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

MassHealth
Transmittal Letter NF-58
December 2011

TO: Nursing Facility Providers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: *Nursing Facility Manual* (Revisions to Appendices D and G)

The Centers for Medicare & Medicaid Services (CMS) requires all trading partners who submit electronic transactions, to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 Version 4010A1 to HIPAA ASC X12 Version 5010. All covered entities (health care providers, health plans, and health care clearinghouses) must be HIPAA 5010 compliant by January 1, 2012.

Revised Appendix G: Supplemental Instructions for TPL Exceptions

This letter transmits a revised Appendix G for the *Nursing Facility Manual*. Appendix G contains revised billing instructions required for HIPAA version 5010/5010A1 for submitting 837I transactions, Direct Data Entry (DDE), and paper claims for members who have Medicare or commercial insurance and whose services are determined to be not covered by the primary insurer.

Appendix G contains specific MassHealth billing instructions that supplement the instructions found in the HIPAA 837I Implementation Guide, in the MassHealth 837I Companion Guide, and in the MassHealth Billing Guide for the UB-04.

Please Note: Effective January 1, 2012, MassHealth is moving toward an all-electronic claims submission policy to achieve greater efficiency. All claims must be submitted electronically, unless the provider has received an approved electronic claim submission waiver. 90-day waiver requests and final deadline appeals may be submitted either electronically via the POSC or on paper. Please see All Provider Bulletin 217, dated September 2011, for more information about MassHealth's paper claims waiver policy. Please also refer to All Provider Bulletin 220 and All Provider Bulletin 221, dated December 2011, for information on how to submit 90-day waiver requests and final deadline appeals electronically.

The TPL Exception Form for Nursing Facilities and All Inpatient Hospitals has been obsoleted. Effective January 1, 2012, providers who have received an approved electronic claim submission waiver must use the TPL Exception Form that has been revised to reflect the 5010 mandate. To download the new form, go to www.mass.gov/masshealth. Click on MassHealth Provider Forms in the lower right panel of the home page, then scroll down the list to the TPL Exception Form.

Providers must submit the UB-04 claim form with the revised TPL Exception Form to report total noncovered charges when billing MassHealth for claims that have been determined to be noncovered by Medicare or the commercial insurer, and that meet the TPL exception criteria described in Appendix G.

The revised Appendix G is effective January 1, 2012.

Revised Appendix D: Specifications for Electronic Submission of MMQs

This letter also transmits a revised Appendix D. The only change in this revised appendix is an update to the address for the MassHealth Casemix Unit. The correct address, which is shown below, has been updated on page D-1 of this appendix. The change in this address is effective immediately. Correspondence to the Casemix Unit at the old address is being forwarded to the new address.

MassHealth
Casemix Unit
100 Hancock Street, 6th Floor
Quincy, MA 02171

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Questions

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 vii, D-1 through D-28, and G-1 through G-4

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

Nursing Facility Manual

Pages vii and G-1 through G-6 — transmitted by Transmittal Letter NF-56

Pages D-1 through D-28 – transmitted by Transmittal Letter NF-53

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. 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.

Specifications for Electronic Submittal of the Management Minutes Questionnaires (MMQs) by Nursing Facilities

MassHealth has developed new specifications for the electronic submission of initial and semiannual MMQs.

General Instructions

- All MMQ data submitted electronically must conform, in all aspects, to the requirements in Appendix E of the *Nursing Facility Manual*.
- All MMQ data and documentation must be available on paper as requested by MassHealth for audits.
- The nursing facility is responsible for ensuring that the MMQ data is accurate, complete, and in compliance with all pertinent regulations and requirements.
- Providers are required to submit a signed certification form with their first electronic submission. The certification forms are not required for subsequent submissions. See form MMQ Cert-1, Electronic MMQ Submission Agreement and Certification Statement, attached to Nursing Facility Bulletin 119.

  To access bulletins, go to www.mass.gov/masshealth and click on MassHealth Regulations and Other Publications. Click on Provider Library and then on Provider Bulletins.
- MMQ information, except for submission purposes, must be sent to the following address.
  MassHealth
  Casemix Unit
  100 Hancock Street, 6th Floor
  Quincy, MA 02171
- MMQ information may be created using software provided by MassHealth. Providers can obtain the software by downloading it from MassHealth's Web site at www.mass.gov/mmq or by contacting MassHealth at the address given above.
- Providers or other entities authorized to use the MMQ batch submission function must log on to the NewMMIS Provider Online Service Center (POSC) using a valid user ID and password.
- On the left side of the page under Provider Services, select the "Manage Members" hyperlink, select the "Long Term Care" link, and then select "Upload Batch MMQ Files," and follow the instructions on the Web page.
- Submitters will receive an acknowledgement from the Provider Online Service Center that their batch has been submitted successfully.
- Submitters must log on to the POSC on the following business day to receive responses to their MMQ submission. The response will include the total number of MMQ records that were processed by NewMMIS and the number of MMQ records that were accepted, rejected, or pended. If a record is rejected or pended, detailed information will be provided in the response to identify the MMQ records and the reasons why the records were rejected or pended.

Time Frames

- Initial MMQs must be submitted for each new MassHealth member within 30 days from the date of admission or conversion from private or Medicare coverage to MassHealth coverage.
- Semiannual MMQs must be submitted no later than the fifteenth of the month. For example: A nursing facility's semiannual submission date is January 1, 2009. The nursing facility must transmit the MMQTD submission no later than January 15, 2009.

Identifying Information for Patient

- Reason for Submission: Acceptable reason codes are 1, 2, 3, 4, 5, or D.
- Member ID must be 12 digits.

Service Information

The table below describes the fields on the questionnaire, and what each code and score mean.

Item	Code	Score	Description/Comments
1. Dispense Medications and Chart	Always 1	Always 30	-
2. Skilled Observations	1 2	0 15	-
3. Personal Hygiene	1 2 3	0 18 20	Score equals higher of bathing or grooming
4. Dressing	1 2 3 4 5	0 30 30 0 0	-
5. Mobility	1 2 3 4 5	0 0 32 32 0	-
6. Eating	1 2 3 4 5 6 7 8	0 20 45 90 90 110 135 135	-
7. Continence/Catheter	1 2 3 4 5 6	0 0 48 48 20 (Bladder only) 18	Score equals higher of bladder or bowel code, unless bladder is code 5 and bowel is code 3 or 4, in which case the score = 38

Service Information (cont.)

8. Bladder/Bowel Retraining	1 2 3 4	0 50 18 68	If bladder code in 7 equals 3, 4, or 5, and the code in 8 equals 2 or 4, the default in 8 is: code = 1, score = 0. If bowel code in 7 equals 3, 4, or 6, and the code in 8 equals 3 or 4, the default in 8 is: code = 1, score = 0.
9. Positioning	1 2	0 36	-
10. Pressure Ulcer Prevention	1 2	0 10	-
11. Skilled Procedure Daily/Pressure Ulcer	0 1-9	0 10 times the frequency; maximum of 90	-
12. Skilled Procedure Daily/Other	0 01-14	0 10 times the frequency; maximum of 90	If the frequency code is 1-9, there must be an entry in the procedure type. If only one procedure type is listed, and it is 02, 07, 10, or 12, the frequency code cannot exceed 3.
13. Special Attention	A = 0, 1 B = 0, 1 C = 0-3 D = 0, 1		If A-D contains all zeros, score = 0. If A-D contains at least one 1, score = 10% (x) subtotal.
14. Restorative Nursing	0 1-7	0 30 (See comment in next column)	Code 1-7: Score = 30 except as follows. If 3 (personal hygiene) is coded 2 or 3, code 2 for this service must default to 0. If 4 (dressing) is coded 2 or 3, code 1 for this service must default to 0. If 5 (mobility) is coded 3 or 4, code 6 for this service must default to 0. If 6 (eating) is coded 2-8, code 3 for this service must default to 0. A maximum of 30 can be coded.
Grand Total - Total of scores for services 1-14. This number should be left justified.			

Service Information (cont.)

Item	Code	Score	Description/Comments
Range of minutes for MMQ categories (Effective January 1, 2000)			
H	30		
J	30.1 – 85.0		
K	85.1 – 110.0		
L	110.1 – 140.0		
M	140.1 – 170.0		
N	170.1 – 200.0		
P	200.1 – 225.0		
R	225.1 – 245.0		
S	245.1 – 270.0		
T	270.1 +		
15. Toilet Use	Must be 1, 2, 3, or 4	N/A	-
16. Transfer	Must be 1, 2, 3, or 4	N/A	-
17. Mental Status	Must be 1, 2, or 3	N/A	-
18. Restraint	Must be 1, 2, or 3	N/A	-
19. Activities Participation	Must be 1, 2, 3, or 8	N/A	-
20. Consultations	00-12 88	N/A	Code 00 enter: Type = 00, Freq = 0 Code 88 enter: Type = 88, Freq = 0 Otherwise: Type = 01-12, Freq = 1-6
21. Medications	Codes 0-8; Frequency: 0-3	N/A	-
22. Accidents/Contracture/Weight Change	1 or 2	N/A	Make entries for all three fields A, C, and WC
23. Primary Diagnosis	Use ICD-9 codes	N/A	Must be left justified; Length may be 3-5 bytes
24. Secondary Diagnosis(es)	Use ICD-9 codes	N/A	Must be left justified
25. RN Evaluator	N/A	N/A	Name of the evaluator

Service Information (cont.)

Item	Code	Score	Description/Comments
26. Eval Date	N/A	N/A	Date the MMQ is completed
27. Name of Administrator	N/A	N/A	Name of the administrator
28. Affiliation	1 2 3	N/A	Code 1 = Nursing facility staff Code 2 = MassHealth staff Code 3 = RN contractor
29. Discharge Code – if applicable	01 to 14	N/A	-
30. Discharge Date – if applicable	N/A	N/A	Date the resident is discharged

MMQ Batch Submission Requirements

The schema developed to process MMQ data is used by both the Direct Data Entry (DDE) function and the MMQ batch function on the Provider Online Service Center (POSC). Batch submitters should be aware that some attributes in the schema that are populated by the DDE function are not required to be submitted in an MMQ batch.

Please note the following.

- The submission data must be encoded in Extensible Markup Language (XML) and conform to the detailed specifications that appear on the following pages.
- Attributes used by the DDE function that are not required for batch submissions are identified in the detailed specifications below.
- An XML Schema Definition (XSD) document for batch MMQ submissions will be made available upon request.
- A sample of an MMQ XML batch submission is provided at the end of this section.
- All MMQ batch submissions must include the following wrapper node: submitMemberMMQRequests.
- The MMQ_ACTION_IND for all MMQ submissions must be "PROC_MMQ."
- All dates must be in YYYYMMDD format.
- If there is no data in the Secondary Diagnosis field, do not send the node for that field.

Note: If you have any questions about the information in this appendix, please contact MassHealth Customer Service at 1-800-841-2900 or by e-mail at providersupport@mahealth.net.

MMQ Batch Input File Specifications

When the vendor submits MMQ data to MassHealth, it must be submitted in the following format.

MMQ Action Indicator – Required Segment

Detail Field	Required?	Description
MMQ_ACTION_IND	Y	Must equal "PROC_MMQ" for batch submission

Personal Information – Required Segment

This segment will contain all the personal information for the MMQ submitted by the provider for the member. The key elements are provider ID/service location and member ID.

Only one personal information segment can be sent per member.

Detail Field	Data Type	Length	Required?	Description
PROVIDER ID	String	9	Y	The provider ID submitting the MMQ
SERVICE_LOCATION	String	1	Y	The service location for the provider ID submitting the MMQ
MEMBER ID	String	12	Y	This is the member ID for the MMQ being submitted by the provider.
FACILITY NAME	-	-	-	***Field should be empty for batch submission.***
DTE_ADMIT	Date	8	Y	This is the date the member was admitted. Date format is YYYYMMDD.
LAST_NAME	String	20	Y	This is the member's last name on the MMQ submitted by the provider.
FIRST_NAME	String	15	Y	This is the member's first name on the MMQ submitted by the provider. At least the first initial of the first name must be populated.
BIRTH_DTE	Date	8	Y	This is the member's date of birth on the MMQ. Date format is YYYYMMDD.
GENDER	-	-	-	***Field should be empty for batch submission.***
RACE	-	-	-	***Field should be empty for batch submission.***
DTE_EFF	Date	8	Y	This is the effective date of the MMQ. Date format is YYYYMMDD.
SUBMIT_REASON	String	1	Y	The reason for submitting the MMQ Valid values are: 1 = Admission 2 = Conversion 3 = Semiannual or significant change 4 = Semiannual category and score change 5 = Semiannual no change D = Discharge

Service Section 1 – Required Segment

This segment contains all of Service Section 1 information (Questions 1-12) for the MMQ submitted by the provider for the member. Only one Service Section 1 segment can be sent per member.

Detail Field	Data Type	Length	Required?	Description
DISP_MED_SCORE	-	-	-	***Field should be empty for batch submission.***
SKILLED_OBSERV_DAILIY_CODE	String	1	Y	Service code for the skilled observation daily service Valid values are: 1 = No observation 2 = Daily observation
SKILLED_OBSERV_DAILIY_SCORE	-	-	-	***Field should be empty for batch submission.***
PERS_HYG_BATH_CODE	String	1	Y	Service code for bathing service Valid values are: 1 = Independent/restorative program 2 = Assist 3 = Totally dependent
PERS_HYG_BATH_SCORE	-	-	-	***Field should be empty for batch submission.***
PERS_HYG_GROOM_CODE	String	1	Y	Service code for grooming service Valid values are: 1 = Independent/restorative program 2 = Assist 3 = Totally dependent
PERS_HYG_GROOM_SCORE	-	-	-	***Field should be empty for batch submission.***
DRESSING_CODE	String	1	Y	Service code for the dressing service Valid values are: 1 = Independent/restorative program 2 = Assist 3 = Totally dependent 4 = Socks and shoes only 5 = Not Dressed
DRESSING_SCORE	-	-	-	***Field should be empty for batch submission.***

Service Section 1 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
MOBILITY_CODE	String	1	Y	Service code for the mobility service Valid values are: 1 = Independent/restorative program 2 = Independent w/wheelchair 3 = Walks with assist 4 = Wheelchair with assist 5 = Nonambulatory
MOBILITY_SCORE	-	-	-	***Field should be empty for batch submission.***
EATING_CODE	String	1	Y	Service code for the eating service Valid values are: 1 = Independent/restorative program 2 = Assist 3 = Totally dependent 4 = Tube fed 5 = I.V. 6 = Tube fed and assist 7 = Tube fed and totally dependent 8 = Tube fed and I.V.
EATING_SCORE	-	-	-	***Field should be empty for batch submission.***
CONT_CATH_BLAD_CODE	String	1	Y	Service code for the continence/catheter - bladder service Valid values are: 1 = Continent 2 = Incontinent occasionally 3 = Incontinent and toileted 4 = Incontinent 5 = Indwelling catheter 6 = Bowel incontinent and bladder training
CONT_CATH_BLAD_SCORE	-	-	-	***Field should be empty for batch submission.***

Service Section 1 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
CONT_CATH_BOWEL_CODE	String	1	Y	Service code for the continence/catheter – bowel service Valid values are: 1 = Continent 2 = Incontinent occasionally 3 = Incontinent and toileted 4 = Incontinent 6 = Bowel incontinent and bladder training
CONT_CATH_BOWEL_SCORE	-	-	-	***Field should be empty for batch submission***
BLAD_BOWEL_RETRAIN_CODE	String	1	Y	Service code for the bladder / bowel retraining service Valid values are: 1 = No retraining received 2 = Bladder retraining 3 = Bowel retraining 4 = Bladder and bowel retraining
BLAD_BOWEL_RETRAIN_SCORE	-	-	-	***Field should be empty for batch submission.***
POSITIONING_CODE	String	1	Y	Service code for the positioning service Valid values are: 1 = Independent 2 = Assist
POSITIONING_SCORE	-	-	-	***Field should be empty for batch submission.***
PRES_ULCER_PREV_CODE	String	1	Y	Service code for the pressure ulcer prevention service Valid values are: 1 = No preventive measures 2 = Preventive measures
PRES_ULCER_PREV_SCORE	-	-	-	***Field should be empty for batch submission.***
SPROC_DAILY_PRES_ULCER_FREQ	String	1	Y	Frequency for the skilled procedure daily/pressure ulcer services Valid values are “0” through “9.”
SPROC_DAILY_PRES_ULCER_SCORE	-	-	-	***Field should be empty for batch submission.***

Service Section 1 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
SPD_PU_STG1_CODE	String	1	Y	Service code for the skilled procedure daily/pressure ulcer, stage 1 service Valid values are "0" through "9."
SPD_PU_STG2_CODE	String	1	Y	Service code for the skilled procedure daily/pressure ulcer, stage 2 service Valid values are "0" through "9."
SPD_PU_STG3_CODE	String	1	Y	Service code for the skilled procedure daily/pressure ulcer, stage 3 service Valid values are "0" through "9."
SPD_PU_STG4_CODE	String	1	Y	Service code for the skilled procedure daily/pressure ulcer, stage 4 service Valid values are "0" through "9."
SPTD_OTHER_FREQ	String	1	Y	Frequency for the skilled procedure type daily/other services Valid values are "0" through "9."
SPTD_OTHER_SCORE	-	-	-	***Field should be empty for batch submission.***
SPTD_OTHER_PROC1_CODE	String	2	Y	Service code for the skilled procedure type daily/other, procedure 1 service. Valid values are: 00 = None 01 = Dressing change 02 = Catheter irrigation 03 = Intermittent catheterization 04 = Eye irrigation 05 = Ear irrigation 06 = Care of heparin locks 07 = Oxygen therapy 08 = Tracheotomy care 09 = Sterile dressing 10 = Suctioning 11 = Not in use at this time 12 = Respiratory therapy 13 = New colostomy care 14 = Other

Service Section 1 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
SPTD_OTHER_PROC1_SCORE	-	-	-	***Field should be empty for batch submission.***
SPTD_OTHER_PROC2_CODE	String	2	Y	Service code for the skilled procedure type daily/other - procedure 2 service Valid values are: 00 = None 01 = Dressing change 02 = Catheter irrigation 03 = Intermittent catheterization 04 = Eye irrigation 05 = Ear irrigation 06 = Care of heparin locks 07 = Oxygen therapy 08 = Tracheotomy care 09 = Sterile dressing 10 = Suctioning 11 = Not in use at this time 12 = Respiratory therapy 13 = New colostomy care 14 =Other
SPTD_OTHER_PROC2_SCORE	-	-	-	***Field should be empty for batch submission.***
SPTD_OTHER_PROC3_CODE	String	1	Y	Service code for the skilled procedure type daily/other, procedure 3 service Valid values are: 00 = None 01 = Dressing change 02 = Catheter irrigation 03 = Intermittent catheterization 04 = Eye irrigation 05 = Ear irrigation 06 = Care of heparin locks 07 = Oxygen therapy 08 = Tracheotomy care 09 = Sterile dressing 10 = Suctioning 11 = Not in use at this time 12 = Respiratory therapy 13 = New colostomy care 14 = Other
SPTD_OTHER_PROC3_SCORE	-	-	-	***Field should be empty for batch submission.***
SUBTOTAL	-	-	-	***Field should be empty for batch submission.***

Service Section 2 – Required Segment

This segment will contain all the Service Section 2 information (Questions 13 and 14) for the MMQ submitted by the provider for the member. Only one Service Section 2 segment can be sent per member.

Detail Field	Data Type	Length	Required?	Description
SPEC_ATT_IMMOBIL_CODE	String	1	Y	Service code for the special attention (code A) immobility service Valid values are "0" and "1."
SPEC_ATT_SEV_SPASTIC_CODE	String	1	Y	Service code for the special attention (code B) severe spasticity/rigidity service Valid values are "0" and "1."
SPEC_ATT_BEH_PROB_CODE	String	1	Y	Service code for the special attention (code C) behavioral problems service Valid values are 0, 1, 2, and 3.
SPEC_ATT_ISOLATION_CODE	String	1	Y	Service code for the special attention (code D) isolation service Valid values are "0" and "1."
SPEC_ATT_SCORE	-	-	-	***Field should be empty for batch submission.***
REST_NRSNG_TYPE1_CODE	String	1	Y	Service code for the restorative nursing/type 2 service Valid values are: 0 = None 1 = Dressing 2 = Personal hygiene 3 = Eating 4 = Ostomy teaching 5 = Diabetic teaching 6 = Ambulation 7 = Range of motion

Service Section 2 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
REST_NRSNG_TYPE2_CODE	String	1	Y	Service code for the restorative nursing/type 2 service Valid values are: 0 = None 1 = Dressing 2 = Personal hygiene 3 = Eating 4 = Ostomy teaching 5 = Diabetic teaching 6 = Ambulation 7 = Range of motion
REST_NRSNG_TYPE3_CODE	String	1	Y	Service code for the restorative nursing/type 3 service Valid values are: 0 = None 1 = Dressing 2 = Personal hygiene 3 = Eating 4 = Ostomy teaching 5 = Diabetic teaching 6 = Ambulation 7 = Range of motion
REST_NRSNG_TYPE3_CODE	-	-	-	***Field should be empty for batch submission.***
GRAND_TOTAL	-	-	-	***Field should be empty for batch submission.***
CATEGORY	-	-	-	***Field should be empty for batch submission.***

Extra Questions – Required Segment

This segment will contain all the additional information (Questions 15-30) for the MMQ submitted by the provider for the member. Only one additional questions segment can be sent per member.

Detail Field	Data Type	Length	Required?	Description
TOILET_USE	String	1	Y	Code classification for toilet use Valid values are: 1 = Independent 2 = Assist 3 = Totally dependent 4 = Not toileted
TRANSFER	String	1	Y	Code classification for transfer Valid values are: 1 = Independent 2 = Assist 3 = Totally dependent 4 = Bedbound
MENTAL_STAT	String	1	Y	Code classification for mental status Valid values are: 1 = Oriented 2 = Disoriented 3 = Not yet determined
RESTRAINT	String	1	Y	Code classification for restraint Valid values are: 1 = Not ordered 2 = Ordered not used 3 = Ordered and used daily
ACTIVITY_PART	String	1	Y	Code classification for activities participation Valid values are: 1 = Always active 2 = Occasionally active 3 = Rarely active or not active 8 = Not yet determined

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
CONSULTATION1_FREQ	String	1	Y	Frequency of consultation Valid values are: 0 = None 1 = Daily 2 = 2 – 3 times per week 3 = Weekly 4 = 2 – 3 times monthly 5 = Monthly 6 = One time only (PRN)
CONSULTATION1_TYPE	String	2	Y	Type of consultation Valid values are: 00 = None 01 = Physician 02 = Psychiatrist 03 = Dentist 04 = Podiatrist 05 = Physical therapist 06 = Psychologist 07 = Dietician 08 = Social services 09 = Occupational therapist 10 = Audiologist 11 = Speech therapist 12 = Other 88 = Not determined
CONSULTATION2_FREQ	String	1	Y	Frequency of consultation Valid values are: 0= None 1 = Daily 2 =2–3 times per week 3 = Weekly 4 =2–3 times monthly 5 = Monthly 6 = One time only (PRN)

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
CONSULTATION2_TYPE	String	2	Y	Type of consultation Valid values are: 00 = None 01 = Physician 02 = Psychiatrist 03 = Dentist 04 = Podiatrist 05 = Physical therapist 06 = Psychologist 07 = Dietician 08 = Social services 09 = Occupational therapist 10 = Audiologist 11 = Speech therapist 12 = Other 88 = Not determined
CONSULTATION3_FREQ	String	1	Y	Frequency of consultation Valid values are: 0 = None 1 = Daily 2 =2–3 times per week 3 = Weekly 4 =2–3 times monthly 5 = Monthly 6 = One time only (PRN)
CONSULTATION3_TYPE	String	2	Y	Type of consultation Valid values are: 00 = None 01 = Physician 02 = Psychiatrist 03 = Dentist 04 = Podiatrist 05 = Physical therapist 06 = Psychologist 07 = Dietician 08 = Social services 09 = Occupational therapist 10 = Audiologist 11 = Speech therapist 12 = Other 88 = Not determined

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
MED1_MED	String	1	Y	Type of medication Valid values are: 0 = None 1 = Tranquilizers 2 = Sedatives/hypnotics 3 = Anti-hypertensive 4 = Narcotics 5 = Pain relievers (non-narcotic) 6 = Anti-psychotics 7 = Antibiotics 8 = Antidepressants
MED1_FREQ	String	1	Y	Frequency of medication Valid values are: 0 = None 1 = Regularly 2 = PRN 3 = One time only
MED2_MED	String	1	Y	Type of medication Valid values are: 0 = None 1 = Tranquilizers 2 = Sedatives/hypnotics 3 = Anti-hypertensive 4 = Narcotics 5 = Pain relievers (non-narcotic) 6 = Anti-psychotics 7 = Antibiotics 8 = Antidepressants
MED2_FREQ	String	1	Y	Frequency of medication Valid values are: 0 = None 1 = Regularly 2 = PRN 3 = One time only

Detail Field	Data Type	Length	Required?	Description
MED3_MED	String	1	Y	Type of medication Valid values are: 0 = None 1 = Tranquilizers 2 = Sedatives/hypnotics 3 = Anti-hypertensive 4 = Narcotics 5 = Pain relievers (non-narcotic) 6 = Anti-psychotics 7 = Antibiotics 8 = Antidepressants
MED3_FREQ	String	1	Y	Frequency of medication Valid values are: 0 = None 1 = Regularly 2 = PRN 3 = One time only

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
MED4_MED	String	1	Y	Type of medication Valid values are: 0 = None 1 = Tranquilizers 2 = Sedatives/hypnotics 3 = Anti-hypertensive 4 = Narcotics 5 = Pain relievers (non-narcotic) 6 = Anti-psychotics 7 = Antibiotics 8 = Antidepressants
MED4_FREQ	String	1	Y	Frequency that medication is taken Valid values are: 0 = None 1 = Regularly 2 = PRN 3 = One time only
ACW_ACCIDENT	String	1	Y	Service code for accidents Valid values are: 1 = Yes 2 = No
ACW_CONTRACTURE	String	1	Y	Service code for contracture Valid values are: 1 = Yes 2 = No
ACW_WEIGHT_CHG	String	1	Y	Service code for weight change Valid values are: 1 = Yes 2 = No
PRIM_DIAGNOSIS	Numeric	5	Y	The primary diagnosis coded on the MMQ
SEC_DIAGNOSIS1	Numeric	5	N	The first secondary diagnosis coded on the MMQ **For batch submission** If there is no data in this field, do not send this node.

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
SEC_DIAGNOSIS2	Numeric	5	N	The second secondary diagnosis coded on the MMQ **For batch submission** If there is no data in this field, do not send this node.
SEC_DIAGNOSIS3	Numeric	5	N	The third secondary diagnosis coded on the MMQ **For batch submission** If there is no data in this field, do not send this node.

Certification Statement – Required Segment

Detail Field	Data Type	Length	Required?	Description
RN_EVAL	String	35	Y	The name of the registered nurse that conducted the evaluation
EVAL_DTE	Date	8	Y	The date the MMQ is completed Date format is YYYYMMDD.
ADMINISTRATOR	String	35	Y	The name of the administrator of the facility.
AFFILIATION	String	1	Y	Enter the appropriate code for the person completing the MMQ. 1 = Nursing facility staff 2 = MassHealth 3 = RN Contractor

Certification Statement – Required Segment (cont.)

DISCHARGE_REASON	String	50	N	The reason for the member's discharge Discharge reason codes are: 01 = Acute hospital 02 = Chronic hospital 03 = Mental hospital 04 = Another nursing home 05 = Rest home 06 = Private residence w/HM-HHA 07 = Private residence w/o HM-HHA 08 = Private residence w/HHA 09 = Private residence w/o HHA 10 = Other 11 = Deceased 12 = Discharged to unknown sight 13 = Private patient 14 = Medicare patient.
DISCHARGE_DATE	Date	8	N	The date the member was discharged Date format is YYYYMMDD.

Sample MMQ Batch Submission

The following is a sample of an MMQ batch submission with two MMQ records.

Sample of MMQ Batch Submission (with two MMQ Records)

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<ADMINISTRATOR>John Jones</ADMINISTRATOR>
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<DISCHARGE_REASON/>
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</MEMBER_SUBMIT>
</submitMemberMMQRequest>
</submitMemberMMQRequests> **< ---- This is the wrapper node that indicates the end.**

Supplemental Instructions for Submitting Claims with Other Insurance

This appendix contains specific MassHealth billing instructions for members who have Medicare, a Medicare Advantage plan, or other insurance and supplements the instructions found in the 837I HIPAA Implementation Guide, the MassHealth 837I Companion Guide, and MassHealth Billing Guide for the UB-04.

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.

Nursing facility services for MassHealth members who have Medicare, a Medicare Advantage plan, or other insurance coverage must initially be billed to the insurance for payment before billing MassHealth, unless a Medicare skilled nursing facility advance beneficiary notice (SNFABN) or a notice of noncoverage has been issued. This requirement applies to dates of service within 100 days of the date of admission or readmission to the facility. Please refer to the date of admission requirements in this appendix.

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, and the member is determined to be at a hospital level of care, or if a member's health insurance coverage status changes, even if Medicare or the other insurer previously denied coverage for the same service.

Date of Admission Requirements

MassHealth Members with Medicare Coverage

MassHealth requires providers to change the admit date on the claim from the original date the member was admitted to the nursing facility if the member has returned to the facility following a qualifying hospital stay. The new admit date must be the day the member returns to the nursing facility following a qualifying hospital stay.

MassHealth Members with a Medicare Advantage Plan and Other Insurance Coverage

MassHealth requires providers to change the admit date on the claim from the original date the member was admitted to the nursing facility if the member's condition changes and requires skilled care, or if the member has returned from a hospital stay. The new admit date must be the day the member requires skilled care or returns from a hospital stay.

TPL Exceptions

This appendix contains supplemental billing instructions for submitting 837I transactions, direct data entry claims (DDE), and paper claims for MassHealth members who have Medicare, a Medicare Advantage plan, or other insurance when services are determined to be not covered. Nursing facility services for MassHealth members who have Medicare, a Medicare Advantage plan, or other insurance coverage must initially be billed to the insurance for payment prior to billing MassHealth, unless a Medicare SNFABN or a notice of noncoverage has been issued for services determined to be not covered.

There may be instances when the services provided are not covered by Medicare, the Medicare Advantage plan, or the other insurer, including if the MassHealth member

- does not have benefits available (benefits exhausted);
- does not meet the insurer's coverage criteria; or
- does not qualify for a new benefit period.

Follow the instructions outlined in this appendix for claim submissions when one of the above TPL exceptions exists.

Providers are required to retain on file for auditing purposes:

- the Medicare SNFABN;
- the remittance advice;
- the insurer's notice of noncoverage;
- the insurer's original explanation of benefits (EOB), the 835 transaction, or the response from the insurer.

Billing Instructions for 837I Transactions

The table below contains the critical loops and segments required for submitting claims to MassHealth that have been determined to be not covered by Medicare, a Medicare Advantage plan, or the other insurer, and that meet the TPL exception criteria described in this appendix. Providers must complete the loops and segments described in the table below and follow the 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.

The "Total Noncovered Amount" segment is used to indicate that the insurer has determined the service to be not covered. Do not report the HIPAA adjustment reason codes and amounts in the 2320 loop containing the total noncovered amount.

Loop	Segment	Value
2320	SBR09 (Claim Filing Indicator)	Medicare = MA Medicare Advantage plan or other insurer = CI
2320	AMT01 (Total Noncovered Amount Qualifier)	A8
2320	AMT02 (Total Noncovered Amount)	The total noncovered amount must = the total billed amount.
2330B	NM109 (Other Payer Name)	Enter the MassHealth-assigned carrier code for the other payer. **Please Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual.

Billing Instructions for Direct Data Entry

Providers must complete the coordination of benefits fields as described in the following table when submitting claims to MassHealth that have been determined to be not covered by Medicare, the Medicare Advantage plan, or the other insurer, and that meet the TPL exception criteria described in this appendix.

Providers must follow the instructions described in the HIPAA 837I Implementation Guide and MassHealth 837I Companion Guide to complete other required COB and non COB data fields of the DDE claim submission that are not specified in the table below.

The "Total Noncovered Amount" field is used to indicate that the insurer has determined the service to be not covered. Do not report the HIPAA adjustment reason codes and amounts on the List of COB Reasons panel when reporting a total noncovered amount.

In the "Coordination of Benefits" tab, click "New Item" and complete the fields as described below.

COB Detail Panel	
Field Name	**Instructions**
Carrier Code	Enter the MassHealth-assigned carrier code for the other payer. **Please Note:** MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Codes) of your MassHealth provider manual.
Carrier Name	Enter the appropriate carrier name. Refer to Appendix C of your MassHealth provider manual.
Payer Claim Number	Enter 99.
Payer Responsibility	Select the appropriate code from the drop-down list.
Total Noncovered Amount	Enter the total billed amount. The total noncovered amount must = total billed amount.
Claim Filing Indicator	Medicare = MA Medicare Advantage plan or other insurer = CI
Release of Information	Select the appropriate code from the drop-down list.
Assignment Benefit	Select the appropriate code from the drop-down list.
Subscriber Information Panel	Enter the appropriate required subscriber information: Subscriber Last Name First Name Subscriber ID The relationship to subscriber code (Select the appropriate code from the drop-down list.)

Please Note: Click "Add" to save the COB panel.

Billing Instructions for Paper Claims

MassHealth requires all claims to be submitted in an electronic format unless the provider has received an approved electronic claim submission waiver. Please refer to All Provider Bulletin 217.

Providers must follow the instructions in the MassHealth Billing Guide for the UB-04. Providers must submit the UB-04 claim form with the TPL Exception Form to report total noncovered charges when billing MassHealth for claims that have been determined to be not covered by Medicare, the Medicare Advantage plan, or the other insurer, and that meet the TPL exception criteria described in this appendix.

To download the new form, go to www.mass.gov/masshealth. Click on MassHealth Provider Forms in the lower right panel of the home page, then scroll down the list to the TPL Exception Form.

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, please refer to Appendix A of your MassHealth provider manual for the appropriate contact information.