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

MassHealth
Nursing Facility Bulletin 133
May 2012

TO: All Nursing Facilities Participating in MassHealth

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

RE: **Update to Third-Party-Liability Claim Submissions**

Background

The purpose of this bulletin is to clarify the following:

- a new 5010 data element, total noncovered amount;
- updated TPL billing requirements for members with another insurer or Medicare Advantage plan;
- updated date of admission requirements for members with another insurer or Medicare Advantage plan; and
- three new TPL error edits.

This bulletin supersedes Nursing Facility Bulletin 124, dated November 2003.

New 5010 Data Element

The HIPAA 5010 version of the 837 claim transaction contains a new segment called "total noncovered amount." The total noncovered amount replaces the use of designated HIPAA adjustment reason codes for TPL exception billing. Providers may report a total noncovered amount on the 837 or direct data entry (DDE) claim transaction by following the billing instructions outlined in Appendix G of the Nursing Facility Manual for claims that meet the TPL exception criteria.

Note: When using the total noncovered amount field, do not enter a remittance date or any HIPAA adjustment reason codes or amounts on the claim transaction.

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TPL Billing Requirements

This section outlines updated TPL requirements when billing claims for members with a Medicare Advantage plan or other insurance coverage.

Generally, MassHealth requires providers to submit COB adjudication details about payment or denial of nursing facility claims for members with a Medicare Advantage plan or other insurance for every claim submission. MassHealth recognizes that these insurers may not approve nursing facility services beyond 100 days of coverage and has revised the billing instructions and claims processing rules as described below.

Providers are required to complete the COB information on the claim transaction for dates of service within 100 days of the date of admission.

- For services approved by the insurer, providers may bill MassHealth if there is a remaining patient responsibility.
- For services denied by the insurer for reasons other than a correctable error, providers may bill MassHealth with the COB adjudication details provided by the insurer. Providers may not submit the claim to MassHealth if the claim is denied for noncompliance with any one of the insurer's billing and authorization requirements as stated in Subchapter 5 of the Nursing Facility Manual.
- For services that meet the TPL exception requirements, providers may bill MassHealth using the total noncovered amount field following the billing instructions in Appendix G of the Nursing Facility Manual.

Providers must bill the insurer at any point if and when benefits become available, such as at the beginning of a new calendar year, during a new benefit period, or when there is a change in a member's medical condition resulting in benefit coverage.

Update to the Date of Admission Requirements

Claims for members with a Medicare Advantage plan or other insurance coverage must follow these new date of admission requirements.

MassHealth requires providers to change the admit date on the claim transaction 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 to the nursing facility from an inpatient hospital stay. The new admit date must be the day the member requires skilled care or returns to the nursing facility from an inpatient hospital stay.

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New TPL Error Edits

The three new MMIS error edits below are specific to nursing facility claims for members with Medicare Part A coverage, Medicare Advantage plan, or other insurance coverage.

Providers submitting claims to MassHealth for members with Medicare Part A coverage, Medicare Advantage plan, or other insurance coverage, are required to complete the COB information on the claim transaction for dates of service within the first 100 days of the date of admission. Failure to provide this information will result in one or more of the error edits listed below.

Error Code 2528 (LTC - Potential Medicare A in first 100 days)
This edit will set on your claim when the member has active Medicare Part A coverage and the date of service on the claim is within 100 days of the date of admission and the claim does not contain COB details pertaining to Medicare Part A coverage.

Error Code 2556 (LTC - Potential Medicare C in first 100 days)
This edit will set on your claim when the member has an active Medicare Advantage plan and the date of service on the claim is within 100 days of the date of admission and the claim does not contain COB details pertaining to Medicare Advantage plan.

Error Code 2557 (LTC - Potential Private Insurance in first 100 days)
This edit will set on your claim when the member has active other insurance coverage and the date of service on the claim is within 100 days of the date of admission and the claim does not contain COB details pertaining to other insurance coverage.

Monitoring

Providers must retain a copy of the insurer's remittance advice, the Medicare Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), insurer's notice of noncoverage, 835 transactions and other insurer's responses for auditing purposes.

Questions

If you have any questions about the information in this bulletin, 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.