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

MassHealth
Transmittal Letter HHA-45
December 2011

TO: Home Health Agency Providers Participating in MassHealth

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

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

The Centers for Medicare & Medicaid Services (CMS) requires all trading partners who submit electronic transactions to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 Version 4010A1 to HIPAA ASC X12 Version 5010. All covered entities (health care providers, health plans, and health care clearinghouses) must be HIPAA 5010 compliant by January 1, 2012.

This letter transmits a revised Appendix D for the *Home Health Agency Manual*. Appendix D contains revised billing instructions required for version 5010/5010A1 for submitting 837I transactions, direct data entry (DDE), and paper claims for members who have Medicare or commercial insurance and whose services are determined to be not covered by the primary insurer.

Appendix D contains specific MassHealth billing instructions that supplement the instructions found in the HIPAA 837I Implementation Guide, in the MassHealth 837I Companion Guide, and in the MassHealth Billing Guide for the UB-04.

Please Note: Effective January 1, 2012, MassHealth is moving toward an all-electronic claims submission policy to achieve greater efficiency. All claims must be submitted electronically, unless the provider has received an approved electronic claim submission waiver. 90-day waiver requests and final deadline appeals may be submitted either electronically via the POSC or on paper. Please see All Provider Bulletin 217, dated September 2011, for more information about MassHealth's paper claims waiver policy. Please also refer to All Provider Bulletin 220 and All Provider Bulletin 221, dated December 2011, for information on how to submit 90-day waiver requests and final deadline appeals electronically.

The TPL Exception Form for Home Health Agencies has been obsoleted. Effective January 1, 2012, providers who have received an approved electronic claim submission waiver must use the TPL Exception Form that has been revised to reflect the 5010 mandate. To download the new form, go to www.mass.gov/masshealth. Click on MassHealth Provider Forms in the lower right panel of the home page, then scroll down the list to the TPL Exception Form.

Providers must submit the UB-04 claim form with the revised TPL Exception Form to report total noncovered charges when billing MassHealth for claims that have been determined to be noncovered by Medicare or the commercial insurer, and that meet the TPL exception criteria described in Appendix D.

The revised Appendix D is effective January 1, 2012.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site 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.)

Home Health Agency Manual

Pages vii and D-1 through D-6

OBSOLETE MATERIAL

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

Home Health Agency Manual

Pages vii and D-1 through D-10 – transmitted by Transmittal Letter HHA-44

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. 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 transactions, direct data entry (DDE) claims, or paper 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, the MassHealth 837I Companion Guide, and the MassHealth Billing Guide for the UB-04.

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 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 MassHealth 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.

Medicare

If one of these TPL exceptions exists above, follow the instructions outlined in this appendix for claim submission.

Providers must file a claim and seek a new coverage determination any time a member's medical condition or medical circumstance changes, even if Medicare previously denied coverage for the same service. 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.

UHealth Solutions, Inc.
Third Party Appeals Unit
Medicare Appeals Unit
100 Century Drive
Worcester, MA 01606

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. 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 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

Claims for MassHealth members who have Medicare or commercial insurance must be initially billed to Medicare or the commercial insurer, or a Medicare ABN must be issued.

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 exhausted);
- does not meet the insurer's coverage criteria; or
- does not 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 retain the following on file for auditing purposes:

- the Medicare ABN;
- the Medicare remittance advice: and
- the commercial insurer's original EOB, 835 transaction, or response from the insurer.

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 = the total billed amount.
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 table below.

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.
Payer Claim Number	Enter 99.
Payer Responsibility	Select the appropriate code from the drop-down list.
Total Noncovered Amount	The total noncovered amount must = the total billed amount.
Claim Filing Indicator	Medicare = MA Commercial insurer = CI
Release of Information	Select the appropriate code from the drop-down list.
Assignment Benefit	Select the appropriate code from the drop-down list.

COB Detail Panel (cont.)	
Field Name	**Instructions**
Subscriber Information Panel	Enter the appropriate required subscriber information: Subscriber last name First name Subscriber ID The relationship to the subscriber code (Select appropriate code from drop-down list.)

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. Refer to All Provider Bulletin 217.

Providers must follow the instructions in the MassHealth Billing Guide for the UB-04. Providers must submit the UB-04 claim form with the TPL Exception form to report total noncovered charges when billing MassHealth for claims that have been determined to be not covered by the other insurer, and that meet the TPL exception criteria.

To download the new form, go to www.mass.gov/masshealth. Click on Masshealth Provider Forms in the lower right panel of the home page, then scroll down the list to the TPL Exception Form.

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.

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