one of the following procedure codes: 00.85 - 00.87, 81.51 - 81.52, or 81.54

Instructions for Submitting Claims for HCACs

For acute inpatient hospitals, privately owned chronic disease and rehabilitation inpatient hospitals, state-owned non-acute inpatient hospitals operated by DPH, psychiatric inpatient hospitals, substance abuse treatment inpatient hospitals, state-owned non-acute inpatient hospitals operated by DMH (UB-04 and 837I institutional claims)

Submit a Type of Bill (TOB) 110 no-pay claim to identify HCAC-related services. HCACs must be identified on the TOB 110 with the appropriate ICD-9-CM diagnosis codes (see Table (2)) and a POA indicator (see Table (1)). This TOB 110 must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The TOB 110 DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an HCAC," and must also state the type of HCAC (from Table (2)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If non-HCAC-related services were also provided during the same statement covers period, submit a second claim to bill for the non-HCAC-related services. The second claim must be billed on a routine type bill TOB 11X (cannot be 110).

See also the "Additional Instructions" in subsection C, below, that providers must follow.

For acute inpatient hospitals billing for acute inpatient hospital-based physician services (CMS-1500 and 837P professional claims)

Submit a separate professional claim to identify HCAC-related services. This claim must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an HCAC," and must also state the type of HCAC (from Table (2)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If non-HCAC-related services were also provided during the same statement covers period, submit a second professional claim to bill for the non-HCAC-related services.

See also the "Additional Instructions" in subsection C, below, that providers must follow.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

B. Other Provider Preventable Conditions (OPPCs) by Subcategory

(1) National Coverage Determinations (NCDs)

Applicable Providers

NCDs apply to all providers listed in Section I above. Providers must follow the NCD billing instructions set forth below if an NCD occurs. See Table (3) for the list of NCDs that may occur in any health care setting.

Table (3). National Coverage Determinations (NCDs)

Description of NCD	*Diagnosis Code*	*Modifier*
Surgical or other invasive procedure performed on the wrong body part	E876.7 (Performance of wrong operation (procedure) on wrong side/body part)	PA (Surgical or other invasive procedure on wrong body part)
Surgical or other invasive procedure performed on the wrong patient	E876.6 (Performance of operation (procedure) on patient not scheduled for surgery)	PB (Surgical or other invasive procedure on wrong patient)
Wrong surgical or other invasive procedure performed on a patient	E876.5 (Performance of wrong operation (procedure) on correct patient)	PC (Wrong surgery or other invasive procedure on patient)

Instructions for Submitting Claims for NCDs

For acute inpatient hospitals, privately owned chronic disease and rehabilitation inpatient hospitals, state-owned non-acute inpatient hospitals operated by DPH, psychiatric inpatient hospitals, substance abuse treatment inpatient hospitals, state-owned non-acute inpatient hospitals operated by DMH (UB-04 and 837I institutional claims)

Submit a TOB 110 no-pay claim to identify NCD-related services, and include the appropriate POA indicator (see Table (1)). NCDs must be identified on the TOB 110 by the applicable diagnosis code from Table (3), above, reported in positions 2 through 9 (not in the External Cause of Injury (E-code) field). This TOB 110 must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The TOB 110 DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an NCD," and must also state the type of NCD (from Table (3)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If services unrelated to the NCD were also performed during the same statement covers period, submit a second claim to bill for the non-NCD-related services. The second claim must be billed on a routine type bill TOB 11X (cannot be 110).

See also the "Additional Instructions**"** in subsection C, below, that providers must follow.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

For acute inpatient hospitals billing for acute inpatient hospital-based physician services (CMS-1500 and 837P professional claims)

Submit a separate professional claim to identify NCD-related services. Append the applicable NCD modifier (from Table (3)) to all claim lines related to the erroneous surgery(ies)/procedure(s). This separate professional claim must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an NCD," and must also state the type of NCD (from Table (3)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If non-NCD-related services were also provided during the same statement covers period, submit a second professional claim to bill for the non-NCD-related services.

See also the "Additional Instructions" in subsection C below, that providers must follow.

(2) Additional Other Provider Preventable Conditions (Additional OPPCs)

Applicable Providers

Additional OPPCs apply to all providers listed in Section I, above, *except for* psychiatric inpatient hospitals and state-owned non-acute inpatient hospitals operated by DMH. These providers must follow the billing instructions for Additional OPPCs set forth below, if an Additional OPPC occurs.

Additional OPPCs may occur in any health care setting and are state-defined other provider preventable conditions that meet the requirements of an "other provider preventable condition" set forth in 42 CFR 447.26(b). Table (4) lists the MassHealth-defined Additional OPPCs for this purpose.

Table (4). Additional Other Provider Preventable Conditions (Additional OPPCs)

Description of Condition
Intraoperative or immediate postoperative/post procedure death in an ASA class 1 patient
Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting
Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
Patient death or serious injury associated with patient elopement (disappearance)
Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a health care setting

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Description of Condition
Patient death or serious injury associated with a medication error (for example, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting
Death or serious injury of a neonate associated with labor and delivery in a low-risk pregnancy
Unstageable pressure ulcer acquired after admission / presentation in a health care setting
Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting
Death or serious injury of a patient or staff member resulting from a physical assault (that is, battery) that occurs within, or on the grounds of, a health care setting

Instructions for Submitting Claims for Additional OPPCs

For acute inpatient hospitals, privately owned chronic disease and rehabilitation inpatient hospitals, state-owned non-acute inpatient hospitals operated by DPH, and substance abuse treatment inpatient hospitals (UB-04 and 837I institutional claims)

Submit a TOB 110 no-pay claim type to identify Additional OPPC-related services, and include the appropriate POA indicator (see Table 1). This TOB 110 must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The TOB 110 DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an Additional OPPC," and must also state the type of Additional OPPC (from Table (4)). The claim will suspend and subsequently deny with Edit 7754 – Denied PPC Claim.

If services unrelated to the Additional OPPC were also provided during the same statement covers period, submit a second claim to bill for the non-Additional OPPC-related services. The second claim must be billed on a routine type bill TOB 11X (cannot be 110).

See also the "Additional Instructions" in subsection C, below that providers must follow.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

For acute inpatient hospitals billing for acute inpatient hospital-based physician services (CMS-1500 and 837P professional claims)

Submit a separate professional claim to identify Additional OPPC-related services. This claim must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an Additional OPPC," and must also state the type of Additional OPPC (from Table (4)). The claim will suspend and subsequently deny with Edit 7754 – Denied PPC Claim.

If services unrelated to the Additional OPPC were also provided during the same statement covers period, submit a second professional claim to bill for the non-Additional OPPC-related services.

See also the "Additional Instructions" in subsection C, below, that providers must follow.

C. Additional Instructions

(1) Follow-up care

Follow the same rules above to report any follow-up inpatient services that were solely the result of a previously reported PPC (inpatient or outpatient) that occurred while a member was being cared for at a facility that is covered under the same license.

(2) Related Services for NCDs

All services provided in the operating room or other health care setting when an NCD occurs are considered related to the NCD and therefore must be reported as NCD-related services in claims submissions in accordance with the instructions for NCDs, above. All providers in an operating room or other health care setting when an NCD occurs, who could bill individually for their services, are not eligible for payment and their services must be reported as NCD-related services. Related services do not include performance of the correct procedure.

(3) Providers Approved for an Electronic Submission Waiver

If a provider has been approved for an electronic submission waiver, the provider may submit a separate UB-04 or CMS-1500 claim, as applicable, on paper for the PPC. Providers must include the appropriate diagnosis codes or modifiers, as applicable, on the separate paper claim as set forth in the instructions above to identify the applicable PPC, and must include a separate attachment with the paper claim stating, "This claim represents an [HCAC][NCD][Additional OPPC]," and must also state the type of PPC (from the appropriate table, above). Providers must submit the completed paper claim, with the attachment, to the following address: MassHealth Claims Operations/PPC Unit, 100 Hancock St., 6th Floor, Quincy, MA 02171. The claim will suspend and subsequently deny with Edit 7754 – Denied PPC Claim.

(4) Health Safety Net (HSN)/Unreimbursed Costs

Providers are prohibited from seeking reimbursement for identified PPC-related services through the Health Safety Net (HSN) or otherwise, and from including such services in any unreimbursed cost reporting.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

(5) Prohibition on Charging Members

Providers are prohibited from charging members for PPCs and PPC-related services, including, without limitation, copayments or deductibles.

(6) Reporting PPCs to the Department of Public Health

The additional instructions in this paragraph 6 apply to the following MassHealth providers.

- acute inpatient hospitals
- privately owned chronic disease and rehabilitation inpatient hospitals
- state-owned non-acute inpatient hospitals operated by the Department of Public Health
- substance abuse treatment inpatient hospitals
- acute inpatient hospitals billing for acute inpatient hospital-based physician services

In addition to complying with the billing instructions set forth above, for any PPC that is also a "serious reportable event (SRE)" as designated by the Massachusetts Department of Public Health (DPH) pursuant to its regulations at 105 CMR 130.332, the hospital must continue to report the occurrence of the PPC as an SRE to DPH, and perform the documented review process as set forth in, and in accordance with, DPH regulations at 105 CMR 130.332(B) and (C). The hospital must also provide copies of such reports to MassHealth and any other responsible third-party payer and inform the patient, as required by, and in accordance with, DPH regulations at 105 CMR 130.332(B) and (C). The copies to MassHealth must be sent to the following address.

PPC/Serious Reportable Event Coordinator
MassHealth
Utilization Management Department
100 Hancock Street, 6th Floor
Quincy, MA 02171

(7) Serious Reportable Events

For all providers listed in Paragraph 6 of these Additional Instructions, above, Appendix U of all provider manuals identifies those events that are designated by DPH as "Serious Reportable Events (SREs)" in accordance with 105 CMR 130.332, but which are **not** "provider preventable conditions" under MassHealth. The SREs listed in Appendix U are governed by applicable provisions on "Serious Reportable Events" set forth in the provider's MassHealth agreement governing payment for hospital services, including, without limitation, provisions concerning nonpayment and reporting for these events.

(8) Coordination of Benefit Claims (COB) – Instructions Pertaining to MassHealth Members with Medicare and/or Other Insurance

Providers must follow the instructions described here to report PPCs for MassHealth members who have Medicare and/or other insurance. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations and their other applicable MassHealth billing and companion guides to submit COB claims as necessary.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

(a) **HCACs**

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth HCAC requirements and instructions described above in Section III for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare crossover claims for dually eligible members to MassHealth for adjudication.

No further action is required for Medicare crossover claims that are submitted by inpatient provider types listed in Section I, above, that are also subject to Medicare's Inpatient Prospective Payment System (IPPS) rules.

Inpatient provider types listed in Section I, above, that are **not** subject to Medicare's IPPS rules must re-bill their crossover claims to MassHealth according to the MassHealth HCAC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to the MassHealth HCAC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

(b) **NCDs**

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth NCD requirements and instructions described above in Section III for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Medicare Crossover Claims

No further action is required for Medicare crossover claims that are automatically transmitted from Medicare to MassHealth for adjudication.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from COBC to MassHealth should be submitted to MassHealth according to MassHealth NCD requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

(c) **Additional OPPCs**

Third Party Liability

If there is a remaining MassHealth liability, submit claim to MassHealth according to the MassHealth Additional OPPC requirements and instructions described above in Section III for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Part 1. Billing Instructions for PPCs for Inpatient Hospitals (cont.)

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare crossover claims for dually eligible members to MassHealth for adjudication.

Medicare crossover claims billed for Additional OPPCs listed in Table (4) must be rebilled to MassHealth according to MassHealth Additional OPPC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to MassHealth Additional OPPC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers

I. Applicable Providers

This part contains PPC billing instructions that apply to outpatient hospital providers (UB-04 or 837I claims); freestanding ambulatory surgery centers (CMS-1500 or 837P claims); and acute outpatient hospital providers billing for acute outpatient hospital-based physician services (CMS-1500 or 837P claims), as indicated below.

A. UB-04 or 837I institutional claims	B. CMS-1500 or 837P professional claims
▪ acute outpatient hospitals and hospital licensed health centers (HLHCs)	▪ acute outpatient hospital and HLHC claims for acute outpatient hospital-based physician services
▪ privately owned chronic disease and rehabilitation outpatient hospitals	▪ freestanding ambulatory surgery centers (FASCs)
▪ psychiatric outpatient hospitals	
▪ state-owned non-acute outpatient hospitals operated by the Department of Mental Health (DMH)	
▪ state-owned non-acute outpatient hospitals operated by the Department of Public Health (DPH)	
▪ substance abuse treatment outpatient hospitals	

II. Provider Preventable Conditions

Under Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (the ACA) and federal regulations at 42 CFR 447.26, providers must report "provider preventable conditions" (PPCs) to Medicaid agencies; and Medicaid agencies are prohibited from paying providers for PPCs in violation of the federal requirements.

A Provider Preventable Condition, for purposes of the providers listed in Section I, above, includes conditions that meet the definition of an "Other Provider Preventable Condition (OPPC)" as defined by CMS in federal regulations at 42 CFR 447.26(b). "Other Provider Preventable Conditions" are further divided into two subcategories: (1) "National Coverage Determinations (NCDs);" and (2) "Additional Other Provider Preventable Conditions (Additional OPPCs)." See Section III, below, for more information on each of these PPC categories, and for the lists of PPCs that apply to the providers subject to this Part 2.

III. Billing Instructions

Set forth below are the MassHealth billing instructions that providers must follow for reporting and billing PPCs, by applicable PPC subcategory. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations, provider manuals, and their other applicable MassHealth billing and companion guides, as necessary.

A. National Coverage Determinations (NCDs)

Applicable Providers

NCDs apply to all providers listed in Section I, above. Providers must follow the NCD billing instructions set forth below if an NCD occurs. See Table (1) for the list of NCDs, which may occur in any health care setting.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

Table (1). National Coverage Determinations (NCDs)

Description of NCD	*Modifier*
Surgical or other invasive procedure performed on the wrong body part	PA (Surgical or other invasive procedure on wrong body part)
Surgical or other invasive procedure performed on the wrong patient	PB (Surgical or other invasive procedure on wrong patient)
Wrong surgical or other invasive procedure performed on a patient	PC (Wrong surgery or other invasive procedure on patient)

Instructions for Submitting Claims for NCDs

For acute outpatient hospitals and HLHCs, privately owned chronic disease and rehabilitation outpatient hospitals, state-owned non-acute outpatient hospitals operated by DPH, psychiatric outpatient hospitals, substance abuse treatment outpatient hospitals, and state-owned non-acute outpatient hospitals operated by DMH **(UB-04 and 837I claims)**

Submit a Type of Bill (TOB) 130 no-pay claim type to identify NCD-related services. Append the applicable NCD modifier (from Table (1)) to all claim lines related to the erroneous surgery(ies)/ procedure(s). This TOB 130 claim must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The TOB 130 DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an NCD," and must also state the type of NCD (from Table (1)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If services unrelated to the NCD were also provided during the same statement covers period, submit a second claim to bill for the non-NCD-related services. The second claim must be billed on a routine type bill TOB 13X (cannot be 130).

See also the "Additional Instructions" in subsection C, below, that providers must follow.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

For acute outpatient hospital and HLHC claims for acute outpatient hospital-based physician services, and freestanding ambulatory surgery centers (FASCs) (CMS-1500 and 837P claims)

Submit a separate professional claim to identify NCD-related services. Append the applicable NCD modifier (from Table (1)) to all claim lines related to the erroneous surgery(ies)/procedure(s). This separate professional claim must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an NCD," and must also state the type of NCD (from Table (1)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If non-NCD-related services were also provided during the same statement covers period, submit a second professional claim to bill for the non-NCD-related services.

See also the "Additional Instructions" in subsection C, below, that providers must follow.

B. Additional Other Provider Preventable Conditions (Additional OPPCs)

Applicable Providers

The Additional OPPCs apply to all providers listed in Section I, above, except for psychiatric outpatient hospitals and state-owned non-acute outpatient hospitals operated by the Department of Mental Health. These providers must follow the billing instructions for Additional OPPCs set forth below if an Additional OPPC occurs.

Additional OPPCs may occur in any health care setting and are state-defined other provider preventable conditions that meet the requirements of an "other provider preventable condition" set forth in 42 CFR 447.26(b). Table (2) lists the MassHealth-defined Additional OPPCs that apply to the providers listed in Section I, above.

Table (2). Additional Other Provider Preventable Conditions (Additional OPPCs)

Description of Condition
▪ Intraoperative or immediate postoperative / post procedure death in an ASA class 1 patient
▪ Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting
▪ Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
▪ Patient death or serious injury associated with patient elopement (disappearance)

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

Description of Condition
▪ Patient suicide, attempted suicide, or self harm resulting in serious injury, while being cared for in a health care setting
▪ Patient death or serious injury associated with a medication error (for example, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
▪ Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting
▪ Death or serious injury of a neonate associated with labor and delivery in a low-risk pregnancy
▪ Unstageable pressure ulcer acquired after admission / presentation in a health care setting
▪ Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
▪ Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
▪ Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
▪ Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting
▪ Death or serious injury of a patient or staff member resulting from a physical assault (that is, battery) that occurs within, or on the grounds of, a health care setting
In addition, the following five Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:
▪ Foreign object retained after surgery
▪ Air embolism
▪ Blood incompatibility
▪ Pressure ulcers, stages III & IV
▪ Falls and trauma related to: a) fractures b) dislocations c) intracranial injuries d) crushing injuries e) burns f) other injuries

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

Instructions for Submitting Claims for Additional OPPCs

For acute outpatient hospitals and HLHCs, privately owned chronic disease and rehabilitation outpatient hospitals, state-owned non-acute outpatient hospitals operated by DPH, and substance abuse treatment outpatient hospitals (UB-04 and 837I claims)

Submit a TOB 130 no-pay claim type to identify Additional OPPC-related services. This TOB 130 claim must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The TOB 130 DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an Additional OPPC," and must also state the type of Additional OPPC (from Table (2)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If services unrelated to the Additional OPPC were also provided during the same statement covers period, submit a second claim to bill for the non-Additional OPPC-related services. The second claim must be billed on a routine type bill TOB 13X (cannot be 130).

See also the "Additional Instructions" in subsection C, below, that providers must follow.

For acute outpatient hospitals and HLHCs billing for acute outpatient hospital-based physician services, and freestanding ambulatory surgery centers (FASCs) (CMS-1500 and 837P claims)

Submit a separate professional claim to identify Additional OPPC-related services. This claim must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" in subsection C, below. The DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an Additional OPPC," and must also state the type of Additional OPPC (from Table (2)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If services unrelated to the Additional OPPC were also provided during the same statement covers period, submit a second professional claim to bill for the non-Additional OPPC-related services.

See also the "Additional Instructions" in subsection C, below, that providers must follow.

C. Additional Instructions

(1) Follow-up Care

Follow the same rules above to report any follow-up outpatient services that were solely the result of a previously reported PPC (inpatient or outpatient) that occurred while a member was being cared for at a facility that is covered under the same license.

(2) Related Services for NCDs

All services provided in the operating room or other health care setting when an NCD occurs are considered related to the NCD and therefore must be reported as NCD-related services in claims submissions in accordance with the instructions for NCDs, above. All providers in an operating room or other health care setting when an NCD occurs, who could bill individually for their services, are not eligible for payment and their services must be reported as NCD-related services. Related services do not include performance of the correct procedure.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

(3) Providers Approved For An Electronic Submission Waiver

If a provider has been approved for an electronic submission waiver, the provider may submit a separate UB-04 or CMS-1500 claim, as applicable, on paper for the PPC. Providers must include the appropriate diagnosis codes or modifiers, as applicable, on the separate paper claim as set forth in the instructions above to identify the applicable PPC, and must include a separate attachment with the paper claim stating, "This claim represents an [NCD][Additional OPPC]," and must also state the type of PPC (from the appropriate table, above). Providers must submit the completed paper claim, with the attachment, to the following address: MassHealth Claims Operations/PPC Unit, 100 Hancock St., 6th Floor, Quincy, MA 02171. The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

(4) Health Safety Net (HSN)/Unreimbursed Costs

Providers are prohibited from seeking reimbursement for identified PPC-related services through the Health Safety Net (HSN) or otherwise, and from including such services in any unreimbursed cost reporting.

(5) Prohibition on Charging Members

Providers are prohibited from charging members for PPCs and PPC-related services, including, without limitation, copayments or deductibles.

(6) Reporting PPCs to the Department of Public Health

The additional instructions in this paragraph apply to the following MassHealth providers.

- acute outpatient hospitals
- privately owned chronic disease and rehabilitation outpatient hospitals
- state-owned non-acute outpatient hospitals operated by DPH
- substance abuse treatment outpatient hospitals
- acute outpatient hospitals billing for acute outpatient hospital-based physician services
- freestanding ambulatory surgery centers

In addition to complying with the billing instructions set forth above, for any PPC that is also a "serious reportable event (SRE)" as designated by the Massachusetts Department of Public Health (DPH) pursuant to its regulations at 105 CMR 130.332 (or 105 CMR 140.308, as applicable), the providers listed above must continue to report the occurrence of the PPC as an SRE to DPH, and perform the documented review process as set forth in, and in accordance with, DPH regulations at 105 CMR 130.332(B) and (C) (or 105 CMR 140.308(B) and (C), as applicable). These MassHealth providers must also provide copies of such reports to MassHealth and any other responsible third-party payer and inform the patient, as required by, and in accordance with, DPH regulations at 105 CMR 130.332(B) and (C) (or 105 CMR 140.308(B) and (C), as applicable). The copies to MassHealth must be sent to the following address.

PPC/Serious Reportable Event Coordinator
MassHealth
Utilization Management Department
100 Hancock Street, 6th Floor
Quincy, MA 02171

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

(7) Serious Reportable Events

For MassHealth providers listed in paragraph 6 of these Additional Instructions, above, Appendix U of all provider manuals identifies those events that are designated by DPH as "Serious Reportable Events (SREs)" in accordance with 105 CMR 130.332 (or 105 CMR 140.308, as applicable), but which are not "provider preventable conditions" under MassHealth. The SREs listed in Appendix U are governed by applicable provisions on "Serious Reportable Events," including, without limitation, provisions concerning nonpayment and reporting for these events set forth, in the case of hospital providers, in the provider's MassHealth agreement governing payment for hospital services, or in the case of freestanding ambulatory surgery centers, in Transmittal Letter FAS-25.

(8) Coordination of Benefit Claims (COB) – Instructions Pertaining to MassHealth Members with Medicare and/or Other Insurance

Providers must follow instructions described here to report PPCs for MassHealth members who have Medicare and/or other insurance. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations and their other applicable MassHealth billing and companion guides to submit COB claims as necessary.

(a) **NCDs**

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth NCD requirements and instructions described above in Section III, for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare crossover claims for dually eligible members to MassHealth for adjudication. No further action is required for Medicare crossover claims.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to MassHealth NCD requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

(b) **Additional OPPCs**

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth Additional OPPC requirements and instructions described above in Section III, for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Part 2. Billing Instructions for PPCs for Outpatient Hospitals and Freestanding Ambulatory Surgery Centers (cont.)

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare crossover claims for dually eligible members to MassHealth for adjudication.

Medicare crossover claims billed for Additional OPPCs listed in Table (2) must be rebilled to MassHealth according to MassHealth Additional OPPC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to MassHealth Additional OPPC requirements and instructions described above in Section III. Providers must report Medicare's COB information on their MassHealth claim submission.

Part 3. Billing Instructions for PPCs for All Other MassHealth Providers

I. Applicable Providers

This part contains PPC billing instructions that apply to all other MassHealth providers (providers other than hospitals or freestanding ambulatory surgery centers), whose services include, or who could bill for, "surgical or other invasive procedures" in a health care setting, as indicated below (CMS-1500 or 837P claims).

CMS-1500 or 837P claims	
▪ dental providers who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7)	▪ radiation and oncology treatment centers
▪ group practice organizations	▪ independent diagnostic testing facilities (IDTF)
▪ independent nurse midwives	▪ freestanding birth centers
▪ independent nurse practitioners	▪ family planning agencies
▪ optometry providers	▪ sterilization clinics
▪ physicians	▪ community health centers
▪ podiatrists	▪ abortion clinics

In addition, if any other MassHealth provider not otherwise listed in Section I of Parts 1, 2, or 3 of Appendix V perform "surgical or other invasive procedures" in a health care setting (as "surgical or other invasive procedure" is defined by CMS in Medicare guidance for National Coverage Determinations (NCDs)), such provider must comply with the billing instructions set forth below for reporting and billing NCDs.

II. Provider Preventable Conditions (PPCs)

Under Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (the ACA) and federal regulations at 42 CFR 447.26, providers must report "provider preventable conditions" (PPCs) to Medicaid agencies; and Medicaid agencies are prohibited from paying providers for PPCs in violation of the federal requirements.

For purposes of the providers listed in Section I, above, PPCs refer to "Other Provider Preventable Conditions" that are the three National Coverage Determinations (NCDs), which may occur in any health care setting. See Table (1), below for the list of NCDs.

Part 3. Billing Instructions for PPCs for All Other MassHealth Providers (cont.)

Table (1). National Coverage Determinations (NCDs)

Description of NCD	*Modifier*
Surgical or other invasive procedure performed on the wrong body part	PA (Surgical or other invasive procedure on wrong body part)
Surgical or other invasive procedure performed on the wrong patient	PB (Surgical or other invasive procedure on wrong patient)
Wrong surgical or other invasive procedure performed on a patient	PC (Wrong surgery or other invasive procedure on patient)

III. Billing Instructions

Set forth below are the MassHealth billing instructions that providers must follow for reporting and billing NCDs. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations, provider manuals and their other applicable MassHealth billing and companion guides, as necessary.

Applicable Providers
These instructions apply to all providers described in Section I, above.

Submit a separate professional claim to identify NCD-related services. Append the applicable NCD modifier (from Table (1)) to all claim lines related to the erroneous surgery(ies)/procedure(s). This separate professional claim must be billed through direct data entry (DDE) unless the provider has an approved paper claim waiver, in which case see the "Additional Instructions" section below. The DDE claim must be billed using Reason Code 11, and must include a separate attachment stating, "This claim represents an NCD," and must also state the type of NCD (from Table (1)). The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

If non-NCD-related services were also provided during the same statement covers period, submit a second professional claim to bill for the non-NCD-related services.

IV. Additional Instructions

(A) **Follow-up Care**
Follow the same rules above to report any follow-up services that were solely the result of a previous PPC reported by the provider involving the same member.

Part 3. Billing Instructions for PPCs for All Other MassHealth Providers (cont.)

(B) **Related Services for NCDs**

All services provided in the operating room or other health care setting when an NCD occurs are considered related to the NCD and therefore must be reported as NCD-related services in claims submissions in accordance with the instructions, above. All providers in an operating room or other health care setting when an NCD occurs who could bill individually for their services are not eligible for payment and their services must be reported as NCD-related services. Related services do not include performance of the correct procedure.

(C) **Providers Approved for an Electronic Submission Waiver**

If a provider has been approved for an electronic submission waiver, the provider may submit a separate CMS-1500 claim on paper for the NCD. Providers must append the appropriate modifiers, as applicable, on the separate paper claim as set forth in the instructions above to identify the applicable NCD and NCD-related services, and must include a separate attachment with the paper claim stating,"This claim represents an NCD," and must also state the type of NCD (from Table (1), above). Providers must submit the completed paper claim, with the attachment, to the following address: MassHealth Claims Operations/PPC Unit, 100 Hancock St., 6th Floor, Quincy, MA 02171. The claim will suspend and subsequently deny with Edit 7754 - Denied PPC Claim.

(D) **Health Safety Net (HSN)/Unreimbursed Costs**

Providers are prohibited from seeking reimbursement for identified PPC-related services through the Health Safety Net (HSN) or otherwise, and from including such services in any unreimbursed cost reporting.

(E) **Prohibition on Charging Members**

Providers are prohibited from charging members for PPCs and PPC-related services, including, without limitation, copayments or deductibles.

(F) **Coordination of Benefit Claims (COB) – Instructions Pertaining to MassHealth Members with Medicare and/or Other Insurance**

Providers must follow instructions described here to report PPCs for MassHealth members who have Medicare and/or other insurance. Providers should continue to otherwise follow the general billing instructions set forth in applicable MassHealth regulations and their other applicable MassHealth billing and companion guides to submit COB claims as necessary.

NCDs

Third Party Liability

If there is a remaining MassHealth liability, submit claims to MassHealth according to the MassHealth NCD requirements and instructions described above in Section III, for MassHealth members with other insurance. Providers must report the other payer's COB information on their MassHealth claim submission.

Medicare Crossover Claims

The CMS Coordination of Benefits Contractor (COBC) automatically transmits paid Medicare crossover claims for dually eligible members to MassHealth for adjudication.

Part 3. Billing Instructions for PPCs for All Other MassHealth Providers (cont.)

No further action is required for Medicare crossover claims that are submitted by applicable provider types listed in Section I, above.

If there is a remaining MassHealth liability, claims for dually eligible members that are not automatically transmitted from the COBC to MassHealth should be submitted to MassHealth according to MassHealth NCD requirements and instructions described in Section III, above. Providers must report Medicare's COB information on their MassHealth claim submission.