December 2016

Health Safety Net (HSN) Claim Update
Secondary Elements on HSN Secondary Claims

This HSN billing update is related to claims submitted on 837I, 837P, 837D

Effective March 1, 2017: HSN requires that claims adjudicated (with payment) by a prior payer and submitted to the HSN for final payment consideration of coinsurances, copays, deductibles and/or non-covered services have the necessary segments populated with correct and active reason codes from the prior payers' adjudication.

HSN will use the following elements to determine HSN Secondary Payments based on a "monetary amounts in alignment" logic:

- Prior Payer Paid Amount,
    - Prior Payer Paid Amount equal to $0 may still be processed as an HSN Secondary Claim for payment of remaining balances when they are not equal to the Total Charges

    - Remaining balance equal to Total Charges will result in the claim being considered under the HSN Primary Claim payment logic.

- Remaining Patient Liability Amount,
    - Remaining Patient Liabilities less than or equal to $0 will be processed as a $0 payment.

    - Claims paid $0 due can be resubmitted as a Replacement Claim with the Remaining Patient Liability Amount corrected to a value greater than $0.

- Patient Responsibility as defined by the use of the Patient Responsibility (PR) Group Code in the Claim or Line Level Adjustment segments,
    - Patient Responsibility Group Code to identify any and all remaining balances as a patient responsibility defined by the prior payer.

- o Commonly used PR codes are:
  - (1) Identifies deductible due
  - (2) Identifies coinsurance due
  - (3) Identifies copay due
    Other codes may be considered due to non-coverage of services by the primary payer(s).

HSN recognizes various prior payers to determine how to pay the balance of a given secondary/tertiary claim, however there are limited categories that all payers fall into for HSN payment consideration:

- MassHealth Limited
  - o HSN will pay for most service denied by MassHealth Limited as non-covered. Providers should follow all guidelines for billing MassHealth Limited before billing to HSN.

- MassHealth (other)
  - o HSN will pay 100% of the remaining deductibles and spend downs (for those MassHealth coverage types that have those) and at the HSN Fee Schedule rate Wrap and/or Covered Services

- Medicare or Medicare-like as Prime
  - o HSN will pay 100% of the remaining HSN Covered Services and/or coinsurance, copays, and/or deductibles.

  - o HSN will not pay for any services that have been denied by the prior payer for the following reasons:
    - provider not credentialed/certified/licensed, or would not be accepted by MassHealth
    - billing was untimely/undocumented/duplicated,
    - documentation was not received/incomplete, and/or
    - balance due to provider initiated adjustments that do not correspond to a patient responsibility balance

- Commercial Insurance as Prime
  - o HSN will pay the remaining HSN Covered Services and/or coinsurance, and/or deductibles by multiplying the balance with the submitting providers Cost-to-Charge ratio for inpatient claims and Payment-on-Account-Factor for outpatient claims as reported to each provider at the beginning of the Fiscal Year.(**Note:** Payment –on-Account-Factor is used only for Hospital payment)

    - INPATIENT EXAMPLE: Deductible of $2,000.00 submitted to the HSN from a provider with a Cost-to-Charge ratio of .533 would result in a payment of $2,000 x .533 = $1,066.00

    - OUTPATIENT EXAMPLE: Coinsurance of $23.92 submitted to the HSN from a provider with a Payment-on-Account-Factor of .368 would result in a payment of $23.92 x .368 = $8.80

  - o HSN will not pay for any services that have been denied by the prior payer for the following reasons:
    - provider not credentialed/certified/licensed
    - billing was untimely/undocumented/duplicated,

- documentation was not received/incomplete, and/or
- balance due to provider initiated adjustments that do not correspond to a patient responsibility balance
- patient received services that are out-of-network

Reporting of inactive Adjustment Codes on the claim file will result in creating items to price at $0. Always use codes that are active for the claims dates of service / prior payers' adjudication.