Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter CDR-25
February 2010

TO: Chronic Disease and Rehabilitation Inpatient Hospitals Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director

RE: *Chronic Disease and Rehabilitation Inpatient Hospital Manual* (Revised Appendix D)

This letter transmits a revised Appendix D for the *Chronic Disease and Rehabilitation Inpatient Hospital Manual*. Appendix D contains a revised set of billing instructions for submitting 837I transactions, paper claims, and direct data entry (DDE) claims for members who have Medicare or commercial insurance, and whose services are determined not covered by the primary insurer. The revised Appendix D is effective February 1, 2010.

This appendix lists the exceptions that need to be considered when billing MassHealth, Medicare, or commercial insurance. It explains the need for providers to make diligent efforts to obtain payment from other resources and to bill MassHealth as the payer of last resort.

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

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

Chronic Disease and Rehabilitation Inpatient Hospital Manual

Pages vi and D-1 through D-8

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(The pages listed here are no longer in effect.)

Chronic Disease and Rehabilitation Inpatient Hospital Manual

Pages vi and D-1 through D-4 — transmitted by Transmittal Letter CDR-24

Appendix A. Directory A-1

Appendix B. Enrollment Centers B-1

Appendix C. Third-Party-Liability Codes C-1

Appendix D. Supplemental Instructions for Claims with Other Insurance D-1

Appendix W. EPSDT Services: Medical and Dental Protocols and Periodicity Schedules W-1

Appendix X. Family Assistance Copayments and Deductibles X-1

Appendix Y. EVS Codes/Messages Y-1

Appendix Z. EPSDT/PPHSD Screening Services Codes Z-1

Supplemental Instructions for Claims with Other Insurance

This appendix contains supplemental billing instructions for submitting 837I transactions, paper claims, and direct data entry claims (DDE) for members who have Medicare or commercial insurance and whose services are determined not covered by the primary insurer. This appendix lists the exceptions that need to be considered when billing MassHealth for members who have Medicare or commercial insurance. These specific MassHealth billing instructions are not provided in the HIPAA Implementation Guide for the 837I transactions, in the 837I Companion Guide, or in the Billing Guide for the UB-04.

Note: To bill MassHealth for services provided to members with Medicare or commercial insurance and whose services are determined not covered by the primary insurer, providers may no longer use the condition code field on the claim form. If submitting a claim electronically, an entry must be made in the adjustment reason code (ARC) segment. If submitting a claim on paper, the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals must be completed and submitted with the claim form. This form is located on the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Provider Forms in the lower-right panel of the page.

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 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.

TPL Exceptions

Chronic inpatient services for a MassHealth member must be initially billed to Medicare or the commercial insurer, or a Medicare notice of noncoverage must be issued. There may be instances when other insurance coverage is no longer available to the MassHealth member, such as when the member

- does not have benefits available (benefits exhausted);
- does not meet the insurer's coverage criteria;
- does not qualify for a new benefit period; or
- is on administrative days.

If any of the above exceptions exist and the initial insurer's denial or notice of noncoverage is on file, follow the instructions outlined in this appendix for claim submission. Claim submissions must include codes found in the HIPAA Adjustment Reason Code Crosswalk table on page D-7 of this appendix.

Providers are required to retain on file for auditing purposes the Medicare notice of noncoverage, Medicare remittance advice, commercial insurer's original explanation of benefits (EOB), 835I transaction, or response from the insurer.

Medicare Part B Ancillary and Reporting Maintenance Therapy

Providers must continue to bill Medicare for all Part B ancillary services and physician services associated with the inpatient stay before billing MassHealth for the noncovered Part A services. This appendix contains instructions for providers reporting Medicare Part B ancillary payments and for providers billing for physical, occupational, or speech therapy that is deemed by Medicare to be maintenance therapy.

Special instructions for each submission type can be found in the remaining sections of this appendix.

Billing Instructions for 837I Transactions

Providers must complete the other payer loops in the 837I transactions as described in the following table when submitting claims to MassHealth that have been initially denied or determined noncovered by the other insurer and that meet the TPL exception criteria.

Loop	Segment	Value Description
2330B	NM109 (Other Payer Name)	Enter the MassHealth-assigned carrier code for the other payer. **837I:** Medicare (Institutional) carrier code = 0084000 **Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual.
2320	SBR09 (Claim Filing Indicator)	**837I:** Medicare (Institutional) carrier code = MA **837I:** Commercial insurer carrier code = C
2320	AMT01 (Allowed Amount Qualifier)	B6
2320	AMT02 (Allowed Amt = 0)	0
2320	AMT01 (Paid Amount Qualifier)	C4
2320	AMT02 (Medicare/Other Insurance Prior Payment Amount)	0
2320	CAS01 (Claim Adjustment Group Code)	OA (other adjustments)

Loop	Segment	Value Description
2320	CAS02 (Claim Adjustment Reason Code)	See the HIPAA Adjustment Reason Code Crosswalk table on page D-7. The table crosswalks the previously used condition codes to the current HIPAA adjustment reason codes (ARCs). Providers must use the correct HIPAA ARC to ensure that claims are processed correctly. **Note:** For maintenance therapy, refer to the Maintenance Therapy Adjustment Reason Code Crosswalk table on page D-7.
2320	CAS03 (Monetary Amount)	Total charges (amount billed to MassHealth)
2330B	DTP03 (Date, Time, or Period)	Date of discharge or end date of service for the claim billing period

The provider must fill in the other payer loops in the 837I transaction as described in the following table to report Medicare Part B ancillary payments.

Medicare Part B Ancillary Payments		
Loop	**Segment**	**Value Description**
2320	SBR09 (Claim Filing Indicator)	MB
2320	AMT01 (Allowed Amount Qualifier)	B6
2320	AMT02 (Allowed Amt = 0)	0
2320	AMT01 (Paid Amount Qualifier)	C4
2320	AMT02 (Medicare/Other Insurance Prior Payment Amount)	Medicare prior payment amount
2330B	NM109 (Medicare Part B)	0085000

Billing Instructions for Direct Data Entry (DDE)

Providers must complete the coordination of benefits fields as described in the following table when submitting claims to MassHealth that have been initially denied or determined noncovered by the other insurer and that meet the TPL exception criteria.

On the coordination of benefits tab, choose "New Item."

Coordination of Benefits	
Field Name	**What to Enter**
Carrier Code	Enter the MassHealth-assigned carrier code for the other payer. Medicare (Institutional) carrier code = 0084000 **Please Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) in your MassHealth provider manual at www.mass.gov/masshealth.
Carrier Name	Enter the appropriate carrier name. Refer to Appendix C of your MassHealth provider manual.
EOB Date	Date of discharge or end date of service for the claim billing period (**Note:** This is a required field.)
Payer Claim Number	Enter the other insurer claim number on the EOB. If there is no EOB, enter 99 as the default payer claim number.
Payer Responsibility	Select the appropriate code.
Allowed Amount	Enter 0.
Payer Paid Amount	Enter 0.
Claim Filing Indicator	Medicare (Institutional) = MA Commercial insurer = CI
Release of Information	Select the appropriate code.
Assignment Benefit	Select the appropriate code.
Subscriber Information Panel	Enter the appropriate subscriber information and required fields (subscriber last name, first name, subscriber ID, and relationship to subscriber code).

Once the above data fields have been entered, scroll down to the bottom of the page to the list of COB reasons subpanel and click "New Item." Input the appropriate COB reasons detail information, according to the following table.

COB Reasons Detail	
Group Code	Select OA (other adjustments).
Units of Service	Enter the appropriate quantity.
Amount	Total charges (amount billed to MassHealth)
Reason	See the HIPAA Adjustment Reason Code Crosswalk table on page D-7. The table crosswalks the previously used condition codes to the current HIPAA ARCs. Providers must bill using the correct HIPAA ARC to ensure that claims are processed correctly. **Note:** For maintenance therapy refer to the Maintenance Therapy Adjustment Reason Code Crosswalk table on page D-7.

Please Note: Once the COB reason detail panel is completed, click “Add” to save the information. Then click “Add” to save the coordination of benefit (COB) detail information.

DDE Billing Instructions for Reporting Medicare Part B Payments

Providers must enter information in the fields given below to report Medicare Part B payments.

Coordination of Benefits	
Field Name	**What to enter**
Carrier Code	Enter the appropriate seven-digit carrier code = 0085000.
Carrier Name	Enter the appropriate carrier name = Medicare Part B.
EOB Date	Date of discharge or end date of service for the claim billing period (**Note:** This is a required field.)
Payer Claim Number	Enter the other insurer claim number on the EOB. If there is no EOB, enter 99 as the default payer claim number.
Payer Responsibility	Select the appropriate code.
Allowed Amount	Enter 0.
Payer Paid Amount	Enter the Medicare B prior paid amount.
Claim Filing Indicator	Select MB.
Release of Information	Select the appropriate code.
Assignment Benefit	Select the appropriate code.
Subscriber Information Panel	Enter the appropriate subscriber information (subscriber last name, first name, subscriber ID, and relationship to subscriber code).

Click "Add" to save the coordination of benefit (COB) detail information for Medicare Part B prior paid amount.

Billing Instructions for Paper Claims

Providers must submit the appropriate claim form, along with the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals when billing MassHealth for claims that have been initially denied or determined noncovered by the other insurer and that meet the TPL exception criteria. This form is available on the MassHealth Web site at www.mass.gov/masshealth. Providers must enter the appropriate HIPAA ARC on this form from the HIPAA Adjustment Reason Code Crosswalk table on page D-7.

Note: For maintenance therapy, refer to the Maintenance Therapy Adjustment Reason Code Crosswalk table on page D-7.

Providers submitting paper claims must refer to the Billing Guide for the UB-04. Otherwise, claims may be processed incorrectly.

HIPAA Adjustment Reason Code Crosswalk Table

Use the adjustment reason codes (ARCs) in the following table to indicate the reason that an insurer is not covering the service.

The table crosswalks the previously used condition codes and previous billing instructions to the current HIPAA ARCs. Providers must enter the correct HIPAA ARC to ensure that claims are processed correctly.

HIPAA Adjustment Reason Code Crosswalk Table			
Prior Condition Code	**Replace with HIPAA Adjustment Reason Code**	**Applies to Medicare?**	**Applies to Commercial Insurers?**
YO - Valid EOB/Denial on file-Benefits exhausted for the calendar year	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	No	Yes
Y1 - Benefit maximum has been reached	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	Yes	Yes
Y8 - Valid EOB-Utilization review notice/services do not meet the skilled level of care	**150** - Payment adjusted because the payer deems the information submitted does not support this level of service.	Yes	Yes

Maintenance Therapy Adjustment Reason Code Crosswalk Table

When providing physical, occupational, or speech therapy to a Medicare member, if the therapy is deemed to be maintenance therapy by Medicare, use the following ARC.

Maintenance Therapy Adjustment Reason Code Crosswalk Table			
Previous Billing Instructions Item FL42	**HIPAA Adjustment Reason Code**	**Applies to Medicare?**	**Applies to Commercial Insurers?**
M	204 - This service/equipment/drug is not covered under the patient’s current benefit plan.	Yes	No

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, refer to Appendix A of your MassHealth provider manual for the appropriate contact information.