The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid, Health Safety Net
100 Hancock Street, 6th Floor.
Quincy, Massachusetts 02171

MAURA HEALEY
Governor

KIM DRISCOLL
Lieutenant Governor

KATE WALSH
Secretary

MIKE LEVINE
Assistant Secretary for
MassHealth

www.mass.gov/eohhs

January 2025 **Billing Update HSN-ALL BU-12**

Requirements for Bad Debt Claim Submissions

The purpose of this update is to review HSN reporting requirements pertaining to Bad Debt claim submissions for various types of facility claims.

Regulation 101 CMR 613.06 (1) (b) states the following reporting requirements for Bad Debt claims:

"(b) Reporting Requirements.

1. Claims Submission. Providers must submit claims in accordance with the requirements of 101 CMR 613.07. Acute Hospitals must submit a claim for each inpatient Bad Debt. Community Health Centers must submit a claim for each Bad Debt.

2. Additional Information. Providers must submit the following additional information for Community Health Center and Acute Hospital inpatient Bad Debt services in a form specified by the Health Safety Net Office. For outpatient services, Acute Hospitals and Hospital Licensed Health Centers must submit this information within 30 days of a request by the Health Safety Net Office.
Patient Identifiers:
Name
Address
Phone#
DOB
SSN#
TCN
Med Record#
MassHealth# (RID and/or RHN)
Date of Service
Total Charge for Services
Net Charge submitted to Health Safety Net
Evidence of Reasonable Collection Efforts:
Date of Initial Bill
Date of Second Bill
Date of Third Bill
Date of Fourth Bill

Date of Returned Mail
Date of Certified Letter for accounts over $1,000
Date of Initial Phone Contact
Date of Follow up Phone Contact
Dates of Other Efforts (other phone calls, letters to patient, attorney or referral to collection agency)
Date Account was submitted to Health Safety Net Office “

Inpatient and Outpatient Bad Debt Requirements:

HSN requires that Bad Debt Applications be completed in the HSN INET system for HSN facilities’ Bad Debt claims generated in inpatient & outpatient acute care hospital settings, community health centers and in Hospital Licensed Health Centers.

For **Inpatient Hospital Bad Debt Claims**, HSN requires that: 1) Bad Debt application be completed and submitted in the INET system; 2) Application ID # must be reported on the BD claim; 3) Evidence in INET must be reported as required in regulation section 101 CMR 613.06 (1) (b); and 4) the valid MMIS Patient ID # must be included in the Inpatient Bad Debt claim.

For **Community Health Center Claims**, HSN requires that: 1) Bad Debt application be completed and submitted in the INET system; 2) the required information per HSN regulation section 101 CMR 613.06 (1) (b) should be kept on file within the facility and be made available to HSN staff within 30 days of a request by the Health Safety Net Office (e.g. for auditing purposes); therefore, this means that the evidence for outpatient claims is NOT required to be submitted in INET; and 3) the valid MMIS Patient ID # must be included in the Outpatient Bad Debt claim.

For **Outpatient Hospital Bad Debt Claims**, HSN requires that: 1) Bad Debt application be completed and submitted in the INET system; 2) the required information per HSN regulation section 101 CMR 613.06 (1) (b) should be kept on file within the facility and be made available to HSN staff within 30 days of a request by the Health Safety Net Office (e.g. for auditing purposes); therefore, this means that the evidence for outpatient claims is NOT required to be submitted in INET; and 3) the valid MMIS Patient ID # must be included in the Outpatient Bad Debt claim.

For **Hospital Licensed Bad Debt Claims**, HSN requires that: 1) Bad Debt application be completed and submitted in the INET system; 2) Application ID # must be reported on the BD claim; 3) the required information per HSN regulation section 101 CMR 613.06 (1) (b) should be kept on file within the facility and be made available to HSN staff within 30 days of a request by the Health Safety Net Office (e.g. for auditing purposes); therefore, this means that the evidence for outpatient claims is NOT required to be submitted in INET; and 4) the valid MMIS Patient ID # must be included in the Outpatient Bad Debt claim.

Please Note the Following:

Providers should not send in their Inpatient Bad Debt Claims without having both the Special Circumstance Bad Debt Application Number # populated in the Loop 2300 REF02 segment REF01 = G1 (i.e. REF*G1) where the Special Circumstance application creates eligibility and provides the Application Number to be reported on the claim **and** having the Evidence

Collection fully attested in the HSN INET system. If these steps are done out of order or if the facility waits until the Bad Debt claim is sent will always create claim denials.

Referred Eligibility Processing:

Bad Debt claims cannot be processed unless submitted with a valid MMIS Patient ID #. In cases where a provider needs to obtain a valid MMIS Patient ID #, a Referred Eligibility process will occur where HSN obtains the valid MMIS Patient ID # from MassHealth and then HSN will report back that valid ID # to providers. The ID # may be found in a Referred Eligibility Report listing the MMIS ID # assigned to an individual. This Report can be downloaded from INET. The valid MMIS Patient ID # must be reported on a bad debt claim.

If a patient has an existing MMIS ID, providers should submit a bad debt claim with the existing MMIS ID #, once the application has been approved.

Once an MMIS ID is assigned, facility representatives may look up member's information in the EVS system via member ID or name / date of birth.

New Dental Administrator

Due to unforeseen MassHealth technical issues, the transition to the new dental administrator, BeneCare, is delayed and is no longer February 1, 2025. The new anticipated operational start date will be announced in the coming weeks.

For more information on the delayed start date, please see Dental Bulletin 51.

For participating providers and members:

No action is needed at this time and there are no immediate changes in MassHealth Dental operations

Please continue to contact MassHealth DentaQuest Customer Service at 800-207-5019 for questions or support until the transition to BeneCare (new start date TBD).

What is the dental third-party administrator and what do they do?

The dental administrator (also called the "TPA") provides the day-to-day functions on behalf of the MassHealth Dental program, including:

- Claims processing
- Customer service for members and providers
- Credentialing and recruitment

- Helping members find a dentist

How can I find out more about the upcoming MassHealth dental administrator transition?

An initial list of frequently asked questions (FAQs) about the upcoming transition is available at FAQ.massdhp.org

- The FAQs will continue to be updated as more information is available.

How can I sign up to receive future email updates about the MassHealth dental administrator transition?

Sign up for the transition email list at: https://survey.massdhp.org/

- Please note that individuals and parties who are interested in TPA transition updates but are not providers are also welcome to sign up for the email list. Please use the same sign up form and enter your organization or n/a under "Dental Practice Name".

For questions regarding the upcoming MassHealth dental administrator transition, please email the MassHealth Dental Provider Relations team, supported by BeneCare, at providerrelations@massdhp.com.

Duplicate claims

Under no circumstances should duplicate claims ever be submitted. Resubmission of previously paid claims should always be submitted as an adjustment, never as an original claim, and should occur only when a change to submitted claims data is warranted.

Frequency Codes

HSN claims will only be accepted and processed based on the following claim frequency codes. Use of other codes will result in claims being denied.
XX1 = Original Claim
XX7 = Replacement Claim
XX8 = Void Claim

TCN/Patient Account Number

As a reminder, providers must not enumerate the reported TCN/Patient Account Number when correcting claims. Any billing system enumeration should be suppressed. Additionally, when sending information or claim reviews to HSN, Providers must send in the entire TCN/Patient Account Number, including any leading zeroes and any prefix or suffix that is part of that identifier.
Include the corresponding ICN for the claim in question.

HSN Secondary Claims

Providers MUST when sending HSN secondary claims include all service lines that are part of the total charges. No service lines should be deleted. Additionally, Providers must give HSN the information on any prior payments, denials, or contractual adjustments. This includes any Mass Health payments, other government payers and commercial payers etc.

Reports available to assist in follow-up for claim status

MassHealth/MMIS RA's 835
HSN validation/error reports
HSN remits

Remediated Remits in INET

Please note that your facility may have more than one payment remit in INET due to HSN processing claims from prior years. Going forward, HSN will continue to process current year's remits as well as previous year's dates of service. For facilities who utilize Billing Intermediaries, please notify your BI that going forward, there may be multiple remits for your facility.

For any questions about this billing update, please contact the HSN Customer Service line at 800-609-7232 or by email at HSNHelpdesk@state.ma.us.

Information about HSN Provider Guides and Billing Updates | Mass.gov
HSN claims and payment information | Mass.gov