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

MassHealth
Transmittal Letter CDR-26
December 2011

TO: Chronic Disease and Rehabilitation Inpatient Hospitals Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

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

The Centers for Medicare & Medicaid Services (CMS) requires all trading partners who submit electronic transactions to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 Version 4010A1 to HIPAA ASC X12 Version 5010. All covered entities (health care providers, health plans, and health care clearinghouses) must be HIPAA 5010 compliant by January 1, 2012.

This letter transmits a revised Appendix D for the *Chronic Disease and Rehabilitation Inpatient Hospital Manual*. Appendix D contains revised billing instructions required for version 5010/5010A1 for submitting 837I transactions, direct data entry (DDE), and paper claims for members who have Medicare or commercial insurance.

Appendix D contains specific MassHealth billing instructions that supplement the instructions found in the HIPAA 837I Implementation Guide, in the MassHealth 837I Companion Guide, and in the MassHealth Billing Guide for the UB-04.

Please Note: Effective January 1, 2012, MassHealth is moving toward an all-electronic claims submission policy to achieve greater efficiency. All claims must be submitted electronically, unless the provider has received an approved electronic claim submission waiver. 90-day waiver requests and final deadline appeals may be submitted either electronically via the POSC or on paper. Please see All Provider Bulletin 217, dated September 2011, for more information about MassHealth's paper claims waiver policy. Please also refer to All Provider Bulletin 220 and All Provider Bulletin 221, dated December 2011, for information on how to submit 90-day waiver requests and final deadline appeals electronically.

The TPL Exception Form for Nursing Facilities and All Inpatient Hospitals has been obsoleted. Effective January 1, 2012, providers who have received an approved electronic claim submission waiver must use the TPL Exception Form that has been revised to reflect the 5010 mandate. To download the new form, go to www.mass.gov/masshealth. Click on MassHealth Provider Forms in the lower right panel of the home page, then scroll down the list to the TPL Exception Form.

Providers must submit the UB-04 claim form with the revised TPL Exception Form to report total noncovered charges when billing MassHealth for claims that have been determined to be noncovered by Medicare or the commercial insurer, and that meet the TPL exception criteria described in Appendix D.

The revised Appendix D is effective January 1, 2012.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Questions

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

Page vii and D-1 through D-8

OBSOLETE MATERIAL

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

Chronic Disease and Rehabilitation Inpatient Hospital Manual

Page vii — transmitted by Transmittal Letter CDR-24

Pages D-1 through D-8 — transmitted by Transmittal Letter CDR-25

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Manuals in the series contain administrative regulations, billing regulations, program regulations, service codes, administrative and billing instructions, and general information. MassHealth regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. MassHealth regulations are assigned Title 130 of the Code. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For chronic disease and rehabilitation inpatient hospitals, those matters are covered in 130 CMR Chapter 435.000, reproduced as Subchapter 4 in the *Chronic Disease and Rehabilitation Inpatient Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which furnish instructions for substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth’s effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and its members.

Supplemental Instructions for Submitting Claims with Other Insurance

This appendix contains specific MassHealth billing instructions for members who have Medicare or commercial insurance and supplements the instructions found in the HIPAA 837I Implementation Guide, MassHealth 837I Companion Guide, and MassHealth Billing Guide for the UB-04.

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

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 retain the following 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 Exhausted During the Inpatient Stay

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

This section contains supplemental billing instructions for submitting 837I transactions, direct data entry claims (DDE), and paper 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.

Chronic inpatient hospital services for a MassHealth member must be initially billed to 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;
- when the member does not qualify for the new benefit period with the other insurer;
- when the other insurer does not support the patient level of service; and
- when the member is on administrative days.

Follow the instructions outlined in this appendix for claim submissions when one of the above TPL exception 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 = 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 table below 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 table below.

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 Advice	Do not enter a remittance date.
Payer Claim Number	Enter 99.
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 = the total billed amount.
Remaining Patient Liability	Do not enter a remaining patient liability.
Payer Responsibility	Select the appropriate code from the drop-down list.

COB Detail Panel (cont.)	
Field Name	**Instructions**
Claim Filing Indicator	Medicare = MA Commercial 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.
Subscriber Information Panel	Enter the appropriate required subscriber information: Subscriber last name First name Subscriber ID The relationship to the subscriber code (Select appropriate code from drop-down list.)

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 nonCOB 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.
COB Payer Paid Amount	Enter the Medicare Part B amount.
COB Detail Panel (cont.)	

Field Name	Instructions
Total Noncvered Amount	Do not enter a total noncovered amount.
Remaining Patient Liability	Do not enter a remaining patient liability.
Payer Responsibility	Select “secondary” from the drop-down list.
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.
Subscriber Information Panel	Enter the appropriate required subscriber information: Subscriber last name First name Subscriber ID The relationship to subscriber code (Select the appropriate code from drop-down list.)

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.

Billing Instructions for Paper Claims

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

Providers must follow the instructions in the MassHealth Billing Guide for the UB-04. Providers must submit the UB-04 claim form with the TPL Exception Form to report total noncovered charges when billing MassHealth for claims that have been determined to be not covered by the other insurer, and that meet the TPL exception criteria described in this appendix. To download the new form, go to www.mass.gov/masshealth. Click on MassHealth Provider Forms in the lower right panel of the home page, then scroll down the list to the TPL Exception Form.

To report Medicare Part B ancillary payments associated with the inpatient stay when a member's Medicare Part A benefit has been exhausted, providers should attach the Medicare Part B EOB to the UB-04 claim form and follow these instructions.

- Circle the applicable EOB information that corresponds to the claim.
- Write the carrier code **0085000** on the EOB.

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

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.

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