Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter NF-54
April 2009

TO: Nursing Facilities Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: *Nursing Facility Manual* (New Appendix G)

This letter transmits Appendix G for the *Nursing Facility Manual*. Appendix G is a new set of instructions for submitting 837I transactions and paper claims (after the implementation of NewMMIS) for members who have Medicare or other insurance benefits where services were deemed to be noncovered because the patient does not have benefits available (benefits exhausted), or does not qualify for a new benefit period.

Appendix G contains specific MassHealth 837I instructions for billing claims for these situations, which are not described in the HIPAA implementation guide for the 837I transaction. It also provides instructions for using the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals to submit paper claims using the new instructions.

When the initial claim has been adjudicated by Medicare, the adjudication details provided by Medicare must be documented on the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals. This form must be attached to the claim to report HIPAA group and HIPAA adjustment reason codes (ARCs). This form is available on the MassHealth Web site at www.mass.gov/masshealth, and is fillable online. A copy of this form is attached to this transmittal letter. Requests for paper copies of this form must be submitted in writing and faxed to 617-988-8973 or mailed to the following address.

MassHealth
ATTN: Forms Distribution
P.O. Box 9118
Hingham, MA 02043

This transmittal letter supersedes the billing instructions in Nursing Facility Bulletin 124, dated November 2003, which is available on the MassHealth Web site at www.mass.gov/masshealth. Previously, providers were instructed to use condition codes to indicate the reason the insurer did not cover the service. After the implementation of NewMMIS, condition codes will no longer be used, but will be replaced by HIPAA adjustment reason codes (ARCs).

The instructions in Appendix G are effective upon implementation of NewMMIS on May 26, 2009.

If you have any questions 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.)

Nursing Facility Manual

Pages vi, vii, and G-1 through G-4

OBSOLETE MATERIAL

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

Nursing Facility Manual

Page vi – transmitted by Transmittal Letter NF-43

Page vii – transmitted by Transmittal Letter NF-34

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

TPL Exception Form for Nursing Facilities and All Inpatient Hospitals

Please Note: Submit this form only with UB-04 paper claim forms.

Instructions on how to use this form:

1. Use this form to report HIPAA group and adjustment reason codes.
2. Use the claim(s) adjudication details provided by the insurer to fill in the form.
3. Use only Other Adjustment (OA) as the HIPAA group adjustment reason code.
4. For more details on how to use this form, refer to the appropriate appendix of your MassHealth provider manual.
5. Complete all fields.

Submission Date: _____ Date of Service (range if applicable): _____ - _____

MassHealth Provider ID/Service Location: _____

NPI: _____

Member Name: _____ MassHealth Member ID: _____

Policyholder First Name: _____ Policyholder Last Name: _____

Policyholder ID: _____ Policyholder No.: _____ Policyholder Group No.: _____

Carrier ID: _____ Carrier Name: _____

HIPAA Group Adjustment Reason Code	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Amount (total charges)	HIPAA Remarks (applies only to nursing homes)
OA			

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. The regulations governing provider participation in MassHealth are assigned Chapters 400 through 499 within Title 130. 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 nursing facilities, those matters are covered in 130 CMR Chapter 456.000, reproduced as Subchapter 4 in the *Nursing Facility Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which furnish instructions for making changes by hand ("pen-and-ink" revisions), and by 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 Claims with Other Insurance

This appendix contains billing instructions for submitting 837I transactions and paper claims for members who have Medicare and/or commercial insurance, and whose services were deemed by the payer to be noncovered because the patient does not have benefits available (benefits exhausted), or does not qualify for a new benefit period.

This appendix contains specific MassHealth billing instructions that are not described in the HIPAA Implementation Guide for the 837I transaction, in the 837I Companion Guide, or in the billing guides for the UB-04.

Providers must continue to bill Medicare for all Part B ancillary services and physician services associated with the inpatient stay before billing MassHealth for the noncovered Part A services. MassHealth will continue to process Medicare Part B crossovers sent by Medicare.

Note: Providers must retain the original EOB (EOB, notice of the noncoverage, or the remittance advice) in their records for auditing purposes.

Billing Instructions for 837I Transactions

Providers must submit an initial claim to the other insurer (Medicare or commercial insurance) for claim determination. When the initial claim has been adjudicated by the insurer, enter the adjudication details provided by that insurer on the other payer loops (2320 and 2330) in the 837I transaction. The provider must fill in the other payer loops in the 837I transaction as described in the following table.

Loop	Segment	Value Description
2330B	NM109 (Other Payer Name)	MassHealth-assigned carrier code **Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Code) in your MassHealth provider manual, or at www.mass.gov/masshealth.
2320	SBR09 (Claim Filing Indicator)	"MA" when the other payer is Medicare "CI" when other payer is commercial insurer
2320	AMT (Amount)	Should not be populated with any insurance payment, coinsurance or deductible.
2320	CAS01 (Claim Adjustment Group Code)	OA (other adjustments)
2320	CAS02 (Claim Adjustment Reason Code)	See Claim Adjustment Reason Code Crosswalk Table on page D-3. The table cross walks the previously used condition codes to the current HIPAA adjustment reason codes. Providers must bill using the correct HIPAA ARC to ensure that claims process correctly.

Loop	Segment	Value Description
2320	CAS03 (Monetary Amount)	Billed amount
2330B	DTP03 (Date, Time, or Period)	Date of discharge or end date of service

If you are billing claims using the remittance advice code, please refer to the crosswalk table below. This is a crosswalk of the previously used remark codes to the current remittance remark code. Providers must bill using the correct code;.otherwise, claims may process incorrectly.

Enter the HIPAA remittance remark code in loop 2320 MIA05.

Remark Code	Replace with Remittance Remark Code
Z6 - Hospital admission; patient did not have a Medicare-qualifying hospital stay	N173 - Remark code - no qualifying hospital stay date where provided for this episode of care
Z7 - Noncertified Medicare bed	N173 - Remark code - no qualifying hospital stay date where provided for this episode of care

Enter the following information to report Medicare Part B prior payments.

Loop	Segment	Value Description
2320	SBR09 (Claim Filing Indicator)	MB
2320	AMT01 (Allowed Amount Qualifier)	B6
2320	AMT02 (Allowed Amt = 0)	0
2320	AMT01 (Paid Amount Qualifier)	C4
2320	AMT02 (Medicare Prior Payment Amount)	Medicare prior payment amount
2330B	NM109 (Medicare Part B)	0085000

Billing Instructions for Paper Claims

Providers must submit an initial claim to the other insurer (Medicare or commercial insurance) for claim determination. When the initial claim has been adjudicated by the insurer, document the adjudication details provided by that insurer on the TPL Exception Form for Inpatient Hospital and Nursing Home Providers to report HIPAA group and adjustment reason codes (ARCs). This form is available on the MassHealth Web site at www.mass.gov/masshealth.

The ARCs given in the following table may be used to indicate the reason that the insurer is not covering the service. MassHealth will allow providers to use ARCs to override Medicare and/or commercial insurance only in the circumstances described in the following table.

Claim Adjustment Reason Code Crosswalk Table				
Reason Code	**Replace with HIPAA Adjustment Reason Code**	**Replace with HIPAA Remittance Remark Code**	**Applies to Medicare**	**Applies to Commercial Insurers**
Hospital admission; patient did not have Medicare-qualifying hospital stay	N/A	N173 – Remark code - no qualifying hospital stay date where provided for this episode of care	Yes	No
Noncertified Medicare bed	N/A	N173 – Remark code - no qualifying hospital stay date where provided for this episode of care	Yes	No

Note: Providers submitting paper claims must refer to the Billing Guide for the UB-04. Otherwise, claims may be processed incorrectly.

Billing Instructions for Both Paper and 837I Transactions

The ARCs given in the following table may be used to indicate the reason that the insurer is not covering the service. MassHealth allows providers to use ARCs to report noncovered or benefits-exhausted services only in the circumstances described in the following table.

Claim Adjustment Reason Code Crosswalk Table				
Reason Code	**Replace with HIPAA Adjustment Reason Code**	**Replace with HIPAA Remittance Remark Code**	**Applies to Medicare**	**Applies to Commercial Insurers**
YO - Valid EOB/Denial on file-Benefits exhausted for the calendar year	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	N/A	Yes	Yes
Y1 - Valid EOB/Denial on file – Cap in service ; benefit maximum has been reached	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	N/A	Yes	Yes
Y8 - Valid EOB-Utilization review notice/services do not meet the skilled level of care	**150** - Payment adjusted because the payer deems the information submitted does not support this level of service.	N/A	Yes	Yes
Y9 - Valid EOB-utilization review notice/patient does not have benefits available or does not qualify for a new benefit period.	**119** - Benefit maximum for this time period or occurrence has been reached for the calendar year.	N/A	Yes	Yes

Note: Either ARC or remittance remark codes can be used; however, both cannot be used at the same time.

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.