



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



**MassHealth
All Provider Bulletin 208
February 2011**

TO: All Providers Participating in MassHealth
FROM: Terence G. Dougherty, Medicaid Director *TGD*
RE: **Overview of Key Changes to Be Implemented on January 1, 2012, to Support the Centers for Medicare & Medicaid Services 5010 Mandate**

Background

The Centers for Medicare & Medicaid Services (CMS) have mandated that, on January 1, 2012, the standards for electronic health care transactions must change from version 4010/4010A1 to version 5010/5010A1.

MassHealth is actively working toward this January 1, 2012, implementation date and, in an effort to keep providers informed, is providing a list of 5010 key concepts, which is attached to this bulletin. This list of key concepts provides a high-level overview of the key changes that will be implemented on January 1, 2012, to support the CMS 5010 mandate. It is not an all-inclusive list of all of the 5010 changes that will impact providers, but it will give providers a sense of what changes are coming.

Further details of all of the specific changes will be communicated in MassHealth's paper billing instructions and 5010 companion guides, slated to be issued in April and May of 2011. Providers may also refer to our Web site at www.mass.gov/masshealth/5010 for information about MassHealth's implementation of the 5010 standards.

Questions

If you have any questions about the information in this bulletin, 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.

MassHealth 5010 Key Concepts

The key concepts listed below provide a high level overview of some of the changes that will be implemented on January 1, 2012, to support the CMS 5010 mandate. It is not an all-inclusive list of the 5010 changes that will impact providers. Further details of all of the specific changes will be communicated in MassHealth’s paper billing instructions and 5010 companion guides slated to be issued in April and May of 2011. Providers may also refer to our Web site at www.mass.gov/masshealth/5010 for information about MassHealth’s implementation of the 5010 standards.

Transaction	Key Changes
Global Concepts	<ul style="list-style-type: none"> ● 4010 Data Elements - 4010 data elements will no longer be displayed on the POSC panels. Claims previously submitted in the 4010 format will be displayed in the 5010 format. The new 5010 data fields that do not apply to the 4010 claims will be left blank when displayed. ● New 5010 Data Elements - The relevant new data elements required for 5010 will be used and displayed throughout the application as required. ● Copy a Claim Feature - DDE users will have the ability to copy a claim that was previously submitted in the 4010 format to support a new claim submission. ● Claim Balancing - DDE Claims submitted to MassHealth must now balance at both the service line and the claim level. This means that the total claim charge amount must balance to the sum of all service line charge amounts. Paper claims are not impacted by this change. ● 999/TA1 - The 997 acknowledgement transaction will be eliminated. It will be replaced with the 999 acknowledgement. MassHealth will no longer support the 997 acknowledgement as of January 1, 2012.
COB	<ul style="list-style-type: none"> ● Payer Paid Amount Balancing - Payer paid amount on all claims submitted to MassHealth must balance at both the service line and the claim level. This means that the total claim payer paid amount must balance to the sum of all service line payer paid amounts, less the claim level adjustment reason code amounts. For claim types B (professional Part B crossover), C (outpatient Part B crossover), M (physician), H (home health and community health), and O (hospital outpatient), the provider billed amount on the service line should balance to the sum of service line payer paid amount and service line adjustment reason code amounts. ● Exception Billing - The “total noncovered amount” must be submitted in lieu of providing the prior payer amount, and any adjustment segments previously submitted in exception billing. This will streamline the exception billing process. ● Payer Allowed Amount - Currently, the payer-allowed amount is an important criterion in claim type determination. This field will be removed in HIPAA 5010. With HIPAA 5010, payer paid amount and patient responsibility amounts will be used to determine the claim type. ● Check/Remittance Date - The claim check or remittance date is critical for COB claims adjudication. Currently, it can be submitted at the claim level and the service line level. HIPAA 5010 restricts its submission to either the claim level or the service line level. MassHealth requires providers to submit the check/remittance date for claim type A, I, or L, at the claim level; and submitting the same for claim type B, C, O, H, or M at the service line level.

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Transaction	Key Changes
837P	<ul style="list-style-type: none"> ● Pharmacy/NDC Data - As applicable, professional claims must include additional drug information and qualifiers, such as NDC code, quantity, composite unit of measure, and prescription date and number. MassHealth will edit to support the new data requirements. ● Compound Drugs - Where applicable, all ingredients that make up a compound prescription must be identified on the claim, and have the same prescription number or the same linkage number, if provided without a prescription. ● Billing Provider Address - A P.O. box will no longer be accepted on a claim under the billing provider address. A street address must be provided. Electronic billers may place P.O. box information in the "Pay to Address Loop." Paper providers must provide a doing business as (DBA) address. ● NPI/Atypical Provider Identifiers - Providers that should have an NPI must report their NPI on all claim submissions. Atypical providers, as defined by MassHealth, must indicate G2 instead of 1D as a qualifier. ● Taxonomy Codes - PXC (Health Care Provider Taxonomy code) will replace the generic value of ZZ (mutually defined) to identify taxonomy. Submit this only if you need to use a taxonomy code or when directed by MassHealth. ● Nine-Digit Zip Code - The billing provider name and address must include the nine-digit zip code on claim submissions. ● Ambulance Pick-up/Drop-off Codes - New pick-up and drop-off codes must be submitted when billing for ambulance or non-emergency transportation services. ● Health Care Diagnosis Codes - Providers will be able to submit up to 12 diagnosis codes per claim, with a maximum of four per service line. This change does not impact paper claim submissions.
837I	<ul style="list-style-type: none"> ● Pharmacy/NDC Data - As applicable, institutional claims must include additional drug information and qualifiers, such as NDC code, quantity, composite unit of measure, and prescription date and number. MassHealth will edit to support the new data requirements. ● Compound Drugs - Where applicable, all ingredients that make up a compound prescription must be identified on the claim, and have the same prescription number or the same linkage number, if provided without a prescription. ● Billing Provider Address - A P.O. box will no longer be accepted on a claim under the billing provider address. A street address must be provided. Electronic billers may place P.O. box information in the "Pay to Address Loop." Paper providers must provide a DBA address. ● NPI/Atypical Provider Identifiers - Providers that should have an NPI must report their NPI on all claim submissions. Atypical providers, as defined by MassHealth, must indicate G2 instead of 1D as a qualifier. ● Taxonomy Codes - PXC will replace the generic value of ZZ (mutually defined) to identify taxonomy. Submit this only if you need to use a taxonomy code or when directed by MassHealth. ● Nine-Digit Zip Code - The billing provider name and address must include the nine-digit zip code on claim submissions. ● Patient Paid Amount - The F5 qualifier (Patient Paid Amount) will be deleted. Providers must use the F3 qualifier (Patient Estimated Amount Due). ● Present on Admission (POA) - Acute inpatient hospitals must provide a POA indicator for the Principal, Other, and External Cause of Injury segments.
835	<ul style="list-style-type: none"> ● Reversals/Voids - Reversed/voided claims will appear on the 835 with a claim adjustment group code of OA. The CR adjustment group code will be eliminated.
270/271	Routine changes (adds, deletes, field length).
276/277	Routine changes (adds, deletes, field length).