



**Commonwealth of Massachusetts**  
**Executive Office of Health and Human Services**  
**Office of Medicaid**  
600 Washington Street  
Boston, MA 02111  
[www.mass.gov/masshealth](http://www.mass.gov/masshealth)



MassHealth  
Transmittal Letter PIH-17  
April 2009

**TO:** Psychiatric Inpatient Hospitals Participating in MassHealth

**FROM:** Tom Dehner, Medicaid Director TD

**RE:** *Psychiatric Inpatient Hospital Manual* (New Appendix D)

This letter transmits Appendix D for the *Psychiatric Inpatient Hospital Manual*. Appendix D 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 D 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](http://www.mass.gov/masshealth), and is fillable online. A copy of the 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 *Psychiatric Inpatient Hospital Bulletin 21*, dated November 2003, which is available on the MassHealth Web site at [www.mass.gov/masshealth](http://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 (ARC).

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

If you have any questions about this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to [providersupport@mahealth.net](mailto:providersupport@mahealth.net), or fax your inquiry to 617-988-8974.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Psychiatric Inpatient Hospital Manual

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

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Psychiatric Inpatient Hospital Manual

Pages vi and vii – transmitted by Transmittal Letter PIH-11



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			

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> Table of Contents	<b>Page</b> vi
	<b>Transmittal Letter</b> PIH-17	<b>Date</b> 05/26/09

Appendix A. Directory .....	A-1
Appendix B. Enrollment Centers .....	B-1
Appendix C. Third-Party-Liability Codes .....	C-1
Appendix D. Supplemental Instructions for Claims with Other Insurance .....	D-1
Appendix X. EPSDT Services: Medical Protocol and Periodicity Schedule .....	W-1
Appendix X. Family Assistance Copayments and Deductibles .....	X-1
Appendix Y. EVS/Codes Messages .....	Y-1
Appendix Z. EPSDT/PPHSD Screening Services Codes.....	Z-1

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> Preface	<b>Page</b> vii
	<b>Transmittal Letter</b> PIH-17	<b>Date</b> 05/26/09
Psychiatric Inpatient Hospital Manual		

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 psychiatric inpatient hospitals, those matters are covered in 130 CMR Chapter 425.000, reproduced as Subchapter 4 in the *Psychiatric Inpatient Hospital 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.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> Appendix D: Supplemental Instructions for Claims with Other Insurance	<b>Page</b> D-1
	<b>Transmittal Letter</b> PIH-17	<b>Date</b> 05/26/09
Psychiatric Inpatient Hospital Manual		

## 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 a claim determination. When the initial claim has been adjudicated by the insurer, enter the adjudication details provided by that insurer in the other payer loops (2320 and 2330) in the 837I transaction. The provider must fill 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. <b>Note:</b> MassHealth-assigned carrier codes may be found in Appendix C (Third-Party-Liability Code) of your MassHealth provider manual, or at <a href="http://www.mass.gov/masshealth">www.mass.gov/masshealth</a> .
2320	SBR09 (Claim Filing Indicator)	“MA” when the other payer is Medicare “CI” if the other payer is another insurer
2320	AMT (Amount)	Should not be filled 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-2. 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.
2320	CAS03 (Monetary Amount)	Billed amount

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> Appendix D: Supplemental Instructions for Claims with Other Insurance	<b>Page</b> D-2
	<b>Transmittal Letter</b> PIH-17	<b>Date</b> 05/26/09
Psychiatric Inpatient Hospital Manual		

Loop	Segment	Value Description
2330B	DTP03 (Date, Time, or Period)	Date of discharge or end date of service

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, the adjudication details provided by that insurer should be documented on the TPL Exception Form for Inpatient Hospital and Nursing Home Providers to report HIPAA group and adjustment reason codes. This form is available on the MassHealth Web site at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

**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 Claims and 837I Transactions

The adjustment reason codes (ARCs) given in the following table may be used for both paper and 837I transactions to indicate 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 table.

<b>Claim Adjustment Reason Code Crosswalk Table</b>			
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

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Psychiatric Inpatient Hospital Manual	<b>Subchapter Number and Title</b> Appendix D: Supplemental Instructions for Claims with Other Insurance	<b>Page</b> D-3
	<b>Transmittal Letter</b> PIH-17	<b>Date</b> 05/26/09

<b>Claim Adjustment Reason Code Crosswalk Table</b>			
<b>Prior Condition Code</b>	<b>Replace with HIPAA Adjustment Reason Code</b>	<b>Applies to Medicare?</b>	<b>Applies to Commercial Insurers?</b>
<b>Y1</b> - Valid EOB/Denial on file – Cap in service; benefit maximum has been reached	<b>119</b> - Benefit maximum for this time period or occurrence has been reached for the calendar year	Yes	Yes
<b>Y8</b> - Valid EOB - Utilization review notice/services do not meet the skilled level of care	<b>150</b> - Payment adjusted because the payer deems the information submitted does not support this level of service. Payer deems the information submitted does not support this level of service.	No	Yes
<b>Y9</b> - Valid EOB - utilization review notice/patient does not have benefits available or does not qualify for a new benefit period.	<b>119</b> - Benefit maximum for this time period or occurrence has been reached for the calendar year	Yes	Yes

### 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.



<p align="center"><b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b></p>	<p align="center"><b>Subchapter Number and Title</b> Appendix D: Supplemental Instructions for Claims with Other Insurance</p>	<p align="center"><b>Page</b> D-4</p>
<p>Psychiatric Inpatient Hospital Manual</p>	<p align="center"><b>Transmittal Letter</b> PIH-17</p>	<p align="center"><b>Date</b> 05/26/09</p>

This page is reserved.