




Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER HHA-33
June 2002

TO: Home Health Agencies Participating in MassHealth
FROM: Wendy E. Warring, Commissioner 
RE: *Home Health Agency Manual* (Revisions to Billing Instructions for Claims for Members with Commercial Health Insurance in Addition to MassHealth)

This letter transmits revisions to the billing instructions for the *Home Health Agency Manual*. This transmittal letter also clarifies the procedure for submitting claims for members who have commercial health insurance in addition to MassHealth. To ensure that MassHealth is the payer of last resort, providers **must** make diligent efforts to obtain payment from other resources, whenever there is potential liability, before billing MassHealth. Accordingly, providers must seek a coverage determination from the insurer any time a member's medical condition or health-insurance-coverage status changes. This transmittal letter provides some examples of such changes or "qualifying events" that would require a provider to obtain a coverage determination. All other rules and regulations for claim submissions continue to apply.

TPL Requirements

If a MassHealth member

- has commercial health insurance, and
- has a change in medical condition or health-insurance-coverage status

providers must submit claims to the commercial insurer for a coverage determination before submitting the claim to MassHealth. These requirements are stated in the Division's Third Party Liability ("TPL") regulations, found at **130 CMR 450.316 and 450.317**. These regulations also require providers to meet all other insurers' billing and authorization requirements. The Division **will deny or recover** payment if the insurer had denied payment because of a provider's noncompliance with the insurer's billing and authorization requirements. Examples of noncompliance include but are not limited to: failing to submit appropriate documentation; providing services outside the service network; untimely billing; making erroneous submissions; and failing to obtain prior authorization. Requesting a denial of coverage by the insurer or appealing an insurer's favorable coverage determination is unacceptable.

Qualifying Event

A “qualifying event” is defined as any change in a member’s condition or circumstances that may trigger a change in insurance coverage. The following list includes some examples of qualifying events that require a provider to request coverage and obtain an Explanation of Benefits (EOB) from a commercial insurer:

- new admission or readmission to the home health agency;
- discharge from an acute or skilled facility;
- cessation of commercial insurance coverage or exhaustion of annual or other periodic benefit(s);
- reinstatement of insurance benefits on an annual basis; or
- change in the patient’s medical condition resulting in a change in the plan of care.

Commercial Insurance Patient Status Codes

For dates of service on or after August 1, 2002, a patient status code must be used when billing MassHealth for a member who has health insurance and who is receiving medically necessary services denied by the insurer. The code verifies that the provider has obtained a valid Explanation of Benefits/Denial and explains why the insurer is not covering the service(s).

The following patient status codes are to be used in **Item 19 of claim form no. 9** when billing MassHealth for a member who has commercial health insurance and for whom the insurer has denied coverage.

- 01 - Valid EOB / Denial on file*—Benefit exhausted for the calendar year
- 02 - Valid EOB / Denial on file*—Cap in service; benefit maximum has been reached
- 03 - Valid EOB / Denial on file*—Insurer denied, stating custodial in nature
- 04 - Valid EOB / Denial on file*—Insurer denied, stating not medically necessary
- 05 - Valid EOB / Denial on file*—Service not a covered benefit under member’s contract
- 06 - Valid EOB / Denial on file*—Insurer denied, stating not homebound
- 07 - Valid EOB / Denial on file*—Insurer denied for other reason as stated on the EOB

Please note that these codes are to be used when billing MassHealth for members with commercial health insurance. To submit claims for members with Medicare, please refer to the billing instructions in Subchapter 5 of the *Home Health Agency Manual*. If a member is eligible for both commercial insurance and Medicare, providers must follow the billing instructions for both insurers, and must use the commercial insurance code.

Change in TPL Billing Requirements

Providers may **no longer** send the Division a single annual EOB for services denied by the commercial insurer, but must obtain and send an EOB whenever the member has a qualifying event. Providers must submit the EOB to the Division **within 10 days** of receiving notification of denial from the insurer. The EOB must include the member's MassHealth identification number. The EOB must be sent to the following address.

Division of Medical Assistance
Benefit Coordination and Recovery
Home Health Claims
600 Washington Street
Boston, MA 02111

Submitting Claims

Providers may submit claims to Unisys electronically or on paper. Providers can continue to submit claims electronically:

- for services when the member does not have a qualifying event, or
- for a continuation of services once the initial insurance denial is obtained.

However, claims submitted to MassHealth over 90 days from the date of service must be submitted on paper and accompanied by an EOB. The EOB that accompanies the claim must be dated within 90 days from the date the EOB was issued. The claim must also indicate an appropriate patient status code in Item 19 of the claim form no. 9, as explained earlier in this transmittal letter.

The provider must keep on file the EOB from the insurance carrier. The patient status code, Item 19 of claim form no. 9, must be completed, indicating the reason the insurance carrier did not cover the service. Whenever the MassHealth member has a qualifying event, a new EOB must be obtained and initial TPL billing procedures must be followed.

DMA's Right to Appeal

The Division reserves the right to appeal any case that, in its determination, may meet the coverage criteria of an insurance carrier. Providers must, at the Division's request, submit the claim and related clinical or service documentation to an insurance carrier if the Division determines that the provider's submission is necessary in order for the Division to exercise this right of appeal.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

These billing instructions are effective August 1, 2002.

NEW MATERIAL

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

Home Health Agency Manual

Pages vi, vii, and 5.3-7 through 5.3-10

OBSOLETE MATERIAL

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

Home Health Agency Manual

Page vi — transmitted by Transmittal Letter HHA-31

Page vii — transmitted by Transmittal Letter HHA-27

Pages 5.3-7 through 5.3-10 — transmitted by Transmittal Letter HHA-30

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The regulations and instructions of the Division of Medical Assistance governing provider participation in MassHealth are published in the Provider Manual Series. The Division publishes a separate manual for each provider type.

Each manual in the series contains administrative regulations, billing regulations, program regulations, service codes and descriptions, billing instructions, and general information. The Division's 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. Regulations promulgated by the Division of Medical Assistance are assigned Title 130 of the Code. The regulations governing provider participation in MassHealth are assigned Chapters 400 through 499 within Title 130. 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 home health agencies, those matters are covered in 130 CMR Chapter 403.000, reproduced as Subchapter 4 in the *Home Health Agency Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which furnish instructions for making changes by hand ("pen-and-ink" revisions), and 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 the Division's effort to give each provider a single convenient source for the essential information providers need in their routine interaction with the Division and with MassHealth members.