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-56
March 2010

TO: Nursing Facilities Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director

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

This letter transmits a revised Appendix G for the *Nursing Facility Manual*. Appendix G contains revised billing instructions for submitting 837I transaction claims, for members who have Medicare or commercial insurance, or who were on medical leave of absence (MLOA), and whose services are determined not covered by the primary insurer. The revised Appendix G is effective April 1, 2010.

This appendix lists the exceptions that need to be considered when billing MassHealth for members who have Medicare, or commercial insurance. It also explains the need for providers to make diligent efforts to obtain payment from other resources and to bill MassHealth as the payer of last resort.

If you have any questions about the information 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-6

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(The pages listed here are no longer in effect.)

Nursing Facility Manual

Pages vi and vii – transmitted by Transmittal Letter NF-54

Pages G-1 through G-4 – transmitted by Transmittal Letter NF-55

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 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 TPL Exceptions
Submitting Claims for Members with Medicare or Commercial Insurance

This appendix contains supplemental billing instructions for submitting 837I transactions, paper claims, and direct data entry (DDE) claims for members who have Medicare or commercial insurance, and whose services are determined not covered by the primary insurer. Refer to MassHealth regulations at 130 CMR 450.309 through 450.321.

This appendix lists certain exceptions that need to be considered when billing MassHealth for members with Medicare or commercial insurance. These specific MassHealth billing instructions are not provided in the HIPAA Implementation Guide for the 837I transactions, in the 837I Companion Guide, or in the Billing Guide for the UB-04.

Note: To bill MassHealth for services provided to members with Medicare or commercial insurance, and whose services are determined not covered by the primary insurer, providers may no longer use the condition code field on the claim form. If submitting a claim electronically, an entry must be made in the adjustment reason code (ARC) segment. If submitting a claim on paper, the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals must be completed and submitted with the claim form. The form is located on the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Provider Forms on the lower-right panel of the home page.

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. Accordingly, 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. Providers must submit a claim to Medicare or the commercial insurer whenever a new benefit period becomes available.

Certain TPL Exceptions

If any of the following exceptions exist, follow the instructions outlined in this appendix for the claim submission medium – 837I transactions, paper claims, or DDE. Claim submissions must include codes found in the HIPAA Adjustment Reason Code Crosswalk Table on page G-5 of this appendix.

There are instances when insurance coverage is no longer available to the MassHealth member. Either the MassHealth member does not have benefits available (benefits exhausted), does not meet the insurer's coverage criteria, does not qualify for a new benefit period, or the member is on a medical leave of absence (MLOA). These exceptions are explained below.

Medicare Denials

When submitting a claim for a dually eligible (Medicare/MassHealth) member, providers must indicate to MassHealth the reason the service has been determined to be noncovered by Medicare. This requirement applies to dates of service within 100 days of the date of admission or readmission to the facility if the member has been admitted within 30 days following a hospital stay lasting three days or longer.

The nursing facility must keep a copy of the Medicare advance beneficiary notice (ABN) issued to the MassHealth member or the Medicare remittance advice on file at the nursing facility as required for auditing purposes.

Commercial Insurance and Medicare Advantage Plan

Nursing facility claims for members with commercial insurance or Medicare Advantage plan coverage (Medicare C) must be billed to the insurer for payment before billing MassHealth. If the insurer indicates that the member does not have benefits available due to benefits exhausted or services not covered, providers may submit the claim to MassHealth for payment. The nursing facility must keep a copy of the insurance denial (EOB), 835 transactions, or response from the insurer on file at the nursing facility as required for auditing purposes.

Medical Leave of Absence

Providers must follow the general billing instructions when billing for medical leave of absence. If the MassHealth member is on medical leave of absence and has Medicare or commercial insurance, use the appropriate HIPAA adjustment reason code listed in the HIPAA Adjustment Reason Code Crosswalk Table on page G-5.

Billing Instructions for 837I Transactions

Providers must complete the other payer loops in the 837I transactions as described in the following table when submitting claims to MassHealth that have been initially denied or determined noncovered by the other insurer, and meet the TPL exception criteria listed on the HIPAA Adjustment Reason Code Crosswalk Table on page G-5.

Loop	Segment	Value Description
2330B	NM109 (Other Payer Name)	Enter the MassHealth assigned carrier code for the other payer. **837I:** Medicare (institutional) carrier code = 0084000. **Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) in your MassHealth provider manual at www.mass.gov/masshealth.
2320	SBR09 (Claim Filing Indicator)	Medicare (Institutional) = MA Commercial insurer = CI
2320	AMT01 (Allowed Amount Qualifier)	B6
2320	AMT02 (Allowed Amt = 0)	0
2320	AMT01 (Paid Amount Qualifier)	C4

Loop	Segment	Value Description
2320	AMT02 (Medicare/Other Insurance Prior Payment Amount)	0
2320	CAS01 (Claim Adjustment Group Code)	OA (other adjustments)
2320	CAS02 (Claim Adjustment Reason Code)	Enter the appropriate HIPAA ARC. See the HIPAA Adjustment Reason Code Crosswalk Table on page G-5.
2320	CAS03 (Monetary Amount)	Total charges (amount billed to MassHealth)
2330B	DTP03 (Date, Time, or Period)	Date of discharge or end date of service for the claim billing period

If you are billing claims using the HIPAA remittance remark code, enter the following information.

Loop	Segment	Value Description
2320	MIA05	Enter the appropriate HIPAA ARC. See the HIPAA Adjustment Reason Code Crosswalk Table on page G-5.

Billing Instructions for Direct Data Entry (DDE)

Providers must complete the coordination of benefits fields as described in the following table when submitting claims to MassHealth that have been initially denied or determined noncovered by the other insurer and that meet the TPL exception criteria.

In the coordination of benefits tab, choose “New Item.”

Coordination of Benefits	
Field Name	**What to Enter**
Carrier Code	Enter the MassHealth-assigned carrier code for the other payer. Medicare (institutional) carrier code = 0084000. **Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual at www.mass.gov/masshealth.
Carrier Name	Enter the appropriate carrier name. Refer to Appendix C of your MassHealth provider manual.
EOB Date	Date of discharge or end date of service for the claim billing period **Note:** This is a required field.

Coordination of Benefits	
Field Name	**What to Enter**
Payer Claim Number	Enter the other insurer claim number on the EOB. If there is no EOB, enter "99" as the default payer claim number.
Payer Responsibility	Select the appropriate code.
Allowed Amount	Enter 0.
Payer Paid Amount	Enter 0.
Claim Filing Indicator	Medicare A (Institutional) = MA Commercial insurer = CI
Release of Information	Select the appropriate code.
Assignment Benefit	Select the appropriate code.
Subscriber Information Panel	Enter the appropriate subscriber information (subscriber last name, first name, subscriber ID, and relationship to subscriber code) **Note:** This is a required field.

Once the above data fields have been entered, scroll down to the bottom of the page to the List of COB Reasons subpanel and click "New Item." Enter the appropriate COB reasons detail information, according to the following table.

COB Reasons Detail	
Field Name	**What to Enter**
Group Code	Select OA (other adjustments).
Units of Service	Enter the appropriate quantity.
Amount	Total charges (amount billed to MassHealth)
Reason	Refer to the HIPAA Adjustment Reason Code Crosswalk Table on page G-5. The table crosswalks the previously used condition codes to the current HIPAA ARCs. Providers must bill using the correct HIPPA ARC codes to ensure that claims process correctly.

Please Note: Once the COB reason detail panel is completed, click "Add" to save the information. Then click "Add" to save the coordination of benefit (COB) detail information.

On the procedures tab, after entering the procedure service details, scroll down to the list of COB line items and click "New Item."

Billing Instructions for Paper Claims

Providers must submit the UB-04 claim form, along with the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals when billing MassHealth for claims that have been initially denied or determined noncovered by the other insurer and that meet the TPL exception criteria. This form is available on the MassHealth Web site at www.mass.gov/masshealth. Providers must enter the appropriate HIPAA ARC on this form from the HIPAA Adjustment Reason Code Crosswalk Table on page G-5.

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

Note: When submitting claims for medical leave of absence (MLOA) days, providers must enter the appropriate HIPAA adjustment reason code on the TPL Exception Form for Nursing Facilities and All Inpatient Hospitals. See the HIPAA Adjustment Reason Code Crosswalk Table on page G-5.

HIPAA Adjustment Reason Code Crosswalk Table

Use the HIPAA ARCs in the following table to indicate the reason that an insurer is not covering the service for all media types. The table crosswalks the previously used condition codes and previous billing instructions to the current HIPAA ARCs.

Providers must enter the correct HIPAA ARC to ensure that claims process correctly.

HIPAA Adjustment Reason Code Crosswalk Table			
Prior Condition Code	**Replace with HIPAA Adjustment Reason 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.	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.	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.	Yes	Yes

HIPAA Adjustment Reason Code Crosswalk Table (cont.)			
Prior Condition Code	**Prior Condition Code**	**Prior Condition Code**	**Prior Condition Code**
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.	Yes	Yes
Z6 - Hospital admission; patient did not have a Medicare-qualifying hospital stay	**A6** - Prior hospitalization or 30 day transfer requirement not met.	Yes	No
Z7 - Noncertified Medicare bed	**78** - Noncovered days/Room charge adjustment.	Yes	No
Medical Leave of Absence Days (MLOA)	**78** - Noncovered days/Room charge adjustment.	Yes	Yes

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 for MassHealth to exercise its right to appeal.

Questions

If you have any questions about the information in this appendix, refer to Appendix A of your MassHealth provider manual for the appropriate contact information.