***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 PIH-18
December 2009

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

**FROM:** Terence G. Dougherty, Interim Medicaid Director

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

This letter transmits a revised Appendix D for the *Psychiatric Inpatient Hospital Manual*. Appendix D contains a revised set of 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. The revised Appendix D is effective December 15, 2009.

This appendix lists the exceptions that need to be considered when billing MassHealth, Medicare, or commercial insurance. It 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.)

Psychiatric Inpatient Hospital Manual

Pages vi and D-1 through D-6

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(The pages listed here are no longer in effect.)

Psychiatric Inpatient Hospital Manual

Page vi – transmitted by Transmittal Letter PIH-17

Pages D-1 through D-4 – transmitted by Transmittal Letter PIH-17

# Supplemental Instructions for TPL Exceptions
## Submitting Claims for Members with Medicare and 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. This appendix lists the exceptions that need to be considered when billing MassHealth for members who have Medicare or commercial insurance. These are specific MassHealth billing instructions that are not described 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, the adjustment reason code segment must be populated. 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 Provider Forms on the lower right panel of the 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 130 CMR 450.316. Providers must submit a claim and seek a new coverage determination from the insurer any time a member's medical condition or health insurance coverage status changes, even if Medicare or a commercial insurer previously denied coverage for the same service.

### TPL Exceptions

If one of the following exceptions exists, and the initial insurer's denial or notice of noncoverage is on file, follow the instructions outlined in this appendix for claim submission. Claim submissions must include codes found in the HIPAA Adjustment Reason Code Crosswalk table on page D-6.

- Psychiatric inpatient services for a MassHealth member must be billed to Medicare or the commercial insurer initially or a Medicare notice of noncoverage must be issued.
- There are instances where other 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, or does not qualify for a new benefit period.

Providers are required to retain the Medicare notice of noncoverage, Medicare remittance advice, commercial insurer's original explanation of benefits (EOB), 835 transaction, or response from the insurer on file for auditing purposes.

### Medicare Part B Ancillary Coverage when Medicare Part A benefits are not available

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. This appendix contains instructions for providers reporting Medicare Part B ancillary payments.

**Billing Instructions for 837I Transactions**

Providers must complete the other payer loops in the 837 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.

| Loop | Segment | Value Description |
|---|---|---|
| 2330B | NM109 (Other Payer Name) | Enter the MassHealth-assigned carrier code for the other payer.<br>**837I:** Medicare (institutional) carrier code is 0084000<br>**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. |
| 2320 | SBR09 (Claim Filing Indicator) | **837I:** Medicare (institutional) carrier code = MA<br>**837I:** Commercial insurer carrier code = CI |
| 2320 | AMT (Amount) | 0 |
| 2320 | CAS01 (Claim Adjustment Group Code) | OA (other adjustments) |
| 2320 | CAS02 (Claim Adjustment Reason Code) | See the HIPAA Adjustment Reason Code Crosswalk table on page D-6.<br>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) | 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 |

The provider must fill in the other payer loops in the 837I transaction as described in the following table to report Medicare Part B ancillary payments.

| Medicare Part B Ancillary Payments | | |
|---|---|---|
| **Loop** | **Segment** | **Value Description** |
| 2320 | SBR09 (Claim filing indicator | MB |
| 2320 | AMT01 (Allowed amount qualifier ) | B6 |

| Medicare Part B Ancillary Payments | | |
|---|---|---|
| **Loop** | **Segment** | **Value Description** |
| 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 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 meet the TPL exception criteria.

In the Coordination of Benefits tab, you must choose "New Item."

| Coordination of Benefits | |
|---|---|
| **Field Name** | **What to enter** |
| Carrier Code | Enter the MassHealth-assigned carrier code for the other payer.<br>Medicare (institutional) carrier code is 0084000.<br>Medicare (professional) carrier code is 0085000.<br>**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. |
| 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 is billing period<br>**Note:** This is a required field.) |
| Payer Claim Number | Enter the other insurer claim number on the EOB. If no EOB, use "99" as the default payer claim number. |
| Payer Responsibility | Select the appropriate code. |
| Allowed Amount | Enter 0. |

| Coordination of Benefits | |
|---|---|
| Payer Paid Amount | Enter 0. |
| **Field Name** | **What to enter** |
| Claim Filing Indicator | Medicare (institutional) carrier code is MA.<br>Medicare (professional) carrier code is MB.<br>Commercial insurer carrier code is 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).<br>**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.

| COB Reasons Detail | |
|---|---|
| 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 D-6. This is a crosswalk of the previously used condition codes to the current HIPAA adjustment reason codes. Providers must bill using the correct codes, otherwise claims may process incorrectly. |

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

**Medicare Part B Ancillary Coverage**

Providers must enter the fields described in the following table to report Medicare Part B payments.

| Coordination of Benefits | |
|---|---|
| **Field Name** | **What to enter** |
| Carrier Code | Enter the MassHealth-assigned carrier code 0085000. |
| Carrier Name | Enter the appropriate carrier name, Medicare Part B. |
| EOB Date | Date of discharge or end date of service for the claim billing period<br>**Note:** This is a required field. |
| Payer Claim Number | Enter the other insurer claim number on the EOB. If no EOB, use "99" as the default payer claim number. |
| Payer Responsibility | Select the appropriate code. |
| Allowed Amount | Enter 0. |
| Payer Paid Amount | Enter the Medicare B prior paid amount. |
| Claim Filing Indicator | Select MB. |
| 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).<br>**Note:** This is a required field. |

Click "Add" to save the coordination of benefit (COB) detail information for Medicare Part B prior paid amount.

**Billing Instructions for Paper Claims**

Providers must submit the appropriate 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 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 adjustment reason code on this form from the HIPAA Adjustment Reason Code Crosswalk table on page D-6.

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

## HIPAA Adjustment Reason Code Crosswalk Table

Use the HIPAA adjustment reason codes (ARCs) in the following table to indicate the 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.

| 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. Payer deems the information submitted does not support this level of service. | No | Yes |
| **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 |

## 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 in order 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.