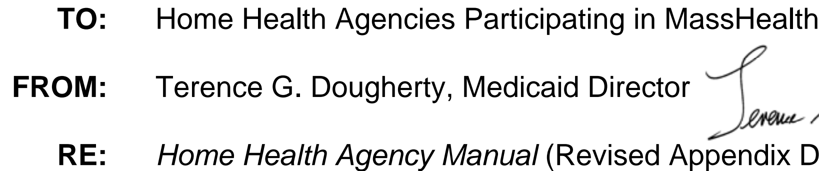
Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter HHA-44
March 2010

TO: Home Health Agencies Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director



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

This letter transmits a revised Appendix D for the *Home Health Agency Manual*. Appendix D contains revised billing instructions for submitting 837I and 837P transaction claims for members who have Medicare or commercial insurance, and whose services are determined not covered by the primary insurer. The revised Appendix D is effective April 1, 2010.

This appendix lists the exceptions that need to be considered when billing MassHealth for members who have Medicare or commercial insurance. It also explains the need for providers to generally make diligent efforts to obtain payment from other resources and to bill MassHealth as the payer of last resort. In addition, home health providers must bill the primary insurer, and obtain and send an explanation of benefits (EOB) from the primary insurer whenever the member has a qualifying event.

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.)

Home Health Agency Manual

Pages vi, vii, and D-1 through D-10

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(The pages listed here are no longer in effect.)

Home Health Agency Manual

Pages vi and D-1 through D-10 – transmitted by Transmittal Letter HHA-43

Page vii – transmitted by Transmittal Letter HHA-38

6. Service Codes and Descriptions 6-1

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

Manuals in the series contain administrative regulations, billing regulations, program regulations, service codes, administrative and billing instructions, and general information. MassHealth 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. MassHealth regulations 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 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 MassHealth's effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and its members.

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

This appendix contains supplemental billing instructions for submitting 837I and 837P transactions, paper claims, 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 lists the exceptions that need to be considered when billing MassHealth for members who have Medicare or commercial insurance. These specific MassHealth billing instructions are not provided in the HIPAA Implementation Guides for the 837I and 837P transactions, in the 837I and 837P Companion Guides, or in the Billing Guides for the UB-04 or CMS-1500 claim forms.

Please Note: To bill MassHealth for services provided to members with Medicare or commercial insurance, and whose services are determined not covered by the primary insurer, providers may no longer use the patient status or condition code field on the claim form. If submitting a claim electronically, an entry must be made in the adjustment reason code (ARC) segment. If submitting a claim on paper, the TPL Exception Form for Home Health Agencies must be completed and submitted with the claim form. This form is located on the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Provider Forms on the lower-right panel of the home page.

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.

Medicare Exceptions

Home health services for a dually eligible member must be billed to Medicare unless one or more of the following exceptions exists.

- The member is not confined to place of residence.
- The member is not part-time or intermittent; death is imminent.
- The member is not part-time or intermittent; alternative is more costly.
- The member is not part-time or intermittent; alternative is being sought.
- The member is not part-time; physician documentation of medical necessity exceeds eight hours.
- The member is not intermittent; physician documentation of medical necessity exceeds 21 days.
- The member is receiving occupational therapy only.

If one of these TPL exceptions exists, follow the instructions outlined in this appendix for claim submission. Claim submissions must include codes found in the HIPAA Adjustment Reason Code Crosswalk Table on page D-7.

Providers are required to retain the Medicare advance beneficiary notice (ABN) for auditing purposes.

Medicare Denials

If a claim for a MassHealth member has been submitted to Medicare and subsequently denied, providers must forward the Medicare remittance advice to MassHealth within 10 days of its receipt.

Remittance advices must be sent to the following address.

MassHealth
Home Health Claims
The Schraffts Center
529 Main Street, Third Floor
Charlestown, MA 02129

Commercial Insurance

Home health services for a member with commercial insurance must generally be billed to the commercial insurer before submitting a claim to MassHealth. See 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 home health agency (HHA);
- new HHA services after discharge from an inpatient hospital or skilled facility stay resulting in a change of skilled services 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 skilled services in 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 Web site at www.mass.gov/masshealth.

Providers are required to retain 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 Web site at www.mass.gov/masshealth.

TPL Exceptions

For subsequent MassHealth submissions, providers must follow the instructions outlined in this appendix. Claim submissions must include codes found in the HIPAA Adjustment Reason Code Crosswalk Table on page D-7.

Providers must seek a new coverage determination from the insurer any time a member's medical condition or health insurance coverage status changes.

Billing Instructions for 837 Transactions

Providers must complete the other payer loops in the 837I transactions as described in the following table when submitting claims to MassHealth that have been initially denied or determined noncovered by the other insurer and meet the TPL exception criteria.

Loop	Segment	Value Description
2330B	NM109 (Other Payer Name)	Enter the MassHealth-assigned carrier code for the other payer. **837I:** Medicare (Institutional) carrier code = 0084000 **837P:** Medicare (Professional) carrier code = 0085000 **Please Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) in your MassHealth provider manual at www.mass.gov/masshealth.
2320	SBR09 (Claim Filing Indicator)	**837I:** Medicare (Institutional) = MA **837P:** Medicare (Professional) = MB **837I or 837P:** Commercial insurer = CI
2320	AMT01 (Allowed Amount Qualifier)	B6
2320	AMT02 (Allowed Amt = 0)	0
2320	AMT01 (Paid Amount Qualifier)	C4
2320	AMT02 (Medicare/Other Insurance Prior Payment Amount)	0
2330B	DTP03 (Date, Time, or Period)	Date of discharge or end date of service for the claim billing period

Loop	Segment	Value Description
2430	SVD01 (Payer ID Code)	Enter the MassHealth-assigned carrier code for the other payer. **837I:** Medicare (Institutional) carrier code = 0084000 **837P:** Medicare (Professional) carrier code = 0085000 **Please Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual at www.mass.gov/masshealth.
2430	SVD02 (Monetary Amount)	0
2430	CAS01 (Service Line Adjustment Group Code)	OA (other adjustments)
2430	CAS02 (Service Line Adjustment Reason Code)	See the Claim Adjustment Reason Code Crosswalk Table on page D-7. The table crosswalks 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)	Total charges (amount billed to MassHealth)
2430	DTP03 (Date, Time, or Period)	Date of discharge or end date of service for the claim billing period

Billing Instructions for Direct Data Entry (DDE)

Providers must complete the coordination of benefits fields as described in the following table when submitting claims to MassHealth that have been initially denied or determined noncovered by the other insurer and that meet the TPL exception criteria.

In the coordination of benefits tab, choose “New Item.”

Billing Instructions for Paper Claims

Providers must submit the appropriate claim form, along with the TPL Exception Form for Home Health Agencies when billing MassHealth for claims that have been initially denied or determined noncovered by the other insurer and meet the TPL exception criteria. This form is available on the MassHealth Web site at www.mass.gov/masshealth. Providers must enter the appropriate HIPAA ARC on this form from the HIPAA Adjustment Reason Code Crosswalk table on page D-7.

Providers submitting paper claims must refer to the Billing Guide for the UB-04 or Billing Guide for the CMS-1500. Otherwise, claims may be processed incorrectly.

Coordination of Benefits	
Field Name	**What to Enter**
Carrier Code	Enter the appropriate seven-digit carrier code number (refer to Appendix C of your MassHealth provider manual).
Carrier Name	Enter the appropriate carrier name (refer to Appendix C of your MassHealth provider manual).
EOB Date	Date of discharge or end date of service for the claim billing period **Note:** This is a required field.
Payer Claim Number	Enter the other insurer claim number on the EOB. If there is no EOB, enter "99" as the default value.
Payer Responsibility	Select the appropriate code.
Allowed Amount	Enter 0.
Payer Paid Amount	Enter 0.
Claim Filing Indicator	Medicare (Institutional) = MA Commercial insurer = CI
Release of Information	Select the appropriate code.
Assignment Benefit	Select the appropriate code.
Subscriber Information Panel	Enter the appropriate subscriber information and required fields (subscriber last name, first name, subscriber ID, and relationship to subscriber code). **Note:** This is a required field.

After entering the data, scroll down to the bottom of the page to the List of COB Reasons subpanel and click "New Item." Enter the appropriate COB reasons detail information, according to the following table.

COB Reasons Detail	
Field Name	**What to Enter**
Group Code	Select OA (other adjustments).
Units of Service	Enter the appropriate quantity.
Amount	Total charges (amount billed to MassHealth)

COB Reasons Detail	
Field Name	**What to Enter**
Reason	Refer to the HIPPA Adjustment Reason Code Crosswalk Table on page D-7. The table crosswalks the previously used condition codes to the current HIPAA ARCs. Providers must bill using the correct HIPAA ARC codes to ensure that claims process correctly.

Please Note: Once you complete the COB reason detail panel, click "Add" to save the information. Then click "Add" to save the coordination of benefit (COB) detail information.

On the procedures tab, after entering the procedure service details, scroll down to the list of COB line items and click "New Item."

COB Line Detail	
Field Name	**What to Enter**
Carrier Code	Enter the appropriate seven-digit carrier code number (refer to Appendix C of your MassHealth provider manual).
EOB Date	Date of discharge or end date of service for the claim billing period **Note:** This is a required field.
Paid Amount	Enter 0.
Paid Units of Service	Enter units of service from procedure service detail panel.
Revenue Code	Enter revenue code from procedure service detail panel.
Procedure Code	Enter procedure code from the procedure service detail panel.
Modifier 1	Enter modifier 1 from the procedure service detail panel.
Modifier 2	Enter modifier 2 from the procedure service detail panel.
Modifier 3	Enter modifier 3 from the procedure service detail panel.
Modifier 4	Enter modifier 4 from the procedure service detail panel.

After entering the data, scroll to the List of COB Reasons subpanel and click "New Item."

COB Reasons Detail	
Field Name	**What to Enter**
Group Code	Select OA (other adjustments).
Amount	Enter total charges from the institutional service detail panel.
Units of service	Enter units from the institutional service detail panel.
Reason	Refer to the HIPAA Adjustment Reason Code Crosswalk Table on page D-7. The table crosswalks the previously used condition codes to the current HIPAA ARCs. Providers must bill using the correct HIPAA ARC codes to ensure that claims process correctly.

Please Note: Click "Add" on the COB reasons detail panel, then click "Add" on the COB lines detail panel, then click "Add" on the institutional service detail panel to save all information.

HIPAA Adjustment Reason Code Crosswalk Table

Use the HIPAA ARCs in the following table to indicate the reason that an insurer is not covering the service. The table crosswalks the previously used condition codes and patient status codes to the current HIPAA ARCs. Providers must bill using the correct HIPAA ARC to ensure that claims process correctly.

HIPAA Adjustment Reason Code Crosswalk Table				
Prior Patient Status Code **Paper Submissions**	**Prior Condition Code** **Electronic Submissions**	**Replace with HIPAA Adjustment Reason Code (ARC)**	**Applies to Medicare?**	**Applies to Commercial Insurers?**
01 - Valid EOB/Denial on file – Benefits exhausted for the calendar year	**YO**	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	No	Yes
02 - Benefit maximum has been reached	**Y1**	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	No	Yes
03 - Insurer denied stating custodial in nature	**Y2**	**50** - These are noncovered services because this is not deemed a "medical necessity" by the payer.	No	Yes

HIPAA Adjustment Reason Code Crosswalk Table (cont.)

Prior Patient Status Code **Paper Submissions**	**Prior Condition Code** **Electronic Submissions**	**Replace with HIPAA Adjustment Reason Code (ARC)**	**Applies to Medicare?**	**Applies to Commercial Insurers?**
04 - Insurer denied stating not medically necessary	**Y3**	**50** - These are noncovered services because this is not deemed a "medical necessity" by the payer.	No	Yes
05 - Services not a covered benefit **Medicare noncoverage reason** • Occupational therapy only	**Y4**	**150** - Payer deems the information submitted does not support this level of service.	Yes	Yes
06 - Insurer denied not stating homebound **Medicare noncoverage reason** • Not confined to place of residence; medically necessary	**Y5**	**150** - Payer deems the information submitted does not support this level of service.	Yes	Yes
07 - Insurer denied for other reason as stated on EOB	**Y6**	**150** - Payer deems the information submitted does not support this level of service.	No	Yes

HIPAA Adjustment Reason Code Crosswalk Table (cont.)				
Prior Patient Status Code **Paper Submissions**	**Prior Condition Code** **Electronic Submissions**	**Replace with HIPAA Adjustment Reason Code (ARC)**	**Applies to Medicare?**	**Applies to Commercial Insurers?**
08 - Service is not part-time or intermittent **Medicare noncoverage reason** • Not part-time or intermittent; medically necessary; death is imminent • Not part-time or intermittent; medically necessary; alternative more costly • Not part-time or intermittent; medically necessary; alternative being sought • Not part-time; physician documentation of medical necessity exceeds eight hours • Not intermittent; physician documentation of medical necessity exceeds 21 days	**Y7**	**152** - Payment adjusted because the payer deems the information submitted does not support this length of service.	Yes	No

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, refer to Appendix A of your MassHealth provider manual for the appropriate contact information.

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