

NewMMIS Billing Tips As of May 27, 2010

Provider Type	Claim Type	Resolution
All provider types	All claim types	Providers that are not approved for coordination of benefits (COB), but submitted override claims in legacy need to contact CST and get approved to submit COB claims in NewMMIS. Providers will then need to submit appropriate loops and segments along with the adjustment reason codes, as appropriate, on their claims.
All provider types		Total charges are now required on all claim types - this includes the CMS-1500 claim form, 837P transaction, UB-04 claim form, and the 837I transaction.
All provider types	All claim types	MassHealth expects the billing provider, and also the doing business as (DBA) address, to be the pay-to-provider, and ignores 2010AB loop on the 837 P/I transactions.
All provider types	All claim types	When adjusting a legacy claim using the legacy TCN, add "20" before the TCN, to make the field 12 characters long.
All provider types that require a referral	Medical Outpatient; Home Health	If submitting a legacy referral number, precede it with two zeros.
All providers that bill on an institutional claim type.	Inpatient Outpatient Long Term Care Home Health	All institutional claims have to be billed with value code 24, which implies Medicaid rate code.
All providers that bill on an institutional claim type.	Inpatient Outpatient Long Term Care Home Health	With NewMMIS, MassHealth has moved to the standard HIPAA code sets. As a result, type of bill codes that processed without errors in legacy cannot be used in NewMMIS, if they are not valid. Codes identified in the NUBC manual as "Reserved for NUBC" cannot be used in NewMMIS as they are invalid.
Acute Inpatient Hospitals	Inpatient	<p>When billing for the following situations, providers should use Patient Status Code (02) to ensure that Transfer Per Diem is the derived rate:</p> <ul style="list-style-type: none"> • If a member is transferred from one acute inpatient facility to another • if a member becomes eligible for MassHealth after admission; • if a member enrolls or disenrolls from a managed care organization during the hospital stay, or • if a member exhausts other insurance benefits after the admission. <p>When a member is admitted to an inpatient facility following outpatient surgery, providers should use patient status code 09 to ensure that transfer per diem is the derived rate.</p>

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Chronic Inpatient Hospitals	Inpatient	In NewMMIS, the admit date on the claim is validated against the PAS admit date. Providers need to make sure they send the patient's true admit date to the hospital on their claims.
Outpatient hospitals	Outpatient	NewMMIS will deny outpatient claims (EDI and paper submissions) if there is a date of service range in the header of the claim. Providers should send in individual EDI claims for each date of service.
Outpatient hospitals; Long-term care providers	Outpatient Long-Term Care	In NewMMIS, the admit type is required for outpatient and long-term-care claims.
Nursing Facilities (NFs)	Long-Term Care	For medical leave of absence (MLOA) days, use the following: a. revenue code = 185 b. occurrence span code = 71 For nonmedical leave of absence (NMLOA) days, use the following: a. revenue code = 183 b. occurrence span code = 74
Nursing Facilities (NFs)	Long-Term Care	When billing only for leave of absence days, providers should not include revenue code 100 for room and board days.
Nursing Facilities (NFs)	Long-Term Care	Providers should use revenue code 100 for room and board days for nursing facilities. The actual description of revenue code 100 is "All-inclusive room and board plus ancillary."
Nursing Facilities (NFs)	Long-Term Care	In NewMMIS, NFs have to bill with a valid diagnosis code that is covered for the date of service on the claim.