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 HHA-42
April 2009

TO: Home Health Agencies Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: *Home Health Agency Manual* (New Appendix D)

This letter transmits Appendix D for the *Home Health Agency Manual*. Appendix D is a new set of instructions for submitting 837I transactions and paper claims (after the implementation of NewMMIS) for members who have Medicare or other insurance benefits where services were deemed to be noncovered because the patient does not have benefits available (benefits exhausted), or does not qualify for a new benefit period.

Appendix D contains specific MassHealth 837I instructions for billing claims for these situations, which are not described in the HIPAA implementation guide for the 837I transaction. It also provides instructions for using the TPL Exception Form for Home Health Agencies to submit paper claims using the new instructions.

When the initial claim has been adjudicated by Medicare, the adjudication details provided by Medicare must be documented on the TPL Exception Form for Home Health Agencies. This form must be attached to the claim to report HIPAA group and adjustment reason codes (ARCs). This form is available on the MassHealth Web site at www.mass.gov/masshealth, and is fillable online. A copy of this form is attached to this transmittal letter. Requests for paper copies of this form must be submitted in writing and faxed to 617-988-8973 or mailed to the following address.

MassHealth
ATTN: Forms Distribution
P.O. Box 9118
Hingham, MA 02043

This transmittal letter supersedes the billing instructions in Home Health Agency Bulletin 41, dated November 2003, which is available on the MassHealth Web site at www.mass.gov/masshealth. Previously, providers were instructed to use condition codes to indicate the reason the insurer did not cover the service. After the implementation of NewMMIS, condition codes will no longer be used, but will be replaced by HIPAA adjustment reason codes (ARC).

The instructions in Appendix D are effective upon implementation of NewMMIS on May 26, 2009.

If you have any questions 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.)

Home Health Agency Manual

Pages vi and D-1 through D-4

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Home Health Agency Manual

Page vi – transmitted by Transmittal Letter HHA-38

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TPL Exception Form for Home Health Agencies

Please Note: Submit this form only with UB-04 paper claim forms.

Instructions on how to use this form:

1. Use this form to report HIPAA group and adjustment reason codes.
2. Use the claim(s) adjudication details provided by the insurer to fill in the form.
3. Use only Other Adjustment (OA) as the HIPAA group adjustment reason code.
4. For more details on how to use this form, refer to the appropriate appendix of your MassHealth provider manual.
5. Complete all fields.

Submission Date:_____ Date of Service (range if applicable):_____ - _____

MassHealth Provider ID/Service Location:_____

NPI:_____

Member Name:_____ MassHealth Member ID:_____

Policyholder First Name:_____ Policyholder Last Name:_____

Policyholder ID:_____ Policyholder Policy No.:_____ Policyholder Group No.:_____

Carrier ID:_____ Carrier Name:_____

Line Number	Date of Service	Revenue Code	Service Code	Billed Amount	HIPAA Group/ Adjustment Reason Code		HIPAA Adjustment Reason Amount
1					OA		
2					OA		
3					OA		
4					OA		
5					OA		
6					OA		
7					OA		
8					OA		
9					OA		
10					OA		
11					OA		
12					OA		
13					OA		
14					OA		
15					OA		
16					OA		
17					OA		
18					OA		
19					OA		
20					OA		

Supplemental Instructions for Claims with Other Insurance

This appendix contains billing instructions for submitting 837I transactions and paper claims for members who have Medicare and/or commercial insurance, and whose services were deemed by the payer to be noncovered because the patient does not have benefits available (benefits exhausted), or does not qualify for a new benefit period.

This appendix contains specific MassHealth billing instructions that are not described in the HIPAA Implementation Guide for the 837I transaction, in the 837I Companion Guide, or in the billing guides for the UB-04.

Note: Providers must continue to submit the Home Health Coverage Determination Form and a copy of the insurer's explanation of benefits (EOB) within 10 days of receipt of the EOB, as described in Home Health Agency Bulletin 46, dated January 2009. Both the form and the bulletin are available on the MassHealth Web site at www.mass.gov/masshealth. Providers must retain the original EOB in their records for auditing purposes.

Billing Instructions for 837I Transactions

Providers must submit an initial claim to the other insurer (Medicare or commercial insurance) for claim determination. When the initial claim has been adjudicated by the insurer, enter the adjudication details provided by that insurer in loops 2320, 2330, and 2430 for each claim line in the 837I transaction.

Loop	Segment	Value Description
2330B	NM109 (Other Payer Name)	MassHealth-assigned carrier code. For Medicare, the carrier code is 0084000 (Part A). **Note**: MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Code) of your MassHealth provider manual, or at www.mass.gov/masshealth.
2320	SBR09 (Claim Filing Indicator)	"MA" when the other payer is Medicare "CI" when other payer is commercial insurer
2320	AMT (Amount)	Should not be populated with any insurance payment, coinsurance, or deductible.
2320	CAS01 (Claim Adjustment Group Code)	OA (other adjustments)
2320	CAS02 (Claim Adjustment Reason Code)	See Claim Adjustment Reason Code Crosswalk Table on page D-3. The table cross walks the previously used condition codes to the current HIPAA adjustment reason codes. Providers must bill using the correct HIPAA ARC to ensure that claims process correctly.

Loop	Segment	Value Description
2320	CAS03 (Monetary Amount)	Billed amount
2330B	DTP03 (Date, Time, or Period)	Date of discharge or end date of service
2430	SVD01 (Payer ID Code)	MassHealth-assigned carrier code. For Medicare, the carrier code is 0084000 (Part A). **Note**: MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Code) of your MassHealth provider manual, or at www.mass.gov/masshealth.
2430	SVD02 (Monetary Amount)	Should not be populated with any insurance payment, coinsurance, or deductible.
2430	CAS01 (Service Line Adjustment Group Code)	OA (other adjustments)
2430	CAS02 (Service Line Adjustment Reason Code)	See Claim Adjustment Reason Code Crosswalk Table on page D-3. The table cross walks the previously used condition codes to the current HIPAA adjustment reason codes. Providers must bill using the correct HIPAA ARC to ensure that claims process correctly.
2430	CAS03 (Monetary Amount)	Billed amount
2430	DTP03 (Date, Time, or Period)	Date of discharge or end date of service

Billing Instructions for Paper Claims

Providers must submit an initial claim to the other insurer (Medicare or commercial insurance) for claim determination. When the initial claim has been adjudicated by the insurer, the adjudication details provided by that insurer should be documented on the TPL Exception Form for Home Health Agencies to report HIPAA group and adjustment reason codes. This form is available on the MassHealth Web site at www.mass.gov/masshealth.

Providers submitting paper claims must refer to the Billing Guide for the UB-04. Otherwise, claims may be processed incorrectly.

Billing Instructions for Both Paper and 837I Transactions

The adjustment reason codes (ARCs) given in the following table may be used to indicate the reason that the insurer is not covering the service. MassHealth allows providers to use ARCs to report noncovered or benefits-exhausted services only in the circumstances described in the table.

Claim Adjustment Reason Code Crosswalk Table			
Prior Condition Code	**Replace with HIPAA Adjustment Reason Code**	**Applies to Medicare?**	**Applies to Commercial Insurers?**
YO - Valid EOB/Denial on file-Benefits exhausted for the calendar year	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	Yes	Yes
Y1 - Benefit maximum has been reached	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	Yes	Yes
Y2 - Insurer denied stating custodial in nature	**50** -These are noncovered services because this is not deemed a “medical necessity” by the payer.	No	Yes
Y3 - Insurer denied stating not medically necessary.	**50** -These are noncovered services because this is not deemed a “medical necessity” by the payer.	No	Yes
Y4 - Services not a covered benefit	**150** - Payer deems the information submitted does not support this level of service.	Yes	Yes
Y5 - Insurer denied not stating homebound	**150** - Payer deems the information submitted does not support this level of service.	Yes	Yes
Y6 - Insurer denied for other reason as stated on EOB	**150** - Payer deems the information submitted does not support this level of service.	No	Yes
Y7 - Service is not parttime or intermittent	**152** - Payment adjusted because the payer deems the information submitted does not support this length of service.	Yes	No

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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