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 CHC-86
December 2009

TO: Community Health Centers Participating in MassHealth

FROM: Terence G. Dougherty, Interim Medicaid Director

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

This letter transmits a new Appendix D for the *Community Health Center Manual*. Appendix D contains billing instructions for claims submitted for dually entitled (Medicare/MassHealth) members receiving behavioral-health services provided by clinicians who are not Medicare-certified providers. Clinicians who do not meet Medicare's clinical criteria are "noncertified," and therefore cannot bill Medicare for their services. The new Appendix D is effective October 1, 2009.

The procedures in this appendix should be used only when a service is not reimbursable by Medicare because a noncertified clinician provided the services. 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. If the member also has commercial insurance, providers must bill the other insurance before billing MassHealth.

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.)

Community Health Center Manual

Pages vi and D-1 through D-6

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Community Health Center Manual

Page vi – transmitted by Transmittal Letter CHC-85

6. Service Codes and Descriptions

Supplemental Instructions for TPL Exceptions
Services Provided by Medicare Noncertified Clinicians

This appendix contains supplemental billing instructions for claims submitted for dually entitled (Medicare/MassHealth) members receiving behavioral-health services provided by clinicians who are not Medicare-certified providers. Clinicians who do not meet Medicare's clinical criteria are noncertified, and therefore cannot bill Medicare for their services.

This appendix contains specific MassHealth billing instructions that are not described in the HIPAA implementation guide for 837P transactions, in the 837P companion guide, or in the billing guides for the UB-04 or CMS-1500.

The procedures in this appendix should be used only when a service is not reimbursable by Medicare because a noncertified clinician provided the services. 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. If the member also has commercial insurance, providers must bill the insurance before billing MassHealth.

Note: Providers may no longer use the Patient Status Code field on the claim form (UB-04 or CMS-1500) to bill MassHealth for services provided to members with Medicare and whose services are determined not covered by the primary insurer because the services were delivered by a Medicare noncertified clinician. If submitting a claim electronically, the adjustment reason code segments must be populated. If submitting a claim on paper, the TPL Exception Form for Noncertified Clinicians must be completed and submitted with the claim form. The form is available from the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Provider Forms on the lower right side of the MassHealth home 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 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 medical condition or health insurance coverage status changes, even if Medicare or a commercial insurer previously denied coverage for the same service.

Certain TPL Exceptions

If any of the following 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-6.

- Services for a MassHealth member must be billed to Medicare initially or a Medicare notice of noncoverage must be issued.
- There are instances where clinicians who do not meet Medicare's clinical criteria are noncertified, and therefore cannot bill Medicare for their services.

Providers must retain the initial Medicare notice of noncoverage, Medicare remittance advice, 835 transactions, or response from the insurer on file for auditing purposes.

Billing Instructions for 837P Transactions

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

Loop	Segment	Value Description
2330B	NM109 (Other Payer Name)	Enter the MassHealth-assigned carrier code for the other payer. **837P:** Medicare carrier code = 0085000 **Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual at www.mass.gov/masshealth.
2320	SBR09 (Claim Filing Indicator)	**837P:** Medicare carrier code = MB
2320	AMT (Amount)	0
2320	CAS01 (Claim Adjustment Group Code)	OA (other adjustments)
2320	CAS02 (Claim Adjustment Reason Code)	Use HIPAA adjustment reason code (ARC) B7 (This provider was not certified or eligible to be paid for this procedure/service on this date of service).
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
2430	SVD01 (Payer ID Code)	Enter the MassHealth-assigned carrier code for the other payer. **837P:** Medicare carrier code = 0085000 **Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual or at www.mass.gov/masshealth.
2430	SVD02 (Monetary Amount)	0
2430	CAS01 (Service Line Adjustment Group Code)	OA (other adjustments)

Loop	Segment	Value Description
2430	CAS02 (Service Line Adjustment Reason Code)	Use HIPAA adjustment reason code (ARC) B7. This provider was not certified or eligible to be paid for this procedure/service on this date of service.
2430	CAS03 (Monetary Amount)	Total charges (amount billed to MassHealth)
2430	DTP03 (Date, Time, or Period)	Date of discharge or end date of service for the claim billing period

Billing Instructions for Direct Data Entry (DDE)

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

On the Coordination of Benefits tab, you must choose New Item.

Coordination of Benefits	
Field Name	**What to enter**
Carrier Code	Enter the MassHealth-assigned carrier code for the other payer. Medicare (professional) carrier code = 0085000 **Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of 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 no EOB, use the default value of “99” for payer claim number.
Payer Responsibility	Select the appropriate code from the drop down list.
Allowed Amount	Enter 0.
Payer Paid Amount	Enter 0.
Claim Filing Indicator	Medicare (professional) carrier code = MB
Release of Information	Select the appropriate code.

Coordination of Benefits	
Field Name	**What to enter**
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). **Note:** This is a required field.

After entering the data, scroll down to the bottom of the page to the list of COB reasons subpanel and click New Item. Enter appropriate COB reasons detail information.

COB Reasons Detail	
Field Name	**What to enter**
Group Code	Select OA (other adjustments).
Units of service	Enter the appropriate quantity.
Amount	Total charges (amount billed to MassHealth)
Reason	Enter the HIPAA adjustment reason code (ARC) B7 (This provider was not certified or eligible to be paid for this procedure/service on this date of service).

Once you complete the COB reasons detail panel, click Add to save the information. Then click Add to save the coordination of benefits (COB) detail information.

On the Procedures tab, after entering the procedure service details, scroll down to the list of COB line items and click New Item. Repeat for each procedure detail.

COB Line Detail	
Field Name	**What to enter**
Carrier Code	Enter the MassHealth-assigned carrier code for the other payer. Medicare (professional) carrier code = 0085000 **Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual at www.mass.gov/masshealth.
EOB Date	Date of discharge or end date of service for the claim is billing period **Note:** This is a required field.
Paid Amount	Enter 0.

COB Line Detail	
Paid Units of Service	Enter units of service from procedure service detail panel.
Revenue Code	Enter revenue code from procedure service detail panel.
Procedure Code	Enter procedure code from the procedure service detail panel.
Modifier 1	Enter modifier 1 from the modifier from service detail panel.
Modifier 2	Enter modifier 2 from the modifier from service detail panel.
Modifier 3	Enter modifier 3 from the modifier from service detail panel.
Modifier 4	Enter modifier 4 from the modifier from service detail panel.

After entering the data, scroll to the list of COB reasons subpanel and click New Item.

COB Reasons Detail	
Field Name	**What to enter**
Group Code	Select OA (other adjustments).
Amount	Enter total charges from the institutional service detail panel.
Units of service	Enter units from the institutional service detail panel.
Reason	Enter the HIPAA adjustment reason code (ARC) B7. (This provider was not certified or eligible to be paid for this procedure/service on this date of service).

Click Add on the COB reasons detail panel, then click Add on the COB lines detail panel, then click Add on the institutional service detail panel to save all information.

Billing Instructions for Paper Claims

Providers must submit the MassHealth-approved claim form with the TPL Exception Form for Noncertified Clinicians, and use HIPAA adjustment reason code (ARC) B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service. Providers must enter this code on the form and also submit the appropriate behavioral-health service code. This form is available on the MassHealth Web site at www.mass.gov/masshealth.

Providers submitting paper claims must refer to instructions in the Billing Guide for the UB-04 or the Billing Guide for the CMS-1500 to ensure claims are processed correctly.

HIPAA Adjustment Reason Code Crosswalk Table

Use the HIPAA adjustment reason code (ARC) given in the following table to indicate the reason that the insurer is not covering the service. MassHealth allows providers to use ARCs to report noncovered services only in the circumstances described in the table.

HIPAA Adjustment Reason Code Crosswalk Table			
Prior Patient Status Code	**Replace with HIPAA Adjustment Reason Code**	**Applies to Medicare?**	**Applies to Commercial Insurers?**
01	**B7** - This provider was not certified / eligible to be paid for this procedure/service on this date of service.	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, please refer to Appendix A of your MassHealth provider manual for the appropriate contact information.