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

MassHealth
Transmittal Letter CHC-92
December 2011

TO: Community Health Center Providers Participating in MassHealth

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

RE: *Community Health Center 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 *Community Health Center Manual*. Appendix D contains revised billing instructions required for version 5010/5010A1 for submitting 837P transactions, direct data entry (DDE), and paper claims 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.

Appendix D contains specific MassHealth billing instructions that supplement the instructions found in the HIPAA 837P Implementation Guide, in the MassHealth 837P Companion Guide, and in the MassHealth Billing Guide for the CMS-1500.

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 Medicare Noncertified Clinicians 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 CMS-1500 claim form with the revised TPL Exception Form to report total noncovered charges when billing MassHealth for behavioral health services that have been furnished by a Medicare noncertified provider.

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.)

Community Health Center Manual

Pages D-1 through D-4

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-88

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. 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 who do not participate in Medicare.

This appendix contains specific MassHealth billing instructions that supplement the instructions found in the HIPAA 837P Implementation Guide, the MassHealth 837P Companion Guide, and in the MassHealth Billing Guide for the CMS-1500.

The procedures in this appendix should be used only when a service is not reimbursable by Medicare, because behavioral health services were provided by a clinician who was not Medicare-certified. 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 commercial insurer before billing MassHealth.

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 get payment from other resources before billing MassHealth. See MassHealth regulations at 130 CMR 450.316.

TPL Exceptions

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. 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 determined not covered by the other commercial insurance, if there is commercial insurance, and that meet the TPL exception criteria for Medicare noncertified clinicians.

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 = the total billed amount.
2330B	NM109 (Other Payer Name)	0085000

Billing Instructions for Direct Data Entry (DDE)

Providers must follow MassHealth billing guidelines. Complete the coordination of benefits (COB) fields in the provider portal direct data entry (DDE) claim panels, as described in the following table, when submitting claims to MassHealth for services that have been determined to be not covered by the commercial insurer, if there is commercial insurance, and that meet the TPL exception criteria for Medicare noncertified clinicians.

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.
Payer Claim Number	Enter 99.
Payer Responsibility	Select the appropriate code from the drop-down list.
Total Noncovered Amount	Enter the total billed amount. The total noncovered amount must = the total billed amount.
Claim Filing Indicator	Enter MB.
Release of Information	Select the appropriate code from the drop-down list.
Assignment Benefit	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 the appropriate code from drop down-list.)

Please Note: Click "Add" to save the COB 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 CMS-1500. Providers must submit the CMS-1500 claim form with the TPL exception form to report total noncovered charges when behavioral health services are furnished by a Medicare noncertified provider. This form is available on the MassHealth Web site at www.mass.gov/masshealth.

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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