Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MassHealth
Nursing Facility Bulletin 124
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TO: Nursing Facilities Participating in MassHealth

FROM: Beth Waldman, Acting Commissioner Beth Waldman

RE: **Electronic Claim Submissions for Members with Medicare and Commercial Insurance**

Background

This bulletin transmits billing instructions for submitting 837I transactions for members who have Medicare and/or commercial insurance but whose services were deemed by the provider to be noncovered. The implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows all coordination-of-benefits claims to be submitted electronically on the 837 transaction. The information in this bulletin contains specific MassHealth billing guidelines, which are not described in the HIPAA Implementation Guide for the 837I transaction.

Providers should continue to follow the billing instructions in Nursing Facility Bulletin 94, dated April 1992, for paper-claim submissions.

Medicare Claims

For Medicare noncovered services:

When billing a claim for a dually eligible (Medicare/MassHealth) member, providers must continue to provide MassHealth with an explanation as to why they determined the services to be noncovered by Medicare. This requirement applies to dates of service within 100 days of the date of admission where the member has been admitted to the facility within 30 days of a hospital stay lasting three days or longer. In lieu of submitting the notice of Medicare noncoverage to MassHealth for an 837I transaction, providers should use the appropriate condition codes listed in this bulletin to describe the reason for noncoverage.

Medicare Claims (cont.)

In these circumstances, the **provider must also populate the other payer loops** (2320 and 2330) in the transaction with Medicare's information and a value of 084 as the MassHealth-assigned carrier code for Medicare in 2330B-NM109 (Other Payer Name – Other Payer Primary identifier). Do not populate any Medicare payments, coinsurance, or deductible in the other payer loops (2320 and 2330) in the transaction.

Providers must bill Medicare if and when Medicare benefits become available (such as at the beginning of a new benefit period or a change in a member's medical condition that could result in benefit coverage) and discontinue using the condition codes.

Medicare approved services:

The Medicare fiscal intermediaries who have a Trading Partner Agreement with the Division will electronically forward Medicare crossover claims to MassHealth for processing. Otherwise, providers may submit crossover claims to the Division on paper or electronically via the 837 transaction.

Commercial Insurance

Nursing facility claims for members with commercial insurance must be billed to the insurer for payment before billing MassHealth. Once the insurer indicates that the member does not have benefits available, providers may submit an 837I transaction for the noncovered services to MassHealth in accordance with any service limitations contained in 130 CMR 456.000. The provider must populate the transaction with one of the condition codes listed in this bulletin to describe the reason for noncoverage. Subsequent services may be billed using the condition codes in lieu of billing the insurer as long as benefits are not available from the commercial insurer.

In these circumstances, the **provider should populate the other payer loops** (2320 and 2330) in the transaction with the insurance information and the appropriate MassHealth-assigned carrier code for that insurance in 2330B-NM109 (Other Payer Name – Other Payer Primary identifier). Do not populate any insurance payments, coinsurance, or deductible in the other payer loops (2320 and 2330) in the transaction.

Commercial Insurance (cont.)

(Note: The MassHealth-assigned carrier codes are available in Appendix C of all provider manuals or at (www.state.ma.us/dma/providers/supp_info/supp-info_IDX.htm). Additional carrier code transaction details are described in the MassHealth Companion Guide (www.mahealthweb.com/HIPAA_Testing.htm).

Providers must bill the insurer if and when benefits become available (that is, at the beginning of a new calendar year, new benefit period, or a change in a member's medical condition resulting in benefit coverage) and discontinue using the condition codes.

Condition Codes

The following condition codes may be used to indicate the reason that the insurer is not covering the service. The Division will allow providers to use condition codes to override Medicare and/or commercial insurance coverage only in the following circumstances.

Condition Code	Condition Code Description	Allowed for Medicare?	Allowed for Commercial Insurance?
Y0	Benefits exhausted for the calendar year	No	Yes
Y1	Benefit maximum has been reached	Yes	Yes
Y8	Services do not meet skilled level of care	Yes	Yes
Y9	Patient does not have Medicare benefits available or does not qualify for a new benefit period	Yes	No
Z6	Hospital admission; patient did not have a Medicare-qualifying hospital stay	Yes	No
Z7	Noncertified Medicare bed	Yes	No

Monitoring

Providers **must** retain a copy of the insurance explanation of benefits, remittance advice, and/or the Medicare notice of noncoverage in the member's file. The Division may request insurance billing records for auditing purposes to ensure that, among other things, providers are using the condition codes appropriately.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.