



# TIPS AND TRICKS FOR MASSHEALTH POSTPARTUM LARC BILLING



To ensure proper payment for long acting reversible contraception (LARC) devices under MassHealth's Acute Hospital RFA and contract, hospitals must follow special billing instructions. PICCK has put together the following document to help assist billers when submitting inpatient claims for LARC devices. For more information on billing instructions for LARC devices, please see: [MassHealth Billing Instructions for LARC Devices](#).

- Inpatient hospital claims for LARC devices (pursuant to Section 5.B.8a of the current Acute Hospital RFA and contract) must be **separately submitted through an 837P** and in compliance with applicable MassHealth regulations, billing instructions, Provider bulletins, and other written statements of policy.
- Costs, charges, and any other claims-based data corresponding to the LARC device **must be excluded from any facility/institutional claim** (including Claim Types I and A).
- The claim **must be billed electronically** (837P).
- Claim separate payment for the LARC device on **a professional claim via Direct Data Entry (DDE)** and include Delay Reason Code 11.
- **The separate DDE must include:** member's name, date(s) of service, appropriate National Drug Code (NDC) identifier and corresponding HCPS code(s) for the device.
- In the event that a provider's **only** means of submission is paper, the provider must meet the MassHealth requirements of a paper submission waiver request.
- Include **a copy of the invoice for the LARC device** from the manufacturer, supplier, distributor, or other similar party with the claim submission for the LARC device. This can be done using the attachment functions in the POSC.
  - Attachments Tab: List of Attachments
  - On the List of Attachments panel, click New Item. The Attachment Detail panel displays
  - Select Report Type from the drop-down list
  - Select Transmission Code from the drop-down list
  - Click Browse and navigate to the attachment file
  - Select the desired file and click Open
  - Click Add / Upload
  - Click the Confirmation tab
- The claims must indicate inpatient place of service **both at the header level and at the detail level** of the claims.
- **The rendering field must be left blank.** If the rendering has the physician information then MMIS looks to the contact rules for Physician and triggers the edits. If it is left blank, the claim will not hit those edits.

