***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-88
July 2010

**TO:** Community Health Centers Participating in MassHealth

**FROM:** Terence G. Dougherty, Interim Medicaid Director

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

This letter transmits a revised Appendix D for the *Community Health Center Manual*. Appendix D contains billing instructions for submitting claims 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 revised Appendix D is effective July 1, 2010.

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.

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 vii and D-1 through D-6

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Community Health Center Manual

Pages D-1 through D-6 — transmitted by Transmittal Letter CHC-86

Page vii — transmitted by Transmittal Letter CHC-85

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 Community Health Centers, those matters are covered in 130 CMR Chapter 405.000, reproduced as Subchapter 4 in the *Community Health Center Manual*.

Revisions and additions to the manual are made as needed by 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 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. Only clinicians who do not meet Medicare's clinical criteria are considered "noncertified" for purposes of these instructions. These instructions do not apply to providers who meet Medicare clinical criteria, but do not participate in Medicare.

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 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, an entry must be made in the adjustment reason code (ARC) segment. 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.

## TPL Exceptions

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 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. Claim submissions must include the code found in the HIPAA Adjustment Reason Code Crosswalk Table on page D-6 of this appendix.

## 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 listed on the HIPAA Adjustment Reason Code Crosswalk Table on page D-6 of this appendix.

| Loop | Segment | Value Description |
|---|---|---|
| 2330B | NM109 (Other Payer Name) | Enter the MassHealth-assigned carrier code for the other payer.<br>**837P:** Medicare carrier code = 0085000<br>**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 | 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) |
| 2320 | CAS02 (Claim Adjustment Reason Code) | Use HIPAA adjustment reason code (ARC) B7 |
| 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.<br>**837P:** Medicare carrier code = 0085000<br>**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 |

| Loop | Segment | Value Description |
|---|---|---|
| 2430 | CAS01 (Service Line Adjustment Group Code) | OA (other adjustments) |
| 2430 | CAS02 (Service Line Adjustment Reason Code) | Use HIPAA adjustment reason code (ARC) B7. |
| 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.<br>Medicare (professional) carrier code = 0085000<br>**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<br>**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. |

| Coordination of Benefits | |
|---|---|
| **Field Name** | **What to Enter** |
| Claim Filing Indicator | Medicare (professional) carrier code = 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). **Note:** This is a required field. |

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." Enter the appropriate COB reasons detail information, according to the following table.

| 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. |

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.<br>Medicare (professional) carrier code = 0085000<br>**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. |

| COB Line Detail | |
|---|---|
| EOB Date | Date of discharge or end date of service for the claim billing period<br>**Note:** This is a required field. |
| **Field Name** | **What to Enter** |
| Paid Amount | Enter 0. |
| 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 procedure detail panel. |
| Modifier 2 | Enter modifier 2 from the modifier from service procedure detail panel. |
| Modifier 3 | Enter modifier 3 from the modifier from service procedure detail panel. |
| Modifier 4 | Enter modifier 4 from the modifier from service procedure 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 professional service detail panel. |
| Units of service | Enter units from the professional service detail panel. |
| Reason | Enter the HIPAA adjustment reason code (ARC) B7. |

**Please Note:** Click "Add" on the COB reasons detail panel, then click "Add" on the COB lines detail panel, then click "Add" on the professional service detail panel to save all information.

**Billing Instructions for Paper Claims**

Providers must submit the appropriate claim form along 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.

## Using Adjustment Reason Codes for 837P Transactions, Paper Claims, and Direct Data Entry (DDE) Claims

Use the HIPAA 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 patient status codes to the current HIPAA ARCs. Providers must bill using the correct HIPAA ARC to ensure that claims process correctly.

| 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.