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

MassHealth
Transmittal Letter CSN-2
January 2022

TO: Continuous Skilled Nursing Agencies Participating in MassHealth

FROM: Amanda Cassel Kraft, Assistant Secretary for MassHealth

RE: *Continuous Skilled Nursing Agency Manual* (New Subchapter 6 and New Appendix D)

This letter establishes a new Subchapter 6: Service Codes and Descriptions and a new Appendix D: Supplemental Instructions for TPL Exceptions of the *Continuous Skilled Nursing Agency Manual*.

Subchapter 6

Service codes were previously part of the *Home Health Agency Manual*. Providers may bill with the service codes and service code/modifier combinations listed in this transmittal letter for any date of service within the billing deadlines described in 130 CMR 450.309: *Time Limitation on Submission of Claims: General Requirements* through 130 CMR 450.314: *Final Deadline for Submission of Claims*.

A. Codes

The following codes have been moved from the *Home Health Agency Manual* to the *Continuous Skilled Nursing Agency Manual*.

Individual Patient Nursing

The following service codes must be used for nursing care provided by one nurse to one member.

T1002	RN services, up to 15 minutes (day) (PA)
T1003	LPN/LVN services, up to 15 minutes (day) (PA)
T1002 UJ	RN services, up to 15 minutes (night) (PA)
T1003 UJ	LPN/LVN services, up to 15 minutes (night) (PA)

Multiple-Patient Nursing

The following service codes are to be used for nursing care provided by one nurse simultaneously to two members.

T1002 TT	RN services, up to 15 minutes (day) (each member) (PA)
T1003 TT	LPN/LVN services, up to 15 minutes (day) (each member) (PA)
T1002 U1	RN services, up to 15 minutes (night; weekend) (each member) (PA)
T1003 U1	LPN/LVN services, up to 15 minutes (night; weekend) (each member) (PA)

The following service codes are to be used for nursing care provided by one nurse simultaneously to three members.

T1002 U2	RN services, up to 15 minutes (day) (each member) (PA)
T1003 U2	LPN/LVN services, up to 15 minutes (day) (each member) (PA)
T1002 U3	RN services, up to 15 minutes (night; weekend) (each member) (PA)
T1003 U3	LPN/LVN services, up to 15 minutes (night; weekend) (each member) (PA)

B. Fee Schedule

If you want to obtain a fee schedule, you may download the Executive Office of Health and Human Services regulations at no cost at www.mass.gov/service-details/eohhs-regulations. The rates for Continuous Skilled Nursing Agency can be found at 101 CMR 361.00: *Rates for Continuous Skilled Nursing Services*.

Appendix D

Appendix D contains supplemental billing instructions for submitting 837I transactions and direct data entry (DDE) claims for members who have Medicare or commercial insurance, and whose services are determined not covered by the primary insurer.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth-transmittal-letters.

Sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins.

Questions

The MassHealth LTSS Provider Service Center is open, 8 a.m. to 6 p.m. ET, Monday through Friday, excluding holidays. LTSS Providers should direct their questions about this letter or other MassHealth LTSS Provider questions to the LTSS Third Party Administrator (TPA) as follows:

Method	**Contact Information for MassHealth LTSS Provider Service Center**
Phone	Toll-free **(844) 368-5184**
Email	support@masshealthltss.com
Portal	MassHealthLTSS.com

Mail	MassHealth LTSS PO Box 159108 Boston, MA 02215
Fax	(888) 832-3006
LTSS Provider Portal	Trainings, general Information, and future enhancements will be available at www.MassHealthLTSS.com.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Continuous Skilled Nursing Agency Manual

Pages vi, 6-1 and 6-2

Pages D-1 through D-4

601 Explanation of Abbreviation

The abbreviation "PA" indicates that MassHealth prior authorization is required (see program regulations in Subchapter 4 of the *Continuous Skilled Nursing Agency Manual*).

602 Definitions

Providers must use a service code and modifier that accurately reflect the nursing service provided. With nursing service codes T1002 and T1003, nursing services provided on a weekend or holiday will be automatically reimbursed in accordance with the applicable fee schedule of the Executive Office of Health and Human Services (EOHHS). No additional service code or modifier is required to indicate weekend or holiday services.

(A) Day – the hours from 7:00 A.M. to 2:59 P.M., Sunday through Saturday.

(B) Night – the hours from 3:00 P.M. to 6:59 A.M., Sunday through Saturday.

603 Service Codes and Descriptions: Continuous Skilled Nursing Services

Revenue Code	Service Code-Modifier	Service Description
		Individual Patient Nursing
		The following service codes must be used for nursing care provided by one nurse to one member.
0552	T1002	RN services, up to 15 minutes (day) (PA)
0552	T1003	LPN/LVN services, up to 15 minutes (day) (PA)
0552	T1002 UJ	RN services, up to 15 minutes (night) (PA)
0552	T1003 UJ	LPN/LVN services, up to 15 minutes (night) (PA)
		Multiple-Patient Nursing
		The following service codes are to be used for nursing care provided by one nurse simultaneously to two members.
0552	T1002 TT	RN services, up to 15 minutes (day) (each member) (PA)
0552	T1003 TT	LPN/LVN services, up to 15 minutes (day) (each member) (PA)
0552	T1002 U1	RN services, up to 15 minutes (night; weekend) (each member) (PA)
0552	T1003 U1	LPN/LVN services, up to 15 minutes (night; weekend) (each member) (PA)
		The following service codes are to be used for nursing care provided by one nurse simultaneously to three members.
0552	T1002 U2	RN services, up to 15 minutes (day) (each member) (PA)
0552	T1003 U2	LPN/LVN services, up to 15 minutes (day) (each member) (PA)
0552	T1002 U3	RN services, up to 15 minutes (night; weekend) (each member) (PA)
0552	T1003 U3	LPN/LVN services, up to 15 minutes (night; weekend) (each member) (PA)

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Supplemental Instructions for TPL Exceptions
Submitting Claims for Members with Medicare or Commercial Insurance

This appendix contains supplemental billing instructions for submitting 837I transactions and direct data entry (DDE) claims for members who have Medicare or commercial insurance, and whose services are determined not covered by the primary insurer. This appendix describes TPL exceptions that may apply when members have Medicare or commercial insurance. This appendix contains specific MassHealth billing instructions and supplements the instructions found in the HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide.

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

Third-Party Liability (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 or health insurance coverage status changes, even if Medicare or a commercial insurer previously denied coverage for the same service.

Members with Medicare

Continuous Skilled Nursing (CSN) services are not covered by Medicare. When MassHealth members with Medicare are receiving CSN services, CSN services may be billed directly to MassHealth. Providers must follow the billing instructions for 837I or DDE as described below to indicate services are not covered by Medicare.

Intermittent home health services, such as intermittent skilled nursing visits, home health aide services, or therapy services may be covered by Medicare. Home health agencies providing intermittent home health services should refer to the Home Health Agency Manual.

Commercial Insurance

CSN services for a member with commercial insurance must generally be billed to the commercial insurer before submitting a claim to MassHealth. Refer to MassHealth regulations at 130 CMR 450.316.

Even if an insurer previously denied coverage for the same service, providers must submit a claim and seek a new coverage determination from an insurer whenever there is a new admission or a change in the member's medical condition or health insurance coverage status, known as a "qualifying event." A qualifying event is defined as any change in a member's condition or circumstance that may trigger a change in insurance coverage. The following list includes some examples of qualifying events that would require a coverage determination by a commercial insurer.

- new services from a CSN agency;
- new CSN agency services after discharge from an inpatient hospital or skilled facility stay resulting in a change in the plan of care;
- new commercial insurance coverage or change of insurer;
- commencement of annual commercial insurance coverage or other periodic benefit(s);
- reinstatement of insurance benefits; or
- change in the patient's medical condition resulting in a change of the plan of care.

If after review, the commercial carrier has denied the claim due to noncoverage, providers should follow the HIPAA implementation guides and MassHealth companion guides for submission of the initial claim to

MassHealth. implementation and companion guides are available on the MassHealth website at www.mass.gov/masshealth.

Providers are required to keep on file for auditing purposes the insurer's original explanation of benefits (EOB), 835 transaction, or response from the insurer. Providers must continue to submit a copy of the insurer's denial accompanied by the Home Health Coverage Determination Form within 10 days of its receipt as instructed in Home Health Agency Bulletin 46, dated January 2009. Both the form and the bulletin are available on the MassHealth website at www.mass.gov/masshealth.

TPL Exception Criteria
Commercial Insurance Claims

Claims for MassHealth members who have commercial insurance must be initially billed to the commercial insurer.

There may be instances when the services provided are not covered by the other insurer, including if the MassHealth member does not:

- have benefits available (benefits have been exhausted);
- meet the insurer's coverage criteria; or
- qualify for a new benefit period.

Follow the instructions outlined in this appendix for claim submissions when a TPL exception exists.

Providers are required to keep the commercial insurer's original EOB, 835 transaction, or response from the insurer on file for auditing purposes.

Billing Instructions for 837I Transactions

Providers must follow HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide instructions. Complete the other payer loops in the 837I transactions as described in the following table when submitting claims to MassHealth that have been determined not covered by the other insurer, and that meet the TPL exception criteria.

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 listed in this section. 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
2320	SBR09 (Claim Filing Indicator)	Medicare = MA 837I: Commercial insurer = CI
2320	AMT01 (Total Noncovered Amount Qualifier)	**A8**
2320	AMT02 (Total Noncovered Amount)	The total noncovered amount must equal the total billed amount.

Loop	Segment	Value
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.

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 section. 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 following table.

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 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	The total noncovered amount must equal the total billed amount.
Remaining Patient Liability	Do not enter any values.
Claim Filing Indicator	Medicare = MA Commercial insurer = CI

COB Detail Panel (cont.)	
Field Name	**Instructions**
Release of Information	Select the appropriate code from the drop-down list.
Assignment of Benefits	Select the appropriate code from the drop-down list.
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.

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.