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-19
March 2010

TO: Psychiatric Inpatient Hospitals Participating in MassHealth

FROM: Terence G. Dougherty, 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 revised billing instructions for submitting 837I transaction 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 April 1, 2010.

This appendix lists the exceptions that need to be considered when billing MassHealth for members who have Medicare, or commercial insurance. It also 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, vii, and D-1 through D-6

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Psychiatric Inpatient Hospital Manual

Pages vi and D-1 through D-6 – transmitted by Transmittal Letter PIH-18

Page vii – transmitted by Transmittal Letter PIH-17

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 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.

Supplemental Instructions for TPL Exceptions
Submitting Claims for Members with Medicare or 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 specific MassHealth billing instructions are not provided 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, an entry must be made in the adjustment reason code (ARC) segment. 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 MassHealth Provider Forms on the lower-right panel of the home 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 MassHealth regulations at 130 CMR 450.316. Accordingly, 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, even if Medicare or a commercial insurer previously denied coverage for the same service.

TPL Exceptions

Psychiatric inpatient services for a MassHealth member must be initially billed to Medicare or the commercial insurer or a Medicare notice of noncoverage must be issued. There may be instances when other insurance coverage is no longer available to the MassHealth member, such as when the member

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

If any of the above exceptions exist, 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 of this appendix.

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

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 837I 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, listed on the HIPAA Adjustment Reason Guide Crosswalk Table on page D-6.

Loop	Segment	Value Description
2330B	NM109 (Other Payer Name)	Enter the MassHealth-assigned carrier code for the other payer. **837I:** Medicare (institutional) carrier code is 0084000 **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 **837I:** Commercial insurer carrier code = CI
2320	AMT01 (Allowed Amount Qualifier)	B6
2320	AMT02 (Allowed Amt = 0)	0
2320	AMT01 (Paid Amount Qualifier)	C4
2320	AMT02 (Medicare /Other Insurance Prior Payment 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. 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
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 that meet the TPL exception criteria.

In the coordination of benefits tab, choose "New Item."

Coordination of Benefits	
Field Name	**What to Enter**
Carrier Code	Enter the MassHealth-assigned carrier code for the other payer. Medicare (institutional) carrier code is 0084000. Medicare (professional) carrier code is 0085000. **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 **Note:** This is a required field.
Payer Claim Number	Enter the other insurer claim number on the EOB. If there is no EOB, enter "99" as the default payer claim number.

Coordination of Benefits	
Field Name	**What to Enter**
Payer Responsibility	Select the appropriate code.
Allowed Amount	Enter 0.
Payer Paid Amount	Enter 0.
Claim Filing Indicator	Medicare (Institutional) = MA Medicare (Professional) = MB Commercial insurer = CI
Release of Information	Select the appropriate code.
Assignment Benefit	Select the appropriate code.
Subscriber Information Panel	Enter the appropriate subscriber information and required fields (subscriber last name, first name, subscriber ID, and relationship to subscriber code). **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, according to the following table.

COB Reasons Detail	
Field Name	**What to Enter**
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. The table crosswalks the previously used condition codes to the current HIPAA ARCs. Providers must bill using the correct HIPPA ARC codes to ensure that claims process correctly.

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

On the procedures tab, after entering the procedure service details, scroll down to the list of COB line items and click "New Item."

DDE Billing Instructions for Reporting Medicare Part B Payments

Providers must enter information in 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 seven-digit 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 **Note:** This is a required field.
Payer Claim Number	Enter the other insurer claim number on the EOB. If there is no EOB, enter "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). **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 UB-04 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 that 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 ARC 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 ARCs in the following table to indicate the reason that an 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. The table crosswalks the previously used condition codes and previous billing instructions to the current HIPPA ARCs. Providers must enter the correct HIPAA ARC to ensure that claims are processed correctly.

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