Supplemental Instructions for Submitting Claims with Other Insurance

This appendix contains specific MassHealth billing instructions for claims for members who have Medicare, a Medicare Advantage plan, or other insurance. This appendix supplements the instructions found in the 837I HIPAA 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.

Nursing facility services for MassHealth members who have Medicare, a Medicare Advantage plan, or other insurance coverage must initially be billed to the insurance for payment before billing MassHealth, unless a Medicare skilled nursing facility advance beneficiary notice (SNFABN) or a notice of noncoverage has been issued. This requirement applies to dates of service within 100 days of the date of admission or readmission to the facility. Please refer to the date of admission requirements in this appendix.

Providers must submit a claim and seek a new coverage determination from the insurer any time a member's condition or health insurance coverage status 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 the other insurer previously denied coverage for the same service.

Date of Admission Requirements

MassHealth Members with Medicare Coverage

MassHealth requires providers to change the admit date on the claim from the original date the member was admitted to the nursing facility if the member has returned to the facility following a qualifying hospital stay. The new admit date must be the day the member returns to the nursing facility following a qualifying hospital stay.

MassHealth Members with a Medicare Advantage Plan and Other Insurance Coverage

MassHealth requires providers to change the admit date on the claim from the original date the member was admitted to the nursing facility if the member's condition changes and requires skilled care, or if the member has returned from a hospital stay. The new admit date must be the day the member requires skilled care or returns from a hospital stay.

TPL Exception Criteria

This appendix contains supplemental billing instructions for submitting 837I transactions and direct data entry (DDE) claims for MassHealth members who have Medicare, a Medicare Advantage plan, or other insurance when services are determined to be not covered. Nursing facility services for MassHealth members who have Medicare, a Medicare Advantage plan, or other insurance coverage must initially be billed to the insurance for payment prior to billing MassHealth, unless a Medicare SNFABN or a notice of noncoverage has been issued for services determined to be not covered.

There may be instances when the services provided are not covered by Medicare, the Medicare Advantage plan, or the other insurer, including if the MassHealth member does not:

- have benefits available (benefits exhausted);
- meet the insurer's coverage criteria; or
- qualify for a new benefit period.

Please Note: When you are billing MassHealth for only Medical Leave of Absence (MLOA) days that are noncovered by the insurer, and the admit date is within 100 days of the date of service, then the "Total Noncovered Amount" segment may be used to indicate that the service is noncovered by the insurer.

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

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

- Medicare SNFABN;
- remittance advice;
- insurer's notice of noncoverage;
- insurer's original explanation of benefits (EOB), the 835 transaction, or the 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 Medicare, a Medicare Advantage plan, or the other insurer, and that meet the TPL exception criteria described in this appendix. Providers must complete the loops and segments described in the table below and follow the 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 the HIPAA adjustment reason codes and amounts in the 2320 loop containing the total noncovered amount.

Loop	Segment	Value
2320	SBR09 (Claim Filing Indicator)	Medicare = MA Medicare Advantage plan or other 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)	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.

Billing Instructions for Direct Data Entry

Providers must complete the coordination of benefits fields as described in the following table when submitting claims to MassHealth that have been determined to be not covered by Medicare, the Medicare Advantage plan, or the other insurer, and that meet the TPL exception criteria described in this appendix.

Providers must follow the instructions described in the HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide 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 report the HIPAA adjustment reason codes and amounts on the List of COB Reasons panel when reporting a total noncovered amount.

In 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 total billed amount.
Remaining Patient Liability	Do not enter any values.
Claim Filing Indicator	Medicare = MA Medicare Advantage plan or other insurer = CI
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: Click "Add" to save the COB 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 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.