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

MassHealth
Transmittal Letter CHC-96
April 2013

TO: Community Health Center Providers Participating in MassHealth

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

RE: *Community Health Center Manual* (Revised Appendix D - Coordination of Benefits Direct Data Entry Enhancements for the Provider Online Service Center)

This letter transmits a revised Appendix D for the *Community Health Center Provider Manual*. Appendix D contains specific MassHealth billing instructions that supplement the instructions found in the HIPAA 837P Implementation Guide, the MassHealth 837P Companion Guide, and the MassHealth Billing Guide for the CMS-1500.

These revisions are effective December 1, 2012.

MassHealth has implemented Provider Online Service Center (POSC) direct data entry (DDE) enhancements for all coordination of benefits (COB) claim submissions. Certain COB fields in the Coordination of Benefits and Procedure tabs will now be prefilled.

The enhancements are described in the "Billing Instructions for Direct Data Entry (DDE)" section of Appendix D.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website 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(The pages listed here are no longer in effect.)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-4 — transmitted by Transmittal Letter CHC-92

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 Exception Criteria

There are instances when 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 equal 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 Online Service Center (POSC) 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.
Remittance Date	Do not enter a remittance date.
Payer Claim Number	Enter 99.
Payer Responsibility	Select the appropriate code from the drop-down list.
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 equal the total billed amount.
Remaining Patient Liability	Do not enter any values.
Claim Filing Indicator	Enter MB.
Release of Information	Select the appropriate code from the drop-down list.
Assignment of Benefits	Select the appropriate code from the drop-down list.

COB Detail Panel (cont.)	
Field Name	**Instructions**
Relationship to Subscriber	Select the appropriate code from the drop-down list.
Subscriber Information Panel	If you select "Relationship to Subscriber," and it is "18 –Self," then click "Populate Subscriber." The panel will fill the following data fields that have already been entered on the "Billing and Service" tab. • Subscriber Last Name • Subscriber First Name • Subscriber Address • Subscriber City • Subscriber State • Subscriber Zip Code If you select any other relationship-to-subscriber code, you must enter the following required fields. • Subscriber Last Name • Subscriber First Name
Subscriber ID	Enter the Other Insurance Subscriber ID number.

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 website 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.