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

MassHealth
Transmittal Letter ALL-217
February 2017

TO: All Providers Participating in MassHealth

FROM: Dan Tsai, Assistant Secretary for MassHealth

RE: Updates to All Provider Manuals, Subchapter 5, Part 7, Administrative and Billing Instructions

This letter transmits revisions to MassHealth's Administrative and Billing Instructions, which is Subchapter 5 of all MassHealth provider manuals. The revisions are located in Part 7, Other Insurance, which contains instructions on how to submit claims for members who have other health insurance or Medicare in addition to MassHealth.

MassHealth is revising this section of Subchapter 5 to

- update the name of the Coordination of Benefits Contractor (COBC) to Benefits Coordination and Recovery Center (BCRC);
- remind providers of the requirement to bill claims electronically unless approved for a temporary electronic claims submission waiver;
- clarify requirements for submitting claims to MassHealth for Medicare-approved services;
- clarify requirements for billing MassHealth when Medicare denied an entire claim; and
- update links to documents within the MassHealth website that pertain to billing Coordination of Benefits (COB) claims.

MassHealth Website

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

Questions

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648), 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 5.7-1 through 5.7-4

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(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 5.7-1 through 5.7-4 — transmitted by Transmittal Letter ALL-195

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.

MassHealth regulations at 130 CMR 450.316 generally require providers to make "diligent efforts" to identify and obtain payment from all other liable parties, including insurers. "Diligent efforts" is defined as making every effort 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 its Eligibility Verification System (EVS), on each date of service and at the time of billing. See Part 1 of these administrative and billing instructions for instructions on using EVS.

For additional information about third-party-liability requirements, see MassHealth regulations at 130 CMR 450.316 through 450.321.

Updating Other Insurance Information

If you have evidence that a member's other health insurance information differs from what appears on EVS, you must fax or mail a Third-Party Liability Indicator (TPLI-MH) form to the TPL Unit. To download this form, go to Provider Library at www.mass.gov/masshealth. Click on MassHealth Provider Forms and scroll down the list. In addition to the TPLI-MH form, please submit acceptable documentation verifying the coverage change to ensure that the member's file is updated to reflect current information. Acceptable documentation for updating member's insurance information includes an explanation of benefits (EOB), a letter from an employer or health insurance carrier, and a copy of the health insurance card for any new insurance.

Contact information for the TPL Unit is at the bottom of the TPLI-MH form. This information can also be found in Appendix A of your MassHealth provider manual.

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. 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.

Coordination of Benefits Claim Submission

837 Transaction

All MassHealth claims must be submitted electronically unless a provider has been approved for a temporary electronic claims submission waiver. (Refer to *All Provider Bulletin 223* (February 2012).)

Providers may submit Coordination of Benefits (COB) claims to MassHealth following instructions found in the HIPAA 837 implementation guides and MassHealth companion guides. Include the other insurer's adjudication information in the transaction as outlined in the guides. Information on how to obtain the *MassHealth Companion Guides* is available in the Provider Library at www.mass.gov.masshealth.

To start submitting claims electronically, contact the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648), e-mail your inquiry to EDI@mahealth.net, or fax your inquiry to 617-988-8974.

Provider Online Service Center Direct Data Entry Claim

You can use the Provider Online Service Center (POSC) at www.mass.gov/masshealth/providerservicecenter to submit COB claims to MassHealth using direct data entry (DDE). Job aids are available on the Web to assist providers with COB claim submissions.

To download POSC Job Aids, go to http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/mmis-posc/training/get-trained.html and choose a job aid from the list.

If you have more questions about DDE claim submission, contact the MassHealth Customer Service Center (above).

Medicare Crossover Claims

After Medicare has made a payment or applied the charge to the deductible, the Benefits Coordination and Recovery Center (BCRC) will automatically transmit claims for dual-eligible members (Medicare and MassHealth) to MassHealth for adjudication. A claim must contain at least one Medicare-approved service line in order for the entire claim to be crossed over automatically to MassHealth. For Medicare crossover payment methodology, please refer to 130 CMR 450.318.

Providers may directly submit electronic claims for dual-eligible members to MassHealth using the 837 Transaction or POSC if one of the following statements is true:

- The member has other insurance in addition to Medicare and MassHealth; or
- The member's Medicare claim has not appeared on a MassHealth crossover remittance advice and/or the claim cannot be located in POSC during a claim status inquiry.

Providers must follow instructions described in the HIPAA 837 implementation guides and MassHealth companion guides when submitting COB claims for dual eligible members for the reasons listed above. Providers must include all the COB information on their claim submission to MassHealth as it is reported on the other payer's Explanation of Benefits (EOB).

When Medicare Denies Your Entire Claim

If there are no Medicare-approved services on your Medicare claim, you may submit a MassHealth claim after you have received an Explanation of Medicare Benefits (EOMB) indicating that the claim was denied for reasons other than a correctable error. COB information, including all valid HIPAA Claim Adjustment Reason Codes (CARC) as reported on the Medicare EOMB, must be submitted in the MassHealth claim.

Adjusting a COB Claim

When the primary insurer (Medicare or other insurance) voids or adjusts a claim that has been previously paid by MassHealth, providers should submit an adjustment claim to MassHealth including the revised COB information on the claim. Refer to MassHealth billing guides for instructions to submit an adjustment claim to MassHealth.

Preventive Pediatric Care and Prenatal Care Services

Preventive pediatric care services may be billed by the provider to MassHealth as primary when the patient has other insurance (as described in the EPSDT and PPHSD Billing Guidelines for MassHealth Physicians and Mid-level Providers, for members younger than 21 years of age, and prenatal care services including routine prenatal office visits and tests for members of any age).

Dependent Has Insurance through a Noncustodial Parent

Providers may bill services to MassHealth as the primary insurer if **both** the following conditions are true.

- The dependent has insurance through a noncustodial parent against whom child support enforcement is being carried out by the State Title IV-D agency (Department of Revenue).
- The provider has billed the other insurer and has not received payment or a response for 30 days after billing.

Providers should include the correct carrier code and the noncovered amount on their claim submission.

Supplemental Instructions

Please refer to the appendix in your MassHealth provider manual (as listed in the table below) for supplemental instructions that may be applicable to your provider type.

Provider Type	Location
All providers subject to provider preventable conditions	Appendix V, All Provider Manuals
Acute inpatient hospitals	Appendix D, *Acute Inpatient Hospital Manual*
Chronic disease and rehabilitation inpatient hospitals	Appendix D, *Chronic Disease and Rehabilitation Inpatient Hospital Manual*
Community health centers	Appendix D, *Community Health Center Manual*
Home health agencies	Appendix D, *Home Health Agency Manual*
Mental health centers	Appendix D, *Mental Health Center Manual*
Nursing facilities	Appendix G, *Nursing Facility Manual*
Psychiatric inpatient hospitals	Appendix D, *Psychiatric Inpatient Hospital Manual*

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