MassHealth

Standard Companion Guide

Health Care Claim: Institutional (837I)

Refers to the Implementation Guides Based on ASC X12N version 005010X223A2

August 2023

Disclosure Statement

This *MassHealth Standard Companion Guide* ("Companion Guide") serves as a companion document to the corresponding ASC X12N/005010X223A2 Health Care Claim: Institutional (837), its related Addenda (005010X223A2), and its related Errata (005010X223E1). MassHealth strongly encourages its trading partners to use this Companion Guide in conjunction with the *ASC X12 Implementation Guide* to develop the HIPAA batch transaction. Copies of the ASC X12 Technical Report Type 3s (TR3s) are available for purchase at www.x12.org.

This document supplements, but does not contradict, disagree, oppose, or otherwise modify the 005010X222 implementation specification in a manner that will make its implementation by users out of compliance. Tables contained in this Companion Guide align with the CAQH CORE v5010 Companion Guide Template. The template is available at www.caqh.org.

About MassHealth

MassHealth is the Medicaid and Children's Health Insurance Program (CHIP) for Massachusetts. MassHealth provides comprehensive health insurance and dental coverage for eligible individuals, families, and people with disabilities across the Commonwealth of Massachusetts. In 2018, the program served approximately 1.85 million residents in the state. MassHealth's coverage is managed and facilitated through an array of programs, including accountable care organizations (ACOs) and managed care organizations (MCOs), which enable members to choose the plan that best meets their needs. The agency is nationally recognized for providing high quality care in an innovative and cost-effective manner.
See www.mass.gov/masshealth.

Medicaid Management Information System and Provider Online Service Center

The Medicaid Management Information System (MMIS) and the Provider Online Service Center (POSC) both support the web-based provider portal that is used by MassHealth providers and relationship entities to access, submit, and retrieve transactions and information that support the administration of health care to MassHealth members. The POSC provides access to online functions, such as member eligibility verification, claim submission and status, prior authorization (PA), referrals, pre-admission screening, online remittance advices, and reports. The tool also facilitates the submission and retrieval of HIPAA ASC X12 transactions.

Contact for Additional Information

MassHealth Customer Service Center
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Preface

This *MassHealth Standard Companion Guide* to the *005010 ASC X12N Implementation Guide* clarifies and specifies the data content when exchanging transactions electronically with MassHealth. This Companion Guide is not intended to convey information that in any way exceeds or replaces the requirements or usages of data expressed in the Implementation Guides. Neither the Executive Office of Health and Human Services nor MassHealth is responsible for any action or inaction, or the effects of such action or inaction, taken in reliance on the contents of this guide.

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1. Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires MassHealth and all other health insurance payers in the United States to comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of the U.S. Department of Health and Human Services (HHS). The ASC X12N implementation guides are the standards of compliance for electronic health care transactions.

SCOPE

The standard adopted by HHS for electronic health care transactions is ASC X12N Version 005010, which became effective January 1, 2012. The unique version/release/industry identifier code for the 837 Health Care Claim: Institutional transactions is 005010X223A2.

This Companion Guide assumes compliance with all loops, segments, and data elements contained in the 005010X223A2. It defines the requirements for HIPAA transactions submitted to and/or received from MassHealth.

OVERVIEW

MassHealth created this Companion Guide for MassHealth trading partners to supplement the *ASC X12N Implementation Guid*e. This Companion Guide contains MassHealth-specific instructions related to the following.

- Data formats, content, codes, business rules, and characteristics of the 837I electronic transaction;
- Technical requirements and transmission options; and
- Information on testing procedures that each trading partner must complete before transmitting electronic transactions.

The information in this document supersedes all previous communications from MassHealth about this 837I electronic transaction. The following standards are in addition to those outlined in the MassHealth provider manuals. These standards in no way supersede MassHealth regulations. Use this guide in conjunction with the information available in your MassHealth provider manual.

REFERENCES

The Implementation Guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The Implementation Guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that your IT staff or software vendor review this document in its entirety and follow the stated requirements to exchange files with MassHealth while maintaining HIPAA compliance.

The Implementation Guides for ASC X12N and all other HIPAA standard transactions are available electronically at www.x12.org.

■ ADDITIONAL INFORMATION

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions. In addition, this information should be shared with the provider's billing office to ensure that all accounts are reconciled in a timely manner.

2. Getting Started

■ WORKING WITH MASSHEALTH

MassHealth trading partners can exchange electronic health care transactions with MassHealth by directly uploading and downloading transactions via the Provider Online Service Center (POSC) or system-to-system using the MassHealth connectivity submission method. Submitters must determine whether they will use the industry standard, Simple Object Access Protocol (SOAP) / Web Services Description Language (WSDL) or HyperText Transfer Protocol (HTTP) Multipurpose Internet Mail Extensions (MIME) Multipart Web service to support the submission of transactions via MassHealth's connectivity method.

After determining the transmission method, each Trading Partner must successfully complete testing of the HIPAA transaction before testing the MassHealth connectivity submission method. Additional information is in the next section of this companion guide. After successful completion of testing, you may exchange production transactions.

Please contact the MassHealth Customer Service Center at (800) 841-2900 or via email at edi@mahealth.net for assistance with the MassHealth connectivity submission method.

■ TRADING PARTNER REGISTRATION

All MassHealth Trading Partners are required to sign a Trading Partner Agreement (TPA), as described in Section 9 below. If you have elected to use a third party to perform electronic transactions on your behalf, you will also be required to complete an Electronic Remittance Advice (ERA) Enrollment Form. If you have already completed this form, you are not required to complete it again. Please contact the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711 or via email at edi@mahealth.net if you have any questions about these forms.

■ CERTIFICATION AND TESTING OVERVIEW

All trading partners that exchange electronic batch transactions with MassHealth must complete trading-partner testing. This includes vendors, clearinghouses, and billing intermediaries that submit on behalf of providers, as well as providers that MassHealth defines as atypical. At the completion of testing, trading partners are certified.

Test transactions exchanged with MassHealth should include a representative sample of the various types of transactions that you would normally conduct with MassHealth. The size of the file should be between 25 and 50 transactions.

MassHealth will post on its website a list of vendors, clearinghouses, and billing intermediaries that have completed trading partner testing. If a billing intermediary or software vendor submits electronic transactions on your behalf, please view the list on our website. Providers who use a billing intermediary or software vendor do not need to test for electronic transactions that their entity submits on their behalf.

3. Testing with MassHealth

Typically, before exchanging production transactions with MassHealth, each Trading Partner must complete testing. All trading partners who plan to exchange transactions must contact the MassHealth Customer Service Center at (800) 841-2900 in advance to discuss the testing process, criteria, and schedule. Trading Partner testing includes HIPAA compliance testing, as well as validating the use of conditional, optional, and mutually defined components of the transaction.

We strongly encourage you to submit any electronic files directly to the POSC to avoid any potential delay in processing your requests.

Please note that providers submitting the eligibility inquiry request via the POSC using direct-data entry (DDE) are not required to test. You must, however, have a valid TPA on file with MassHealth to submit claims.

Before submitting production transactions to MassHealth, each Trading Partner must test. Trading Partners planning to submit transactions must contact the MassHealth Customer Service Center at (800) 841-2900 in advance to discuss the testing process, criteria, and schedule.

Trading Partner testing includes HIPAA compliance testing, as well as validating the use of conditional, optional, and mutually defined components of the transaction.

The test files should contain as many types of claims as necessary to cover each of your business scenarios.

Trading Partners must address the following conditions in any standard test file.

Test files must have a minimum of 10 and a maximum of 50 test claims.

- Member and provider data valid for a mutually agreed upon effective date.
- Original claims;
- Void claims (if you plan to submit void transactions);
- Replacement claims (if you plan to submit void transactions and replacement claims);
- Coordination of Benefits (COB) claims testing. This is required for providers who plan to submit COB claims. Providers submitting test files containing COB claims (where the member has other insurance) should include a minimum of 10 and a maximum of 50 COB claims with the following criteria:
    - Claims with commercial insurance (denied/paid);
    - Claims with Medicare (denied/paid);

- Claims with multiple insurance (if applicable); and
- Claims with a total non-covered amount if applicable to the submitter only as described in provider manual appendices.

Providers are advised to submit third-party 835 remittance advices and/or the paper explanation of benefits (EOB) from the other insurers to be used in the testing process for verification of data in the COB loops. Providers must indicate which claims on the 835 remittance advice and/or paper EOB correspond to the claims on the test file.

MassHealth will process these transactions in a test environment to verify that the file structure and content meet HIPAA standards and MassHealth-specific data requirements. Once this validation is complete, the trading partner may submit production transactions to MassHealth for adjudication. Test claims adjudicate in the test system but will not be adjudicated for payment.

4. Connectivity with MassHealth/Communications

Users/providers may connect with MassHealth to submit ASC X12N-formatted batch transactions via the POSC.

■ TRANSMISSION ADMINISTRATIVE PROCEDURES

System Availability

The system is typically available 24 hours a day, seven days a week, except for scheduled maintenance windows.

Transmission File Size

The current maximum size for any file submitted to MassHealth is 16-MB. Any transaction files submitted to MassHealth that are greater than 16 MB will be rejected. If you have any questions on file size limits, please contact the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711. Please note that the POSC does not unzip or decompress files. Transmit all files in an unzipped or uncompressed format.

Transmission Errors

When processing EDI transactions that have Interchange Control Header (ISA) errors, an Interchange Acknowledgement (TA1) will be generated for each ISA error. Providers must submit the same ISA and Functional Group Header (GS) and Functional Group Trailer (GE) values for all ISA-Interchange Control Trailer (IEA) envelopes within the same file with the exception of the date/time and control # data elements. Files submitted with inconsistent values will be rejected in pre-compliance.

Please see Section 8 for additional details regarding the TA1 process.

If the Interchange Header is valid, but the transaction fails compliance, a 999 will generate.

Production File-naming Convention

Files transmitted to MassHealth using the POSC do not need to confirm to any particular file-naming convention. The system will rename files upon receipt and issue a tracking number for reference.

■ RETRANSMISSION PROCEDURE

MassHealth does not require any identification of a previous transmission of a file. All files sent should be marked as original transmissions.

■ COMMUNICATION PROTOCOL SPECIFICATIONS
Provider Online Service Center (POSC)

The POSC is a web-based tool accessible via the internet, which aids providers in effectively managing their business with MassHealth electronically. The POSC may be used to enroll as a MassHealth provider to

- manage a provider's profile information;
- enter claims via direct data entry (DDE);
- enter member eligibility requests via DDE;
- view member eligibility response transactions; or
- upload and download batch transaction files, access reports, and receive messages/communications.

■ CORE CONNECTIVITY SUBMISSION METHOD

MassHealth provides a Committee on Operating Rules for Information Exchange (CORE) connectivity submission method that allows trading partners to submit HIPAA transactions from their system directly to the MMIS via internet protocol using one of the two Envelope Standards; HTTP MIME Multipart (Envelope Standard A) or Simple Object Access Protocol (SOAP)/Web Services Description Language (WSDL) (Envelope Standard B) to ensure a standardized safe harbor connectivity. For Envelope Standard B, this system-to-system EDI web service is supported by a standard CORE schema and WSDL as defined in the section 4.2.2 Specifications for SOAP+WSDL in the Phase II CORE 270: Connectivity Rule Document.

While the HTTP MIME Multipart does not provide a standard schema specification, MMIS implementation of the MIME Multipart will expect that each data element has the corresponding "name" property that matches the SOAP schema definitions as well as the same "operations" names.

For more information about MassHealth's CORE Connectivity Method, contact the MassHealth Customer Service Center at (800) 841-2900 or by email at edi@mahealth.net.

■ PASSWORDS

Providers using the POSC to submit their EDI transactions must follow MassHealth's requirements for use of passwords. Providers, trading partners, and relationship entities that have been assigned a User ID/password to access MMIS Provider Online Service Center (POSC) and connectivity methods are solely responsible for the use of that user ID and password. Sharing User IDs and password is a violation of the Virtual Gateway (VG) Terms and Conditions. Each user is prompted to agree with the VG Terms and Conditions upon initial sign-in on any Commonwealth VG hosted application (e.g., MMIS). Each User ID that violates the Terms and Conditions may be subject to termination.

Each provider is responsible for managing their own data and access to their organization's data through the MMIS security function. Each provider must take all necessary precautions to ensure that they are safeguarding their information and sharing their data (i.e., granting access) only with users and entities who meet their required privacy standards.

It is equally important that providers know who on their staff are linked to other providers or entities that perform functions on their behalf. Once a staff person terminates or the relationship with another entity that performs functions for your organization is terminated, the provider must ensure that access is removed and accounts are de-linked. MassHealth is not responsible for any action taken by any individual in MMIS whose access results from a provider's failure to abide by these requirements.

In the event that the Primary User and assigned backup leaves the provider, trading partner, or relationship entity organization, that organization must immediately identify a replacement Primary User, complete a new Data Collection Form (DCF), and submit it to MassHealth to officially notify the agency of the change.

For more information on passwords and the use of passwords, contact the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711.

5. Contact Information

■ EDI CUSTOMER SERVICE

For written correspondence

MassHealth Customer Service Center
PO Box 7
Boston, MA 02112-0007

For electronic claims/hard media submissions

MassHealth Customer Service Center
PO Box 7
Boston, MA 02112-0007
Email: edi@mahealth.net
Phone: (800) 841-2900, TDD/TTY: 711
Fax: (617) 988-8971

■ EDI TECHNICAL ASSISTANCE

MassHealth Customer Service Center
PO Box 7
Boston, MA 02112-0007
Email: hipaasupport@mahealth.net
Phone: (800) 841-2900, TDD/TTY: 711
Fax: (617) 988-8971

■ PROVIDER SERVICE NUMBER

MassHealth Customer Service Center
PO Box 7
Boston, MA 02112-0010
Email: provider@masshealthquestions.com
Phone: (800) 841-2900, TDD/TTY: 711
Fax: (617) 988-8974

■ APPLICABLE WEBSITES/EMAIL

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for interindustry electronic interchange of business transactions. See www.x12.org.

Centers for Medicare & Medicaid Services (CMS)

- CMS is the agency within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets standards at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.

Committee on Operating Rules for Information Exchange (CORE)

- A multiphase initiative of CAQH, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care. See www.caqh.org.

Council for Affordable Quality Healthcare (CAQH)

- CAQH is a nonprofit alliance of health plans and trade associations, working to simplify health care administration through industry collaboration on public-private initiatives. Through two initiatives—the Committee on Operating Rules for Information Exchange (CORE) and Universal Provider Datasource (UPD)—CAQH aims to reduce administrative burden for providers and health plans. See www.caqh.org.

MassHealth (MH)

- The MassHealth website assists providers with HIPAA billing and policy questions, as well as enrollment support. See www.mass.gov/masshealth.

National Committee on Vital and Health Statistics (NCVHS)

- The National Committee on Vital and Health Statistics was established by Congress to serve as an advisory body to HHS on health data, statistics, and national health information policy. See www.ncvhs.hhs.gov/.

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. See www.ncpdp.org.

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. See http://www.wpc-edi.com/.

6. Control Segments/Envelopes

■ ISA (INTERCHANGE CONTROL HEADER)

This section describes MassHealth's use of the interchange control segments. It includes the expected sender and receiver codes, authorization information, and delimiters. All ISA segments within a single file must be consistent with the exception of the date/time and control # data elements. The following chart and all charts in this document align with the CAQH CORE v5010 Companion Guide Template format. The template is available at www.caqh.org.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.4	-----	ISA01	Authorization Information Qualifier	00	
C.4	-----	ISA02	Authorization Information		10 blank spaces
C.4	-----	ISA03	Security Information Qualifier	00	
C.4	-----	ISA04	Security Information		10 blank spaces
C.4	-----	ISA05	Interchange ID Qualifier	ZZ	
C.4	-----	ISA06	Interchange Sender ID		Trading partner ID assigned by MassHealth (10-character MMIS provider ID/service location)
C.5	-----	ISA07	Interchange ID Qualifier	ZZ	
C.5	-----	ISA08	Interchange Receiver ID	DMA7384	Claims from MassHealth providers
				HSN3644	Claims from HSN providers

■ GS (FUNCTIONAL GROUP HEADER)

This section describes MassHealth's use of the functional group control segments. It includes the expected application sender and receiver codes. All GS segments within a single file must be consistent with the exception of the date/time and control # data elements.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	-----	GS02	Application Sender's Code		Trading partner ID assigned by MassHealth (10-character MMIS provider ID/service location)
C.7	-----	GS03	Application Receiver's Code	DMA7384	Claims from MassHealth providers
				HSN3644	Claims from HSN providers

7. MassHealth-Specific Business Rules and Limitations

This section describes MassHealth's business rules, including

- billing for specific services such as durable medical equipment (DME), ambulance, home health services; and
- communicating payer-specific edits

Before submitting electronic claims to MassHealth, please review the appropriate HIPAA implementation guide and MassHealth companion guide. In addition, MassHealth recommends that you review the MassHealth billing guides. The CMS-1500 and UB-04 billing guides provide additional billing instructions for specific provider types. These guides are located on the MassHealth website at https://www.mass.gov/lists/masshealth-hipaa-companion-guides.

The following sections outline recommendations, instructions, and conditional data requirements for claims submitted to MassHealth. This information is designed to help trading partners construct transactions in a manner that will allow MassHealth to efficiently process claims.

■ CLAIM SUBMISSION GUIDELINES

ST/SE segments within transactions submitted to MassHealth must not contain more than 5,000 claims. Submissions larger than 5,000 claims will be rejected. All submitters (i.e., providers, billing intermediaries, clearinghouses, and software vendors) must ensure that transaction sets do not include more than 5,000 claims per ST/SE segment.

MassHealth strongly encourages all submitters to ensure that redundant or excessive transactions are not submitted for processing. Transactions should only be submitted to MassHealth to directly support services that have or will be provided directly to MassHealth members.

■ NATIONAL PROVIDER IDENTIFIER (NPI)

MassHealth expects the provider's National Provider Identifier (NPI) in the appropriate NM109 data element, and taxonomy code in the appropriate PRV data element. If you have an NPI, you are required to use it. If you are an atypical provider and don't have an NPI, submit your 10-character provider ID (comprising nine digits and an alpha character to denote the service location) in the appropriate REF02 data element with an REF01 qualifier of G2.

For adjudication, MassHealth expects to receive the billing provider identification and the "doing business as" (DBA) addresses for the billing provider address and ignores the 2010AB loop (Pay to Provider).

To facilitate accurate cross walking of claims, please include your actual DBA address in the appropriate fields as well. This should not include PO box addresses.

■ CLAIMS ATTACHMENTS

CMS has not mandated an electronic standard for claims attachments. Until a standard is federally mandated, MassHealth has developed an alternative method for handling electronic claims that require attachments under HIPAA (e.g., medical form, consent forms, etc.).

Please Note: "Attachments" does not refer to COB attachments such as an EOB from another insurer. Refer to "Coordination of Benefits" for more information regarding EOBs from other insurers.

Claims that require attachments may be submitted through DDE on the POSC.

Until CMS mandates a standard for electronic attachments, providers and billing intermediaries that submit claims with attachments to MassHealth must submit the attachments via DDE.

MassHealth has reviewed its requirements for attachments, and will allow providers to keep the following attachments on file in the office, rather than requiring them to be submitted with the claim or through the DDE process.

If you submit this type of attachment...	...and you are this provider type	...you may keep the attachment on file (enter code PWK02).
Certification for Payable Abortion (CPA-2) form	Acute Inpatient Hospital Acute Outpatient Hospital	AA Refer to Section 10: Transaction Specific Information

Refer to Transaction Specific Information for instructions on completing the PWK segment.

Submit all attachments electronically through DDE on the POSC, with the exception of those attachments listed above.

Periodically, MassHealth may ask providers to verify the completion of attachments kept on file. In cases where MassHealth reviews have revealed provider noncompliance with the recordkeeping requirements of 130 CMR 450.205(A) through (C), MassHealth may pursue any legal remedies available to it, including, but not limited to, recovery of overpayments and imposing sanctions in accordance with the provisions of 130 CMR 450.234 through 450.260.

■ VOID AND REPLACEMENT TRANSACTIONS

Void Transactions

Submitters use void transactions to correct and report any one of the following situations.

- duplicate claims erroneously paid;
- payment to the wrong provider;
- payment for the wrong member;
- payment for overstated or understated services; or
- payment for services for which payment has been received from third-party payers.

Submit void transactions at the claim-header level and be sure to include the original MassHealth-generated internal control number (ICN) for the service with a claim frequency code equal to "8."

Replacement Transactions

Submitters use replacement transactions to adjust paid claims. If the submitter is trying to correct a paid claim where the member ID, provider ID, and claim type are staying the same, they may send in a replacement claim with appropriate lines from the original claim (both paid and denied). Submitters can omit correctly denied lines that should not be resubmitted, add additional lines if necessary, or correct data elements on existing detail lines as appropriate. Replacement transactions must include the original MassHealth-generated internal control number (ICN) for the service with a claim frequency code equal to "7."

Please note that a submitter should not attempt to void the original claim before sending in a replacement. This will result in denial of the replacement claim for error 550-Adjustment Failed. Instead, the submitter should send in only the replacement claim. The system will automatically inactivate the original claim.

■ COORDINATION OF BENEFITS (COB)

COB Claims

Providers can submit 837 transactions for COB claims for members with Medicare and/or commercial insurance to MassHealth, after billing all other resources. When submitting an 837 transaction to MassHealth for members with other insurance, providers must supply the other payer's adjudication details from the 835 transaction or paper remittance advice.

Providers are required to enter the other payer's adjudication details at the claim level for inpatient and skilled nursing facility room and board claims. Line-level adjudication details are required for outpatient, home health, nursing facility ancillary services, inpatient ancillary services and hospice claims on each detail service line. The adjustment reason codes entered in the COB loops should be the exact codes given by the other payer or the equivalent codes as described in the implementation guide. MassHealth requires providers to enter the payer's seven-digit MassHealth-assigned carrier code on the 837 transaction to identify the other insurance. MassHealth-assigned carrier codes may be found in Appendix C: Third Party Liability Codes of your MassHealth provider manual at www.mass.gov/masshealth. The Eligibility Verification System (EVS) provides a seven-digit insurance carrier code for all applicable insurance coverage for a member.

For further details, refer to Section 10: Transaction-Specific Information.

COB Claims with Medicare

After Medicare has made a payment or applied the charge to the Medicare deductible or coinsurance, claims are transmitted (crossover) by the Medicare Benefits Coordination and Recovery Center (BCRC) to MassHealth.

Providers may submit electronic claims for dual-eligible members directly to MassHealth using the 837 transaction following the COB requirements if one of the following statements is true.

- The member has other insurance in addition to Medicare and MassHealth; or
- The member's Medicare claim has not appeared on a MassHealth crossover remittance advice and/or the claim cannot be located in POSC during a claim status inquiry.

■ COB — OTHER

The remittance date is critical for COB claims adjudication.

Inpatient and Skilled Nursing Facility Room and Board Claim Types	
Claim type	Description
A	Inpatient Part A Crossover
I	Hospital Inpatient
L	Long-Term Care

NOT Inpatient and Skilled Nursing Facility Room and Board Claim Types	
Claim type	Description
C	Outpatient Part B Crossover UB-92 (includes crossovers for home health; hospice; renal dialysis; mental health; community health, nursing facility ancillary services; and inpatient ancillary services).
H	Home Health and Community Health
O	Hospital Outpatient

■ 340B DRUG INFORMATION

For drugs administered in an outpatient or clinic setting, MassHealth requires the modifier "UD" with the applicable HCPCS code to identify drugs purchased through the 340B program for drugs.

■ SERVICE CODES

Please consult Subchapter 6 or the appropriate appendix of your MassHealth provider manual for information on acceptable revenue and service codes. This information is also available on the web.

■ PROVIDER TYPES TO INVOICE TYPES MAP

If you currently submit on the UB-04 paper claim form and you are this provider type...	and you are billing this allowable service[1]	... use this HIPAA transaction.
Acute Inpatient Hospital	Acute Inpatient Services	837I
Chronic Inpatient Hospital	Chronic Inpatient Services	837I
Psychiatric Inpatient Hospital	Psychiatric Inpatient Services	837I

If you currently submit on the UB-04 paper claim form and you are this provider type...	and you are billing this allowable service[1]	... use this HIPAA transaction.
Non-RFA Semi-acute Inpatient Hospital	Non-RFA semi-acute Inpatient Services	837I
Intensive Residential Treatment Program	Intensive Treatment Program Services	837I
Non-RFA Semi-acute Outpatient Hospital	Non-RFA Semi-acute Outpatient Services	837I
Acute Outpatient Hospital	Acute Outpatient Services	837I
Hospital-licensed Health Center	Hospital-licensed Health Center Services	837I
Chronic Outpatient Hospital	Chronic Outpatient Services	837I
Psychiatric Outpatient Hospital	Psychiatric Outpatient Services	837I
Community Health Center (CHC)	Home Health Services	837I
Home Health Agency	Home Health Services	837I
Hospice	Hospice Services	837I
Nursing Facility	Nursing Facility Services	837I
ICF-MR State School	ICF-MR Services	837I
Acute Inpatient Hospital	Acute Inpatient Services	837I

[1] Please consult Subchapter 6 or the appropriate appendix of your MassHealth provider manual for information on acceptable revenue and service codes. This information is also available on www.mass.gov.

■ ADDITIONAL INFORMATION

MassHealth does not process loops that do not apply to the MassHealth business model.

In certain circumstances, these loops may be required in a compliant 837 transaction. However, the data content of these loops will not affect the MassHealth claims adjudication process.

8. Acknowledgements and Reports

All transaction files uploaded to the POSC generate a confirmation number indicating successful file uploads. A TA1 interchange acknowledgment is generated for all Interchange Control Header (ISA) errors within a batch file, when ISA14 is set to 1. A 999 Implementation Acknowledgement is generated for all batch files that are not rejected due to interchange (ISA) errors. These acknowledgements will be available for download from the POSC and/or retrieved through the MassHealth system-to-system connectivity method.

■ THE TA1 INTERCHANGE ACKNOWLEDGEMENT

MassHealth will generate a TA1 for all ISA errors. Files must contain the same ISA and GS values for all ISA-IEA envelopes within the same file with the exception of the date/time and control # data elements. Files submitted with inconsistent values will be rejected in pre-compliance. Files that contain multiple envelopes will generate multiple TA1s. For any interchange header error identified in a single envelope, MassHealth will generate a TA1 for all interchange headers in the file.

■ THE 999 IMPLEMENTATION ACKNOWLEDGEMENT

Each submission of an ASC X12 V5010 file to MassHealth generates a 999 implementation acknowledgement and is sent to the submitter within one business day.

■ REPORT INVENTORY

There are no acknowledgement reports at this time.

9. Trading-Partner Agreements

Providers who intend to conduct electronic transactions with MassHealth must sign the MassHealth TPA. A copy of the agreement is available at www.mass.gov or you may contact the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711.

■ TRADING PARTNERS

Electronic Data Interchange (EDI) defines a trading partner as any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that conducts electronic transactions with MassHealth. The trading partner and MassHealth acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Each party agrees to take all steps reasonably necessary to ensure that all electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder.

Payers have EDI TPAs that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The TPA relates to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement between each party to the agreement.

10. Transaction-Specific Information

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of tables. The tables contain a row for each segment that MassHealth has something specific and additional, over and above, the information in the IGs. That information can

- limit the repeat of loops, or segments;
- limit the length of a simple data element;
- specify a subset of the IGs internal code listings;
- clarify the use of loops, segments, composite, and simple data elements; and
- provide other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with MassHealth.

In addition to the row for each segment, MassHealth uses one or more additional rows to describe its usage for composite and simple data elements and for any other information. Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

STANDARD CLAIMS

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
69	----	BHT04	Transaction Set Creation Date		Enter the date claims were billed.
69	----	BHT06	Claim Identifier	CH	
72	1000A	NM109	Submitter Identifier		Trading Partner ID assigned by MassHealth (the 10-character MassHealth MMIS provider number including service location)
77	1000B	NM109	Receiver Primary Identifier	DMA7384	Claims from MassHealth providers
				HSN3644	Claims from HSN providers
80	2000A	PRV03	Provider Taxonomy Code		Enter the taxonomy code as instructed in the MassHealth Billing Guide.
110	2000B	SBR09	Claim Filing Indicator Code	MC	
114	2010BA	NM109	Subscriber Primary Identifier		Enter the 12-character MassHealth member ID
118	2010BA	DMG03	Subscriber Gender Code	M, F	
123	2010BB	NM109	Payer Identifier	DMA7384	For MassHealth claims
				HSN3644	For HSN claims

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
129	2010BB	REF01	Reference Identification Qualifier	G2	If NPI is not submitted in billing provider identifier loop, atypical providers must enter G2
130	2010BB	REF02	Provider Secondary Identifier		If NPI is not submitted in billing provider Identifier loop, atypical providers must enter the 10-character MassHealth provider number including Service Location.
156	2300	PWK02	Attachment Transmission Code	AA	Claims submitted with this transmission code indicate an approved attachment is on file at the provider's office in accordance with Section 7: MassHealth-Specific Business Rules and Limitations.
163	2300	REF02	Referral Number		Enter the 10-character referral number if the member you are billing for is enrolled in a PCC plan and all services being billed require PCC authorization.
165	2300	REF02	Prior Authorization Number		If PA exists, enter the MassHealth-assigned 10-character PA number.
175	2300	REF02	Peer Review Authorization Number		If preadmission screening is required for this claim, enter the assigned 10-character preadmission screening number.
258	2300	HI	Occurrence Span Information		If you are reporting medical leave-of-absence (MLOA) or nonmedical leave-of-absence (NMLOA) days, enter this segment.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
258	2300	HI XX-2 XX ranges from 01 to 12	Occurrence Span Code	71	Use this occurrence span code for MLOA days.
319	2310A	NM1	Attending Provider Name		The attending provider should be enrolled with MassHealth.
425	2400	SV202	Composite Medical Procedure Identifier		Nursing facility providerrs must bill HIPPS code on their room and board claims with revenue code 0022. Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code
425	2400	SV202-1	Product/Service ID Qualifier	HP	For EDI Claims, submit data element SV202 with a qualifier of HP.

COB CLAIM

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
349	2310F	NM1	Referring Provider		Enter the referring provider's NPI; the referring provider entered in this segment should be enrolled with MassHealth
356	2320	SBR09	Claim Filing Indicator Code	MA, MB, CI	
385	2330B	NM109	Other Payer Primary Identifier		Enter the MassHealth-assigned seven-digit carrier code (refer to Appendix C: Third-Party Liability Codes in your MassHealth provider manual, or to the Provider Library at www.mass.gov/masshealth for information.)
476	2430	SVD01	Other Payer Primary Identifier		Enter the MassHealth-assigned seven-digit carrier code.

APPENDICES

Appendix A. Implementation Checklist

This appendix contains all necessary steps for implementing the transactions with MassHealth.

1. Call the EDI Help Desk with any questions at (800) 841-2900, TDD/TTY: 711. Please see Section 5 – Contact Information.

2. Check www.mass.gov/masshealth for the latest information on MassHealth's system.

3. Confirm that you have an EOHHS user name and/or Provider ID.

4. Confirm that you can access the live system (and the test environment, if testing) with your POSC username.

5. Make the appropriate changes to your systems/business processes to comply with the ASC X12 V5010 Implementation Guide and MassHealth Standard Companion Guide.
   - If you have a third-party vendor or use a-third party software, work with your vendors to have the appropriate software installed.
   - If testing the system-to-system connectivity method interface, the trading partner or provider must work with your software vendor to have the appropriate software installed at their site(s) prior to performing testing with MassHealth.

6. Identify the functions you will be testing.
   - Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
   - Health Care Claim Status Request and Response (276/277)
   - Health Care Payment/Advice (835)
   - Health Care Claim: Institutional (837I)
   - Health Care Claim: Professional (837P)
   - Crossover/COB Claims

7. Confirm you have reported all the NPIs you will be using by validating them with MassHealth. Make sure your claim(s) successfully pay to your correct Provider ID, if you have associated multiple MassHealth Provider IDs to one NPI and/or taxonomy code.
   - If the entity is a billing intermediary or software vendor, they should use the provider's identifiers on the transaction.

8. When submitting files, make sure the members/claims you submit are representative of the type of service(s) you provide to MassHealth members.

9. If you determine that you will test the transaction, or testing is mandated by MassHealth:
   - Schedule a tentative week for the initial test.
   - Confirm the name and email/phone number of the primary testing contact.

Appendix B. Business Scenarios

This appendix contains typical business scenarios. The actual data streams linked to these scenarios are included in Appendix C.

1. V5010 MassHealth 837I Transaction with NDC information being billed.
2. V5010 MassHealth 837I Transaction for inpatient claims with COB.
3. V5010 MassHealth 837I Transaction for outpatient claims with COB.
4. V5010 MassHealth 837I Transaction for a member with MDS.

Appendix C. Transmission Examples

This appendix contains actual data streams. The business scenarios linked to the data streams are included in Appendix B.

1. Example of a 5010 MassHealth 837I Transaction with NDC information being billed

```
ISA*00*          *00*          *ZZ*999999999A     *ZZ*DMA7384
                 *110701*1030*^*00501*789113000*0*T*>-
GS*HC*999999999A*DMA7384*20110701*1030*7001*X*005010X223A2-
ST*837*60002*005010X223A2-
BHT*0019*00*000001*20110701*1030*CH-
NM1*41*2*OUTPATIENT CLAIM*****46*999999999A-
PER*IC*EDI DEPT*TE*8605551124-
NM1*40*2*MassHealth*****46*DMA7384-
HL*1**20*1-
PRV*BI*PXC*261QM2500X-
NM1*85*2*BILLING AGENT*****XX*1234567890-
N3*111 ABC DRIVE-
N4*BOSTON*MA*022151234-
REF*EI*012345678-
HL*2*1*22*0-
SBR*P*18*******MC-
NM1*IL*1*LAST*FIRST****MI*010101010111-
N3*222 DEF ST-
N4*CITY*MA*01701-
DMG*D8*19460630*F-
NM1*PR*2*MassHealth*****PI*DMA7384-
N3*333 GHI ST-
N4*CITY*MA*00000-
CLM*SAMPLE*10***13>A>1**A*Y*Y-
DTP*096*TM*1000-
DTP*434*RD8*20110625-20110625-
DTP*435*DT*201106251000-
CL1*3*1*01-
HI*BK>71159>>>>>>>Y-
HI*BJ>71159-
HI*PR>71159-
NM1*71*1*DOCTOR*ONE****XX*1234567890-
LX*1-
SV2*250*HC>J9250>UD*10*UN*1-
PWK*03*AA-
DTP*472*D8*20110625-
LIN**N4*11694089408-
CTP****1*UN-
REF*XZ*698-
SE*37*60002-
GE*1*7001-
IEA*1*789113000-
```

2. Example of a 5010 MassHealth 837I Transaction for Inpatient claim with COB

```
ISA*00*          *00*          *ZZ*999999999C     *ZZ*DMA7384
                 *111116*1345*^*00501*999126088*0*T*>~
GS*HC*999999999C*DMA7384*20111116*1345*999126088*X*005010X223A2~
ST*837*54001*005010X223A2~
BHT*0019*00*000001*20111116*1137*CH~
NM1*41*2*INPATIENT CLAIM*****46*999999999C~
PER*IC*EDI DEPT*TE*8605551124~
NM1*40*2*MassHealth*****46*DMA7384~
HL*1**20*1~
PRV*BI*PXC*282N00000X~
NM1*85*2*PROVIDER*****XX*1234567890~
N3*1 SOME STREET~
N4*SOMETOWN*MA*021290000~
REF*EI*123456789~
HL*2*1*22*0~
SBR*S*18*******MC~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*100000101010~N3*2
SOME ROAD~
N4*SOME CITY*MA*021110000~
DMG*D8*19420630*F~
NM1*PR*2*MassHealth*****PI*DMA7384~
N3*600 SOME ST~
N4*SOME CITY*MA*00000~
CLM*SAMPLE*430***11>A>1**A*Y*Y~
DTP*435*DT*201110271122~
DTP*434*RD8*20111106-20111109~
DTP*096*TM*1122~
CL1*3*2*01~
REF*EA*2326093~
HI*BK>78701~
HI*BJ>78701~
HI*BE>80>>>2~
NM1*71*1*LASTNAME*FIRSTNAME****XX*1234567890~
SBR*P*18*******MA~
CAS*CO*45*150~
CAS*PR*1*100**2*80~
AMT*D*100~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*999999999A~
NM1*PR*2*MEDICARE A*****PI*0084000~
DTP*573*D8*20111115~
LX*1~
SV2*120**430*UN*3~
DTP*472*D8*20111106~
SE*43*54001~
GE*1*999126088~
IEA*1*999126088~
```

3. Example of a 5010 MassHealth 837I Transaction for Outpatient claim with COB

```
ISA*00*          *00*          *ZZ*1111          *ZZ*DMA7384
                 *110906*0058*^*00501*112481369*0*T*:-
GS*HC*1111*DMA7384*20110906*005853*100000035*X*005010X223A2-
ST*837*000000001*005010X223A2-
BHT*0019*00*14401    112450004250TO*20110905*2323*CH-
NM1*41*2*XXX*****46*14401-
PER*IC*YYY*TE*1234567890-
NM1*40*2*MASSACHUSETTS HEALTH*****46*DMA7384-
HL*1**20*1-
PRV*BI*PXC*123456-
NM1*85*2*XXX*****XX*123456-
N3*101 XXX ST-
N4*SOME CITY*MA*111112222-
REF*EI*111111-
NM1*87*2-
N3*101 XXX STREET*ATTN  YYY-
N4*ANY CITY*MA*111112222-
HL*2*1*22*0-
SBR*U*18*******MC-
NM1*IL*1*AAA*BBBB****MI*123456789012-
N3*2 XXX ST-
N4*NEW CITY*MA*00000-DMG*D8*19280720*F-
NM1*PR*2*MASSACHUSETTS HEALTH*****PI*DMA7384-N3*1
ANY PLACE*11TH FLOOR-
N4*ANY CITY*MA*00000-
CLM*12345*400***13:A:1**A*Y*Y
-DTP*434*RD8*20110812-20110812-
CL1*9*1*01-
REF*EA*007817106-
HI*BK:75240-
HI*BH:A1:D8:19280720*BH:B1:D8:19280720-
HI*BE:76:::48-
NM1*71*1*CCC*DDD*O***XX*1234567890-
SBR*P*18**MEDICARE*****MA-
AMT*D*148.34-
OI***Y***Y-
MOA*.48**MA01-
NM1*IL*1*CCC*ZZZ****MI*1234567-
N3*2 XXX ST-
N4*NEW CITY*MA*00000-NM1*PR*2*MEDICARE*****PI*14401-N3*75
ANY DRIVE-
N4*TOWN*MA*00000-
REF*F8*21123500062302RIA-
LX*1-
SV2*0510*HC:99205*400*UN*1-
DTP*472*D8*20110812-
SVD*14401*148.34*HC:99205*0510*1
-CAS*CO*45*214.57-
CAS*PR*2*37.09-
DTP*573*D8*20110906-
SE*50*000000001-
GE*1*100000035-
IEA*1*112481369-
```

4. Example of a 5010 MassHealth 837I transaction for a member with MDS

```
ISA*00*          *00*          *ZZ*111111111A     *ZZ*DMA7384
                 *230717*1030*^*00501*789113000*1*T*>~
GS*HC*111111111A*DMA7384*20230717*1030*8001*X*005010X223A2~
ST*837*60001*005010X223A2~
BHT*0019*00*000001*20230717*1030*CH~
NM1*41*2*NAME*****46*111111111A~
PER*IC*NAME*TE*6175551212~
NM1*40*2*MASSHEALTH*****46*DMA7384~
HL*1**20*1~
PRV*BI*PXC*1234000000X~
NM1*85*2*NAME*****XX*1234567890~
N3*123 ANY STREET~
N4*CITY*MA*123459999~
REF*EI*123456789~
HL*2*1*22*0~
SBR*P*18*******MC~
NM1*IL*1*LNAME*FNAME****MI*1234567890~
N3*ANY ST~
N4*CITY*MA*123459999~
DMG*D8*19240706*F~
NM1*PR*2*MASSHEALTH*****PI*DMA7384~
N3*ANY STREET~
N4*BOSTON*MA*123459999~
CLM*NOTE*CT L***21>A>3**A*Y*Y~
DTP*434*RD8*20230601-20230630~
DTP*435*D8*20230529~
CL1*3*1*30~
REF*EA*7250~
REF*LU*MA~
HI*BE>24>>>7250*BE>80>>>30*BE>FC>>>111.11~
HI*ABK>G301>>>>>>>Y~
HI*ABJ>G301~
HI*ABF>F0280~
HI*BH>50>D8>20230529~
NM1*71*1*LNAME*FNAME****XX*1234567890~
LX*1~
SV2*0100**7250*DA*30~
LX*2~
SV2*0022*HP>FDPE1*0*DA*30~
SE*37*60001~
GE*1*8001~
IEA*1*789113000~
```

Appendix D. Frequently Asked Questions

This appendix contains a compilation of questions and answers. Typical questions would involve a discussion about code sets and their effective dates.

Q: MassHealth has allowed outpatient departments that perform dental procedures to use the CDT codes and the CPT codes for oral surgery services. The 837D Implementation Guide states that CDT codes are the only service codes allowed when filing an electronic claim. What is the process for an outpatient department to submit claims for oral surgery services using a CPT code?

A: Outpatient departments should submit oral surgery claims with CPT codes using the 837I claim format, and all other dental services using the 837D format.

Q: Hospitals billing on the paper UB-04 claim form are required to enter revenue code 0001 indicating "Total Charge" when submitting claims to MassHealth. Should this revenue code be entered on an 837I transaction?

A: No. Revenue code 0001 is not required on the 837I transaction, but continues to be required on the paper UB-04 claim form.

Q: If I identify other insurance that does not have a MassHealth-assigned carrier code, how do I submit the claim?

A: To obtain the MassHealth-assigned carrier code, cross-reference the insurance name with the appropriate carrier code in Appendix C: Third-Party Liability Codes of your MassHealth provider manual, and enter the seven-digit code on your 837 transaction. If a carrier code is not assigned, you should complete the Third-Party Carrier Code Request form and submit to

MassHealth
Third-Party Liability Unit
Fax: (617) 886-8134

Note: Do not send claim forms to the above fax number.

Q: I never received a response to my batch claim file.

A: We recommend that you wait up to 2 – 24 hours after submitting your 837 batch file to download your 999. Review the 999 and make sure that the 270 file was accepted.

Q: What is the limit of diagnosis codes allowed?

A: MassHealth will accept up to 12 diagnosis codes within a single claim reported in Loop 2300. The file will reject if the number exceeds 12.

Q: What is the MassHealth payor ID?

A: For MassHealth claims, you should use "DMA7384" and for Health Safety Net (HSN) claims you should use "HSN3644." Remember to separate out your HSN claims from your MassHealth claims and send in separate files.

Q: What is the limit to the number of detailed claim lines allowed in a single claim?

A: The MassHealth limit is 50. The file will fail compliance if the number exceeds the limit.

Q: How do I report primary/secondary insurance?

A: You should report the primary payor in Loop 2320 and the secondary payor in Loop 2000B.

Q: Why did my claim deny for edit 1945?

A: There are a few reasons why your claim received a 1945 edit. This is usually the result of a discrepancy with the DBA address and the billing address that is reported in the file and what is on record in the MMIS system.

Appendix E. Change Summary

This version of the MassHealth Companion Guide follows the CAQH CORE V5010 Companion Guide template. All references to the ASCX12 Implementation Guide are necessary to convey MassHealth's specific usage of the data elements to support electronic processing of the transaction with its trading partners, including codes and specific program instructions. The following changes have been made to this MassHealth Companion Guide.

The following fields have been added or modified in this Companion Guide.

Standard Claims

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
425	2400	SV202	Composite Medical Procedure Identifier		Nursing facility providers must bill HIPPS code on their room and board claims with revenue code 0022. Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code
425	2400	SV202-1	Product/Service ID Qualifier	HP	For EDI claims, submit data element SV202 with a qualifier of HP.
N/A	N/A	N/A	Appendix C Transmission Examples		Updated Appendix C Transmission examples. Number 4 was added to reflect 5010 MassHealth 837I transaction for a member with MDS.