Supplemental Instructions for Submitting Claims with Other Insurance

This appendix contains specific MassHealth billing instructions for claims for members who have Medicare or commercial insurance. This appendix supplements the instructions found in the HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide.

MassHealth requires all claims to be submitted in an electronic format unless the provider has received an approved electronic claim submission waiver. See All Provider Bulletin 217.

Third-Party Liability (TPL) Requirements

To ensure that MassHealth is the payer of last resort, generally providers must make diligent efforts to obtain payment from other resources before billing MassHealth. See MassHealth regulations at 130 CMR 450.316.

Providers must submit a claim and seek a new coverage determination from the insurer any time a member's condition changes and the member is determined to be at a hospital level of care, or if a member's health insurance coverage status changes, even if Medicare or a commercial insurer previously denied coverage for the same service.

Providers are required to keep the following items on file for auditing purposes:

- the Medicare remittance advice;
- other insurer's notice of noncoverage; and
- other insurer's original explanation of benefits (EOB), 835 transaction, or response from the insurer.

Medicare Crossover Claims When Part A Benefits Have Been Exhausted During the Inpatient Stay

Medicare crossover claims (for dually eligible members) that contain both Medicare-covered and noncovered days are automatically transmitted from the coordination of benefits contractor (COBC) to MassHealth for processing. These crossover claims are suspended with error code 1803 (Recycle Medicare Part A Claim). MMIS systematically collects the Medicare Part B ancillary payments associated with the inpatient stay that have adjudicated in MMIS and deducts the Medicare Part A and Part B payments from the final mid-stay crossover claim payment. Providers should **not** bill separately to MassHealth for the Medicare noncovered days, since the payment for the Medicare-covered and noncovered days is included in the MassHealth mid-stay crossover claim payment.

Providers may submit the claim to MassHealth electronically, following the MassHealth coordination of benefits (COB) requirements if:

- 60 days have passed since they 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.

When billing MassHealth for Medicare inpatient mid-stay claims that contain Medicare-covered and noncovered days for dually eligible members, providers should **not** report the Medicare Part B ancillary payments associated with the inpatient stay on their inpatient claim submission. Medicare Part B ancillary payments are systematically deducted from the MassHealth mid-stay crossover claim payment. Providers should follow instructions found in MassHealth billing guides for claims submissions.

TPL Exception Criteria

This section contains supplemental billing instructions for submitting 837I transactions and direct data entry (DDE) claims for members who have Medicare or commercial insurance when services are determined to be not covered by the primary insurer.

Providers must continue to bill Medicare for all Part B ancillary and physician services associated with the inpatient stay before billing MassHealth for the noncovered Part A services. This section describes the TPL exceptions that may apply when members have Medicare or commercial insurance.

Providers must bill chronic inpatient hospital services for a MassHealth member who has Medicare or the commercial insurer before billing MassHealth, unless a notice of noncoverage from the other insurer has been issued for services determined to be not covered.

There may be instances when the services provided are not covered by the other insurer including when:

- the benefit maximum for this time period or occurrence has been reached;
- the member does not qualify for the new benefit period with the other insurer;
- other insurer does not support the patient level of service; or
- the member is on administrative days.

Follow the instructions outlined in this appendix for claim submissions when one of the above TPL exceptions exists.

Providers are required to retain the following on file for auditing purposes:

- the Medicare remittance advice;
- the other insurer's notice of non-coverage;
- the other insurer's original EOB or 835 transaction; and
- response from the insurer.

Billing Instructions for 837I Transactions

The table below contains the critical loops and segments required for submitting claims to MassHealth that have been determined to be not covered by the other insurer, and that meet the TPL exception criteria described in this appendix. Providers must complete the loops and segments as described in the table below and follow instructions described in the HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide to complete other required COB and non-COB portions of the 837I claim submission.

The "Total Noncovered Amount" segment is used to indicate that the insurer has determined the service to be not covered. Do not report HIPAA adjustment reason codes and amounts in the 2320 loop containing the total noncovered amount.

Loop	Segment	Value Description
2320	SBR09 (Claim Filing Indicator)	Medicare = MA Commercial insurer = CI
2320	AMT01 (Total Noncovered Amount Qualifier)	A8
2320	AMT02 (Total Noncovered Amount)	The total noncovered amount must equal the total billed amount.
2330B	NM109 (Other Payer Name)	MassHealth-assigned carrier code for the other payer **Please Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual.

Medicare Part B

The following table contains the critical loops and segments required to report Medicare Part B ancillary payments associated with the inpatient stay when a member's Medicare Part A benefit has been exhausted.

Providers must complete loops and segments as described in the table below and follow instructions described in the HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide to complete other required COB and non-COB portions of the 837I claim submission.

Chronic disease and rehabilitation inpatient state facilities are not required to report Medicare Part B ancillary payments.

Please Note: For COB balancing, the sum of the claim level Medicare Part B payer paid amount and HIPAA adjustment amounts must balance to the claim billed amount. Providers should report a claim adjustment segment (CAS) with the appropriate HIPAA adjustment reason code and amount on their Medicare Part B payer loop.

Medicare Part B Ancillary Payments		
Loop	**Segment**	**Value Description**
2320	SBR09 (Claim Filing Indicator)	MB
2320	AMT01 (Paid Amount Qualifier)	D
2320	AMT02 (Medicare/Other Insurance Prior Payment Amount)	Payer paid amount
2330B	NM109 (Medicare Part B)	0085000

Medicare Part B Ancillary Payments (cont.)		
Loop	**Segment**	**Value Description**
2330B	DTP01 (Date Claim Paid Qualifier)	573
2330B	DTP03 (Check or Remittance Date)	Medicare's payment date

Billing Instructions for Direct Data Entry (DDE)

Providers must enter the COB information as described in the following table when submitting claims to MassHealth that have been determined to be not covered by the other insurer, and that meet the TPL exception criteria described in this appendix. Providers must follow instructions in the MassHealth billing guides to complete other required COB and non-COB data fields of the DDE claim submission that are not specified in the following table.

The "Total Noncovered Amount" field is used to indicate that the insurer has determined the service to be not covered. Do not enter HIPAA adjustment reason codes and amounts on the List of COB Reasons panel when reporting a total noncovered amount.

On the "Coordination of Benefits" tab, click "New Item" and complete the fields as described below.

COB Detail Panel	
Field Name	**Instructions**
Carrier Code	Enter the MassHealth-assigned carrier code for the other payer. **Please Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual.
Carrier Name	Enter the appropriate carrier name. Refer to Appendix C of your MassHealth provider manual.
Remittance Date	Do not enter a remittance date.
Payer Claim Number	Enter 99.
Payer Responsibility	Select the appropriate code from the drop-down list.
COB Payer Paid Amount	Do not enter a COB payer paid amount.
Total Noncovered Amount	Enter the total billed amount. The total noncovered amount must equal the total billed amount.
Remaining Patient Liability	Do not enter any values.
Claim Filing Indicator	Medicare = MA Commercial insurer = CI
Release of Information	Select the appropriate code from the drop-down list.

COB Detail Panel (cont.)	
Field Name	**Instructions**
Subscriber Information Panel	If you select "Relationship to Subscriber," and it is "18 –Self," then click "Populate Subscriber." The panel will fill the following data fields that have already been entered on the "Billing and Service" tab. • Subscriber Last Name • Subscriber First Name • Subscriber Address • Subscriber City • Subscriber State • Subscriber Zip Code If you select any other relationship-to-subscriber code, you must enter the following required fields. • Subscriber Last Name • Subscriber First Name
Subscriber ID	Enter the Other Insurance Subscriber ID number.

Please Note: Click "Add" to save the COB panel.

Medicare Part B

Providers must enter information in the fields given below to report Medicare Part B ancillary payments associated with the inpatient stay when a member's Medicare Part A benefit has been exhausted. Providers must follow instructions in the MassHealth billing guides to complete other required COB and non-COB data fields of the DDE claim submission that are not specified in the table below.

Chronic disease and rehabilitation inpatient state facilities are not required to report Medicare Part B ancillary payments.

On the "Coordination of Benefits" tab, click "New Item" And complete the fields as described below.

COB Detail Panel	
Field Name	**Instructions**
Carrier Code	Enter 0085000.
Carrier Name	Enter Medicare Part B.
Remittance Date	Enter the other payer's EOB date. **Please Note:** This is a required field.
Payer Claim Number	Enter the other insurer claim number on the EOB.
Payer Responsibility	Select the appropriate code from the drop-down list.
COB Payer Paid Amount	Enter the Medicare Part B amount.
Total Noncovered Amount	Do not enter a total noncovered amount.
Remaining Patient Liability	Do not enter any values.
Claim Filing Indicator	Select MB from the drop-down list.
Release of Information	Select the appropriate code from the drop-down list.
Assignment of Benefits	Select the appropriate code from the drop-down list.
Relationship to Subscriber	Select the appropriate code from the drop-down list.

COB Detail Panel (cont.)	
Field Name	**Instructions**
Subscriber Information Panel	If you select "Relationship to Subscriber," and it is "18 –Self," then click "Populate Subscriber." The panel will fill the following data fields that have already been entered on the "Billing and Service" tab. • Subscriber Last Name • Subscriber First Name • Subscriber Address • Subscriber City • Subscriber State • Subscriber Zip Code If you select any other relationship-to-subscriber code, you must enter the following required fields. • Subscriber Last Name • Subscriber First Name
Subscriber ID	Enter the Other Insurance Subscriber ID number.

Please Note: For COB balancing, the sum of the Medicare Part B payer paid amount entered on the COB detail panel and HIPAA adjustment amounts entered on the list of COB reasons panel should balance to the total charges entered on the Billing and Services tab.

To submit a HIPAA adjustment reason code and amount for the Medicare Part B payer from the list of COB reasons panel click on "New Item" and enter the following:

List of COB Reasons Panel	
Field Name	**Instructions**
Group Code	Select the appropriate code from the drop-down list.
Amount	Enter the adjustment amount associated with the group/reason code.
Units of Service	Enter the units of service.
Reason	Enter the reason code identifying the detailed reason the adjustment was made.

Click "Add" to save COB reasons. Click "Add" to save the COB detail panel.

MassHealth's Right to Appeal

MassHealth reserves the right to appeal any case that, in its determination, may meet the coverage criteria of an insurance carrier. Providers must, at MassHealth's request, submit the claim and related clinical or service documentation to an insurance carrier if MassHealth determines that the provider's submission is necessary in order for MassHealth to exercise its right to appeal.

Questions

If you have any questions about the information in this appendix, please refer to Appendix A of your MassHealth provider manual for the appropriate contact information.