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

MassHealth
Transmittal Letter CBHC-2
November 2023

TO: Community Behavioral Health Centers Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: *Community Behavioral Health Center (CBHC) Manual* (New Appendix D)

This letter transmits a new Appendix D for the *CBHC Manual*. Appendix D contains billing instructions for claims submitted for dually eligible (Medicare/MassHealth) members receiving behavioral health services provided by clinicians who are not Medicare-certified providers. For the purposes of these instructions, only clinicians who do not meet Medicare's clinical criteria are considered noncertified. These instructions do not apply to providers who meet Medicare clinical criteria but do not participate in Medicare (see MassHealth regulations (130 CMR 450.316 D) for other insurance participation requirements. The new Appendix D is effective **January 3, 2023**.

These procedures should be used only in circumstances where Medicare won't reimburse the cost of behavioral health services provided by a clinician who isn't certified by Medicare. Providers must continue to bill Medicare for all services provided by a certified Medicare provider before billing MassHealth. Providers must retain the documentation that supports services performed by a Medicare noncertified clinician in their records for auditing purposes.

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.

MassHealth Website

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

Sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins.

Questions

If you have any questions about this transmittal letter, please contact MassHealth Customer Service at (800) 841-2900, TDD/TTY: 711 or email your inquiry to provider@masshealthquestions.com.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Community Behavioral Health Center Manual

Pages vi and D-1 through D-4

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Home Health Agency Manual

Page vi — transmitted by Transmittal Letter CBHC-1

6. Service Codes

Supplemental Instructions for Services Provided by Medicare Noncertified Clinicians

This appendix contains supplemental billing instructions for claims submitted for dually eligible (Medicare/MassHealth) members receiving behavioral health services provided by clinicians who are not Medicare-certified providers. For the purposes of these instructions, only clinicians who do not meet Medicare's clinical criteria are considered noncertified. These instructions do not apply to providers who meet Medicare clinical criteria but do not participate in Medicare (see MassHealth regulations (130 CMR 450.316 (D) for other insurance participation requirements.

This appendix contains specific MassHealth billing instructions that supplement the instructions found in the HIPAA 837P Implementation Guide and MassHealth 837P Companion Guide.

These procedures should be used only in circumstances where Medicare won't reimburse the cost of behavioral health services provided by a clinician who isn't certified by Medicare. Providers must continue to bill Medicare for all services provided by a certified Medicare provider before billing MassHealth. Providers must retain the documentation that supports services performed by a Medicare noncertified clinician in their records for auditing purposes.

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, providers must make diligent efforts to get payment from other resources before billing MassHealth. See MassHealth regulations at 130 CMR 450.316.

TPL Exception Criteria

There are instances where clinicians who do not meet Medicare's clinical criteria are deemed Medicare noncertified, and therefore cannot bill Medicare for their services. If these exceptions exist, follow the instructions outlined in this appendix for claim submission.

Billing Instructions for 837P Transactions

Providers must follow the HIPAA 837P Implementation Guide and the MassHealth 837P Companion Guide instructions. For services determined not to be covered by Medicare and that meet the TPL exception criteria for Medicare noncertified clinicians, complete the other payer loops in the 837P transactions as described in the following table.

Loop	Segment	Value
2320	SBR09 (Claim Filing Indicator)	MB
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)	0085000

Billing Instructions for Direct Data Entry (DDE)

Providers must follow MassHealth billing guidelines. When submitting claims to MassHealth for services that are not covered by Medicare, and that meet the TPL exception criteria for Medicare noncertified clinicians, complete the coordination of benefits (COB) fields in the Provider Online Service Center (POSC) direct data entry (DDE) claim panels, as described in the following table.

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 B.
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	Enter MB.
Release of Information	Select the appropriate code from the drop-down list.
Assignment of Benefits	Select the appropriate code from the drop-down list.

COB Detail Panel (cont.)	
Field Name	**Instructions**
Relationship to Subscriber	Select the appropriate code from the drop-down list.
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.

Do not enter COB data on the 'List of COB Reasons' panel in Procedure tab in POSC.

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, please go to www.mass.gov/info-details/contact-masshealth-information-for-providers.

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