Health Safety Net (HSN) Claim Updates

January 2017

Please make note of the following edit changes being implemented by Health Safety Net (HSN). The Experian Health claims clearinghouse and claims products will implement these edits per the information below.

1. Subscriber vs Patient Hierarchical Level

This HSN billing update is related to claims submitted on 837I (HSNMI) & 837P (HSNMP)

Effective February 1, 2017, providers must insure that the following claim file requirements are met for claim payment consideration from HSN:

HSN requires that providers do not invoke the patient Hierarchical Level segment. This insures that only one patient is associated to a unique MMIS ID:

- Destination Payer's Subscriber segment must contain the Individual relationship Code equal to 18.
- Claims submitted without the Individual Relationship Code of 18 at the Destination Payer's Subscriber Level will be denied by HSN and not eligible for payment consideration.

Claims denied at HSN for Individual Relationship Code missing can be corrected. Providers should void the claim passed at MMIS and resubmit a new original claim with all corrections on the new original.

2. Zero ($0) Charges and Total Charges

This HSN billing update is related to claims submitted on 837I (HSNMI) & 837P (HSNMP)

Effective February 1, 2017, HSN requires the following in terms of charges submitted on claims:

- **Institutional (837I) claims** must have a Monetary Amount greater than $0 in the Claim Segment (Total Charges). All Revenue Code Lines with monetary amount populated must equal the Total Charge Amount in the Claim Segment when added together.
  - It is allowable for some lines to report $0 when applicable, however if all lines are equal to $0 and results in Total Charges equal to $0, the claim will be denied by HSN and not eligible for payment consideration.
  - Claims denied for Total Charge Equal to $0 can be corrected. Providers should void the paid claim in MMIS and submit a new original claim with all corrections.

- **Professional (837P)** must have a Monetary Amount greater than $0 in the Claim Segment (Total Charges). All Service Lines with Monetary Amount populated must equal the Total Charge Amount in the Claim Segment when added together.

    - It is allowable for some lines to report $0 when applicable, however if all lines are equal to $0 and results in Total Charges equal to $0, the claims will be denied by HSN and not eligible for payment consideration.

    - When a service line is reported with Monetary Amount equal to $0, this line will not be priced as part of the per service payment.

    - Claims denied for Total Charges Equal to $0 can be corrected. Providers should void the paid claim in MMIS and submit a new original claim with all corrections.

  Claims that are paid by the HSN but determined to be underpaid due to missing charges should be resubmitted as a Replacement Claim with the appropriate amount reported for pricing and payment reconsideration.

3. Duplicate Lines vs. Differing Rendering Providers

This HSN billing update is related to claims submitted on 837P (HSNMP)

Effective March 1, 2017, HSN requires that providers submitting Professional claims where the same CPT/HCPCS/CDT code could be reported by different providers on the same patient for the same date of service be separately identified at the Line Level. This will affect any dates of service going forward, as well as any dates of service where a claim is reprocessed.

a. Claims with two individuals providing the same service on the same claim must contain two service lines for the repeating CPT/HCPCS/CDT while identifying the separate providers in the Rendering Provider loop (NPI). Identify each as a Person in the Entity Type Qualifier using the code equal to 1. These lines will be separately priced and then considered for payment.

b. Claims with two individuals providing the same service on separate claims must also contain the Rendering Provider (NPI) loop on each claim at the line with the repeating CPT/HCPCS/CDT.

c. Claims that do not identify all the individuals on the claim will only consider the claim with the identified individual for pricing and payment.

d. Claim(s) that are paid by the HSN but then determined to be underpaid due to missing Rendering Provider details should be corrected by voiding the claim with MMIS and submitting on a single claim as an Original Claim with the appropriate Rendering Provider (NPI) details reported on each line that has a repeating CPT/HCPCS/CDT code. .

e. Claims that are submitted with duplicating services for the same date of service at the same Rendering Site (OrgID) and no indication of differing Rendering Individuals (NPI) will be denied as a Duplicate Claim.

f. Claims that are denied due to Duplicate but should be paid separately, should be resubmitted as an Original Claim combining all services and reporting the Rendering Provider (NPI) at the Line Level to show differentiation. These claims will then be priced and considered for payment.

4. Secondary Elements on HSN Secondary Claims

This HSN billing update is related to claims submitted on 837I (HSNMI) & 837P (HSNMP)

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.
  - 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:

- <u>MassHealth Limited</u>
  - 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)
    - 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
    - HSN will pay 100% of the remaining HSN Covered Services and/or coinsurance, copays, and/or deductibles.

    - 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
    - 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

    - 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.

HSN Billing Reminders:

- Billing Updates Posted Online: Provider should be checking the HSN website regularly for "billing updates". HSN will be posting all billing updates and reminders going forward.

- Secondary Claims: Providers are reminded that when submitting secondary claims, HSN must have the primary payer information to assist in correct payment.

- TCN/Patient Account Number: As a reminder, providers must not enumerate the reported TCN/Patient Account Number when correcting claims. Any billing system enumeration should be suppressed. Additionally, when sending information or claim reviews to HSN, Providers must send in the entire TCN/Patient Account Number, including any leading zero's and any prefix or suffix that is part of that identifier.