



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



MassHealth
Transmittal Letter HHA-58
October 2023

TO: Home Health Agencies Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: Home Health Agency Manual (Revised Appendix D)

This letter transmits revisions to Appendix D in the Home Health Agency Manual. This change aligns with the dual-eligible (Medicare and Medicaid) billing guidance in Home Health Agency Provider Bulletin 90 and is effective October 18, 2023.

Revised Appendix

MassHealth is making the following revisions to the Home Health Agency Manual:

Appendix D Supplemental Instructions for [Third-Party Liability, or TPL] Exceptions

- Appendix D is being amended to include certain exception guidance for dual-eligible individual (Medicare and Medicaid) billing. Appendix D is also being revised to instruct providers on TPL requirements for Medicare Advantage members and dual-eligible billing exceptions.

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 8:00 a.m. through 6:00 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).

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 MassHealthLTSS.com .

NEW MATERIAL

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

Home Health Agency Manual

Pages vi and D-1 through D-5

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Home Health Agency Manual

Page vi — transmitted by Transmittal Letter HHA-56

Pages D-1 through D-6 — transmitted by Transmittal Letter HHA-57

Commonwealth of Massachusetts MassHealth Provider Manual Series Home Health Agency Manual	Subchapter Number and Title Appendix D: Supplemental Instructions for TPL Exceptions	Page vi
	Transmittal Letter HHA-58	Date 10/18/23

6. Service Codes and Descriptions.....	6-1
Appendix A. Directory.....	A-1
Appendix C. Third-Party Liability Codes.....	C-1
Appendix D. Supplemental Instructions for TPL Exceptions.....	D-1
Appendix E. Criteria for Provider Liability	E-1
Appendix T. CMSP Covered Codes	T-1
Appendix U. DPH-Designated Serious Reportable Events That Are Not Provider Preventable Conditions	U-1
Appendix V. MassHealth Billing Instructions for Provider Preventable Conditions	V-1
Appendix W. EPSDT Services Medical and Dental Protocols and Periodicity Schedules	W-1
Appendix X. Family Assistance Copayments and Deductibles.....	X-1
Appendix Y. EVS Codes and Messages	Y-1
Appendix Z. EPSDT/PPHSD Screening Services Codes	Z-1

Commonwealth of Massachusetts MassHealth Provider Manual Series Home Health Agency Manual	Subchapter Number and Title Appendix D: Supplemental Instructions for TPL Exceptions	Page D-1
	Transmittal Letter HHA-58	Date 10/18/23

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 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.

Medicare Exceptions

Home health services for a MassHealth member must be billed to Medicare unless the following exceptions exist.

- Providers do not have to bill Medicare before billing MassHealth for members who are not homebound (i.e., member is not confined to place of residence).
- Providers do not have to bill Medicare before billing MassHealth for members who are homebound and receiving oral medication administration visits (MAVs). Visits for the purpose of certification and recertification fall within this exception.
 - Members who are homebound and receiving other home health services in addition to MAVs administered orally must bill Medicare for the other home health services.

If this TPL exception exists, 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, the provider may submit the claim to MassHealth with the Medicare denial reason reported on the claim. The provider must retain the Medicare remittance advice. If requested by the MassHealth agency, submit the Medicare remittance advice to MassHealth within 10 days of its receipt.

Commonwealth of Massachusetts MassHealth Provider Manual Series Home Health Agency Manual	Subchapter Number and Title Appendix D: Supplemental Instructions for TPL Exceptions	Page D-2
	Transmittal Letter HHA-58	Date 10/18/23

Mail or fax a copy of the Medicare remittance advice to

Third Party Appeals Unit MA
UMass Chan Medical School
333 South Street
Shrewsbury, MA 01545-4169
(877) 533-4381
(508) 421-8990 (fax)

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 website at 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 retain a copy of the insurer's denial. If requested by the agency, submit to MassHealth within 10 days of its receipt.

Mail or fax a copy of the EOB to:

Third Party Appeals Unit MA
UMass Chan Medical School
333 South Street
Shrewsbury, MA 01545-4169
(877) 533-4381
(508) 421-8990 (fax)

Commonwealth of Massachusetts MassHealth Provider Manual Series Home Health Agency Manual	Subchapter Number and Title Appendix D: Supplemental Instructions for TPL Exceptions	Page D-3
	Transmittal Letter HHA-58	Date 10/18/23

TPL Commercial Exception Criteria

Claims for MassHealth members who have commercial insurance must be initially billed to the commercial insurer. Providers must use the coverage determination process and follow guidelines established by the member's plan for noncovered items.

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 commercial exception exists.

Providers are required to keep the following items on file for auditing purposes.

- the Medicare ABN; 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 equal the total billed amount.
2330B	NM109 (Other Payer Name)	MassHealth-assigned carrier code for the other payer Please Note: MassHealth-assigned carrier codes are in Appendix C (Third-Party-Liability Carrier Codes) of your MassHealth provider manual.

Commonwealth of Massachusetts MassHealth Provider Manual Series Home Health Agency Manual	Subchapter Number and Title Appendix D: Supplemental Instructions for TPL Exceptions	Page D-4
	Transmittal Letter HHA-58	Date 10/18/23

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 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
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.

Commonwealth of Massachusetts MassHealth Provider Manual Series Home Health Agency Manual	Subchapter Number and Title Appendix D: Supplemental Instructions for TPL Exceptions	Page D-5
	Transmittal Letter HHA-58	Date 10/18/23

COB Detail Panel (cont.)	
Field Name	Instructions
Subscriber Information Panel	<p>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.</p> <ul style="list-style-type: none"> 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 <https://www.mass.gov/info-details/contact-masshealth-information-for-providers> for the appropriate contact information.

Commonwealth of Massachusetts MassHealth Provider Manual Series Home Health Agency Manual	Subchapter Number and Title Appendix D: Supplemental Instructions for TPL Exceptions	Page D-6
	Transmittal Letter HHA-58	Date 10/18/23

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