

MMIS POSC Job Aid: Supplemental Instructions for Submitting Inpatient Claims for MassHealth Dually Eligible Members with Medicare Part B Coverage Only

This job aid contains supplemental billing instructions for submitting 837I transactions, or direct-data entry claims (DDE), for dually eligible members (Medicare and MassHealth) who have active MassHealth coverage and active Medicare Part B coverage, but no active Medicare Part A coverage.

For specific billing information, providers should reference the relevant billing guides available at www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/ (click [MassHealth Billing Guides for Paper Claim Submitters](#) to access a specific guide).

To ensure that MassHealth is the payer of last resort, providers must generally make diligent efforts to obtain payment from other resources before billing MassHealth. See MassHealth regulations at 130 CMR 450.309 through 450.321.

Billing Instructions for 837I Transactions

The following table contains the critical loops and segments that providers must first complete for submitting inpatient claims to MassHealth for dually eligible members who have active MassHealth coverage and active Medicare Part B coverage, but no active Medicare Part A coverage. Providers then must 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.

This section of the job aid supplements the instructions found in the HIPAA 837I Implementation Guide or the MassHealth 837I Companion Guide.

Loop	Segment	Value Description
2320	SBR09 (Claim Filing Indicator)	MB
2320	AMT01 (Paid Amount Qualifier)	D
2320	AMT02 (Paid amount)	Medicare Part B paid amount
2330B	NM109 (Other Payer Name)	0085000
2330B	DTP01 (Date Claim Paid Qualifier)	573
2330B	DTP03 (Check or Remittance Date)	Medicare payment date

Note: For COB balancing, the sum of the claim-level Medicare Part B Payer Paid Amount and HIPAA adjustment reason code amounts must balance to the claim billed amount. Providers should report a claim adjustment segment (CAS) with the appropriate HIPAA Adjustment Reason Code and Amount on their Medicare Part B payer loop.

Billing Instructions for Direct Data Entry (DDE)

This section of the job aid reviews the process of submitting an electronic Institutional claim in the Provider Online Service Center (POSC) for dually eligible members who have active MassHealth coverage and active Medicare Part B coverage, but no active Medicare Part A coverage.

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These instructions supplement the instructions found in the *Institutional Claim Submission with MassHealth* job aid. Providers should follow the instructions described in the *Institutional Claim Submission with MassHealth* job aid, and then come back to this job aid when reporting COB information on the claim. You can find POSC job aids on the web [here](#).

On the Coordination of Benefits Tab

On the **List of Coordination of Benefits (COB)** panel:

1. Click **New Item**. The **Coordination of Benefits (COB) Detail** panel displays.
On the **Coordination of Benefits (COB) Detail** panel:
2. In the **Carrier Code** field, enter **0085000**.
3. In the **Carrier Name** field, enter **Medicare B**.
4. In the **Remittance Date** field, enter the Medicare Part B remittance payment date.
5. In the **Payer Claim number** field, enter the Medicare claim number from the EOMB.
6. In the **Payer Responsibility field**, select the appropriate code from the drop-down list.
7. In the **COB Payer Paid Amount** field, enter the Medicare Part B paid amount.
8. Do not enter a value in the **Total Noncovered Amount** field. You should enter the total noncovered amount only for authorized TPL exception billing. Refer to supplemental instructions in your provider manual appendix for conditions for which this field may be used.
9. Do not enter a value in the **Remaining Patient Liability** field. This is not a required field and is not necessary for claims adjudication.
10. In the **Claims Filing Indicator** field, select **MB – MEDICARE PART B** from the drop-down list.
11. In the **Release of Information** field, select the appropriate code from the drop-down list.
12. In the **Assignment of Benefits** field, select the appropriate code from the drop-down list.
13. In the **Relationship to Subscriber** field, select the appropriate code from the drop-down list.
14. If you selected “**18 – SELF**” from the “**Relationship to Subscriber**” drop-down list, then click “**Populate Subscriber**.” The following data fields that have been entered on the “**Billing and Service**” tab will be populated.
 - Subscriber Last Name
 - Subscriber First Name
 - Subscriber Address
 - Subscriber City
 - Subscriber State
 - Subscriber Zip Code

If you select any other value from the “**Relationship to Subscriber**” drop-down list, you must enter the following required fields.

- Subscriber Last Name
 - Subscriber First Name
15. In the **Subscriber ID** field, enter the other insurance subscriber ID number.