# Massachusetts Health Care Training Forum
# April 2012 Questions & Answers

This document supplement the presentations made during the Massachusetts Health Care Training Forum (MTF) meetings by offering Questions & Answers, and additional presenter comments if applicable.

All information within this document is organized in the order the presentations were given.

Click on any link below to access a Question and Answer section.



## MASSHEALTH UPDATES

### Questions from the MTF April 2012 Roundtable Forms:

**Client lost job, has COBRA $666/monthly, running out. Assets way over in stocks, saved diligently and has a new car paid off. She has $109/weekly unemployment. She is going through assets rapidly.**
This person should file an application to see if they are potentially eligible for any benefits.

**Can MAP show the 12 digit ID?**
This is a good suggestion we will take this back.

**When can an individual's plan change from Senior Buy In Plus/standard to CommonHealth?**

A person can be eligible for CommonHealth when they are disabled and working (40 hours per month) or once they have met a onetime deductible (under 65). Full CommonHealth regulations are available at www.mass.gov/masshealth.

**Do SSDI beneficiaries get MassHealth Standard automatically?**
No they must meet certain universal and financial requirements to qualify for MassHealth.

**Are day habilitation bills covered under CommonHealth?**
Rehabilitation services are covered under MassHealth CommonHealth. Please call MassHealth provider services at 1-800-841-2900 for specific details.

**Is premium payment paid by MassHealth? Which programs? How is information communicated? Can you get it retroactively?**
A) I am assuming you are referring to "Premium Assistance" and if so yes, we may assist in paying all or part of one's Employer Sponsored health insurance premium. For more information, please call the Family Assistance Unit at 1-888-291-4464.
B) I don't believe we have a retro component to this feature and correspondence is made via mailings. Our Enhanced Coordination of Benefits (ECOB) unit handles that area and they are very good when trying to assist folks with premium payments.

**Over 65 clients, case closed for more than 30 days, you said we should do a new SMBR. Is this the same as a new VG electronic application or it should be the paper one?**
If a case is closed for a member who is over 65 for more than 30 days a new paper SMBR should be completed.

**MAP has very old information, old address, 5 years old, even though submitting older annual review '09. Couple months ago – ERV submitted. Moved from Essential to Commonwealth Care.**
A Head of Household (The person who signed written signature or electronic signature for the application for benefits) can use the member facing my account page (MAP) to change their address. It is very important the current address is on file. MassHealth sends out frequently sends out correspondence and if the mail is returned undeliverable the case/benefits could close.

**Regarding the residency question on the VG application "Is this person residing in MA and has the intention to stay?" The answer is "yes" if the person is not a visitor. In the Members Booklet on page 6 it indicates that medical assistance is available for visitors for an emergency medical condition. How can we indicate this on the ERV?**
Have the applicant answer the questions that are asked on the VG application and MassHealth will determine residency and if emergency medical can be provided based on the responses on the application.

**Please explain the process for determining cost effectiveness for premium assistance. We are hearing that families with CommonHealth who have an increased premium are no longer eligible for Premium Assistance.**
Some of the factors that determine cost effectiveness are employer contribution, benefit level of plan, and cost. The Premium Assistance unit can provide full details of the determination process at 1-800-862-4840.

**The MA HIV Drug Assistance Program is not directly linked to MassHealth, unlike most state ADAP's that are directly affiliated with the state Medicaid office. Would it be possible to have a MassHealth contact person/liaison in order to facilitate unique issues related to HDAP and MassHealth?**
There is currently no contact person/liaison for HDAP program related issues.

**Most state ADAP's are connected with their state's Medicaid Office, but in MA, HDAP is not connected with MassHealth. Could HDAP have access to full Virtual Gateway without having a provider # OR MA 21?**
The Virtual Gateway help desk is the place to begin for gaining access. 1-800-421-0938

**What is MA 21?**
It's one of the computer systems that determine eligibility. "Medical Assistance for the 21st Century".

**How do you select "Wage Type" if applicant works Per Diem and has varying income?**
Check if it is full or part time and then send in verification to explain circumstances.

**3-Way Call – Can we be on call/inconsistency on what representatives will**
Different staff will be answering phones at different time intervals. It is unlikely you will get the same representative on the phone at any given time.

**When MassHealth member becomes 19, do they get ERV?**
MassHealth members who are turning 19 will get a transitional eligibility review sent to them before they turn 19.

**If the MassHealth system is out of date; what is the best way to get updated information? What is the timeframe?**
Members can get automated information on the 24/7 automated line at 1-888-665-9993. HOH's can also get information on the member facing MAP after they register. www.mass.gov/vg/selfservice

**We understand there is a back log at the MEC but why are renewals taking almost 10 weeks?**
Eligibility reviews are currently taking 40 days to process.

**If a person says they get paid $75.00 a week for 25 hours of work or hand writes a letter stating they get paid $200.00 a week (cash) doing odd jobs; how is this verified and processed?**
**Below is the policy for income verification.**

506.005: Verification of Income
**(A)** Verification of gross monthly earned income is mandatory and shall include, but not be limited to, the following:
**(1)** two recent paystubs;
**(2)** a signed statement from the employer; or
**(3)** the most recent U.S. Tax Return.
**(B)** Verification of gross monthly unearned income is mandatory and shall include, but not be limited to, the following:
**(1)** a copy of a recent check or paystub showing gross income from the source;

**(2)** a statement from the income source, where matching is not available; or
**(3)** the most recent U.S. Tax Return.
**(C)** Verification of gross monthly income may also include any other reliable evidence of the applicant's or member's earned or unearned income.

**What does Emergency Aid to Elderly, Disabled mean and can we refer a specialist?**
It's a program administered at the Department of Transitional Assistance. Go to www.mass.gov/dta for full details.

**Can we make copies of the Absent Parent Form to mail?**
You can download them at the MassHealth website in the publications/forms section. www.mass.gov/masshealth

**A patient comes in pregnant with 2 children, staying with in-laws; husband living in another country. Would you enter married or separated with one income?**
This application would need to be completed based on correct and true circumstances. Are parents married? Is mom completing the absent parent section? Is the husband coming over here to live with the family? Etc.

**What is the best method to have patients pick plan?**
When an applicant is found eligible for coverage they are sent a packet with health plan enrollment information. They can choose a plan by filling out health enrollment form and mailing to MassHealth or by call MassHealth Customer Services at 1-800-841-2900. A MassHealth member can call customer service any time to change their plan.

## Questions from the April 2012 Meeting Evaluations:

**Can an over 65 disabled MH applicant get MHCH if they work 40 hours /week or more? I think that was mentioned in the meeting but I don't understand how they could qualify for MHCH as I didn't think you asked about disability after age 65 as almost everyone has "something" after age 65 AND most are retired. Please clarify.**
MassHealth CommonHealth can be for both under and over 65 populations. The regulations for each are found in detail at the MassHealth website. www.mass.gov/masshealth.

**The Neuro-Restorative Host Home program (enhanced Adult Foster Care (AFC) for brain injury survivors) is finding it more and more difficult to serve brain injury survivors who could greatly benefit from the program because their MassHealth applications are not being processed quickly enough. Currently, MassHealth will not review and process the prior authorization for funding for the applicant/program until the application has been approved and the member has active coverage. Often by the time this transpires the individual has progressed beyond needing physical assist with ADL's but still requires critical supervision for cognitive/functional activity in the home and community setting and no longer meet the eligibility criteria for program funding. Then many of these survivors are stuck with nowhere to go at the prime time for engaging in recovery efforts through outpatient therapies and home and community integration. Is there a way to prioritize these applications and expedite the eligibility process? Is it possible to process prior authorization while eligibility is being determined with proof that applications have been submitted to MassHealth/Social Security so they can begin services and billing can be submitted retroactively back to date of eligibility?**

**A.** The fastest way to complete an application is through the Virtual gateway with all required verifications ready.
**B.** Goes to Prior Approval Unit.

**Can out of state individuals that have emergency services in MA apply for MassHealth for those bills?**
Yes, a person can complete a MassHealth application at any time.

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## SOCIAL SECURITY: SSDI AND SSI PROGRAMS

### Questions from the MTF April 2012 Roundtable Forms:

**There seems to be a lot of gray areas of when it is appropriate of people to apply for SSDI.**
1. **Some people have mental health or medical issues and can still work part-time but are unable to work enough to support themselves.**
2. **What about cancer patients, it is unclear if it will be long term.**

For a person to receive Social Security disability benefits, the beneficiary must be unable to do any substantial gainful work because of a medical condition expected to last for at least 12 months or to end in death. When a beneficiary with a disability works, we must decide if the work is substantial gainful activity (SGA).

Substantial" work is the performance of physical or mental duties that are productive in nature; "gainful work" is work done for pay or profit. After deducting disability-related work expenses, we consider that average earnings of more than $1,010 per month ordinarily show that a person has the ability to do substantial gainful work.

**If an individual under 65 and disabled/living in long term facility is receiving their monthly income under their deceased or living parent's retirement, is there an asset limit of $2000.00? (From MassHealth or Social Security). Parents who are Rep Payee were told no…**
It is important to confirm what type of benefit an individual is receiving from the Social Security Administration. Beneficiaries receiving benefits from the Social Security trust fund (i.e. Retirement, Disability, Childhood Disability Benefits, etc) do not have a resource limit.

Supplemental Security Income (SSI) recipients do have a resource limit. The design of the SSI program is to ensure a minimum level of income for needy people who are age 65 or older, blind, or disabled. Since it is a program for the needy, we consider an individual's income and resources when deciding eligibility. An eligible individual may have resources (including cash savings) of not more than $2,000.

Information about MassHealth's resource limits can be found in MassHealth regulations 130 CMR Chapter 520 MassHealth Financial Eligibility. Click here to view the regulations: http://www.mass.gov/eohhs/docs/masshealth/regs-member/regs-memb-520.pdf.

**Regarding the start/change to direct deposit of Social Security checks, how does a S.N.F. as Rep. Payee go from paper checks (delivered to the nursing home) to direct deposit? What account would the direct deposit to the SNF go into, their operating account to apply to recipients A/R or the individual PNA account?**

Most beneficiaries who become entitled to benefits for the first time after May 1, 2011, will receive payments electronically into an account at a financial institution that was opened in their behalf by their representative payee. For all other beneficiaries, we strongly recommend the safety and convenience of direct deposit to receive benefits.

When opening a financial account to hold beneficiary funds, you must establish a fiduciary savings or checking account at a bank, trust company, credit union, or savings and loan association that is insured under Federal or State law. Some important points to remember when establishing and managing an account at a financial institution:

- Set up an account that minimizes fees and provides you with clear, complete records;
- Keep beneficiary accounts separate from accounts holding organizational funds;
- Ensure the beneficiary does not have direct access to the account; and
- Remember, any interest earned on the account belongs to the beneficiary.

More information is found in our *Guide for Organizational Representative Payees* at http://www.socialsecurity.gov/payee/NewGuide/toc.htm.

**Client lost A&B coverage due to incarceration. Does someone follow up with people in that situation? Tried to get caught up through Mass.Gov.**

Medicare Part A and Part B do not end due to incarceration. Part A coverage continues while incarceration. To keep the medical insurance (Part B) coverage, the individual must pay the monthly premiums or the coverage will end. If the coverage ends because they did not pay the Medicare premiums, the individual will be able to enroll during the general enrollment period (January through March of each year). If the individual enrolls during a general enrollment period, the insurance coverage will start in July in the year in which you enroll. The individual will be responsible for any unpaid past-due premiums and the ongoing premium may be higher.

**Is eligibility based on citizenship or just go by their working history?**

We base the amount of Social Security disability benefit on the worker's lifetime earnings before the disability began. We will pay monthly Social Security and SSI benefits to a claimant/beneficiary who is present in the U.S. and who is a U.S. citizen, U.S. national, or lawfully present alien as determined by the Attorney General.

**Can a person under 65 residing in a Skilled Nursing Facility (SNF) receive SSI/SSDI plus social security?**

Residing in a nursing home can affect an SSI benefit but it depends on the type of facility and length of stay. Recipients must notify Social Security when they enter or leave a nursing home, assisted living facility, hospital, skilled nursing facility or any other kind of institution. In many cases, the SSI payment will be reduced or stopped.

Generally, if the recipient enters a nursing home or hospital (or other medical facility) where Medicaid pays for more than half of the cost of care, the SSI benefit is limited to $30 a month. Some States supplement this $30 benefit. We may lower the SSI benefit by any income (including Social

Security benefits) you may have. However, there is a special rule if they will be in a facility for a short time.

A special rule applies if they will be in the facility for 90 days or less. If they give us certain information, they may continue to receive their regular SSI benefit. A doctor must state in writing that the recipient will be in the facility for 90 consecutive days or less. We also need a statement from the recipient or someone knowledgeable about their circumstances that the recipient needs the SSI benefits to maintain his or her home or living arrangement while they are in the facility.

We need these statements as soon as possible after they enter the facility. They must be submitted before the recipient leaves or by the 90th day they are there, whichever is earlier. We often work with admissions offices so that the information we need is available quickly.

**If someone has stolen identity, what can we do?**

If someone is a victim of identity fraud, the first thing they should do is file a police report with the police department where the identity theft took place, and keep a copy of the police report as proof of the crime. Then, they should notify the Federal Trade Commission (FTC), which maintains a centralized database (https://www.ftccomplaintassistant.gov/ or 1-877-438-4338). The individual should then contact the fraud units of the three consumer reporting companies (Equifax, Trans Union, and Experian. They should also contact each of the creditors involved to report fraud for any account that has been tampered with or opened fraudulently. Individuals should monitor their credit report periodically. Free credit reports are available online at www.annualcreditreport.com.

**What is the difference between SSI and SSDI? Does the date of the check received help determine which is which?**

We finance Social Security retirement, survivors, and disability insurance benefits primarily from taxes that workers (and their employers) pay during their working years. The Social Security program pays benefits to eligible workers and their families regardless of the amount of their resources and income other than earnings.

To qualify for Social Security benefits, a worker must have worked enough under Social Security to meet the work requirements. We directly relate the amount of Social Security benefits payable to the amount of earnings that the worker had under Social Security before his or her disability, retirement, or death.

We finance the SSI program entirely from general revenues of the U.S. Department of the Treasury. There are no work requirements. The SSI program provides payments for aged, blind, and disabled people who have limited income and resources. SSI payments are issued on the 1st of the month.

**Does SSDI exist at age 65 and up?**

Social Security disability benefits payable on a beneficiary's own record automatically change to retirement benefits at the same amount, when the beneficiary becomes full retirement age. The law does not allow a person to receive both retirement and disability benefits on one earnings record at the same time.

**Is there a SSA list serve for provider of services to elder populations?**

Our Public Affairs Specialist and Regional Communications Director keep an email contact list to share our latest press releases and announcements. If you are interested in getting electronic messages from SSA, please email BOS.RCD@ssa.gov.

**If someone is expected to be unable to work for 12+ months, they can get their first SSDI check after eligibility determination?**

We pay Social Security disability benefits after we find a worker disabled continuously throughout a period of five full calendar months. In the seventh month of disability, we pay the first benefit for the sixth month. This five-month waiting period ensures that we pay benefits only to persons with long-term disabilities and avoid duplicating other income protection plans (such as employer sick-pay plans) during the early months of disability.

**Overpayments to SSI; how is a hardship request done? How are they calculated? How far back does it go?**

We must recover incorrect payments when a beneficiary receives benefits that are not due. However, the beneficiary does not have to repay us if they can show that they are not responsible for causing the incorrect payments. In addition, they must show that repayment would deprive them of income needed for ordinary living expenses or that repayment is unfair for another reason. We decide whether they meet these conditions through the information furnished on a "Request for Waiver of Overpayment Recovery or Change in Repayment Rate" (Form SSA-632BK).

**How do you set up direct deposit accounts for children with disabilities?**

If the child is already receiving benefits, you can start or change Direct Deposit online. You can also sign up at your bank, credit union or savings and loan. Or call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

**Do you have to take Medicare part B if you get disability?**

The medical insurance program (Part B of Medicare) helps pay for doctors' services and other medical expenses. It is a voluntary program financed through Federal general revenues and monthly premiums paid by enrollees. We automatically enroll people in Part B who are entitled to Part A of Medicare unless they sign a statement that they do not want Part B coverage.

If an individual wishes to re-enroll into Part B, in most cases, we increase a beneficiary's premium for Part B by 10 percent for each full 12 months in which he or she could have been, but was not, enrolled in the program. This increase takes into consideration the higher cost of insuring people who delay enrolling until their health begins to decline.

**I was unable to verify the status of my client's application online as a third party. Do I need to register? If yes, how?**

Please call 1-800-772-1213 or your nearest local field office for assistance.

**Is it true that in order to apply for disability, you must be a US citizen?**

We will pay monthly Social Security and SSI benefits to a claimant/beneficiary who is present in the U.S. and who is a U.S. citizen, U.S. national, or lawfully present alien as determined by the Attorney General. A noncitizen may receive Supplementary Security Income (SSI) if the person meets the requirements of the laws for noncitizens that went into effect on August 22, 1996 and all the other requirements for SSI eligibility, such as the limits on income and resources.

**Do you have to call SSA to switch benefits from SSA Disabled to SSA aged?**
If a person is still receiving disability benefits when he or she reaches full retirement age, the disability benefits will automatically convert to retirement benefits. There is no need to call SSA.

**When can you start to collect? At age 66 or 67?**
If a person was born in 1944 or earlier, they are already eligible for your full Social Security benefit. If they were born from 1943 to 1960, the age at which full retirement benefits are payable varies and increases gradually to age 67. Beneficiaries can get Social Security retirement benefits as early as age 62. However, you will receive a reduced benefit if you retire before your full retirement age. For example, if you retire at age 62, your benefit would be about 25 percent lower than what it would be if you waited until you reach full retirement age.

A person may choose to keep working even beyond their full retirement age. If they do, they can increase their future Social Security benefits in two ways. Each additional year they work adds another year of earnings to their Social Security record. Higher lifetime earnings may mean higher benefits when you retire. Also, the benefit will increase automatically by a certain percentage from the time they reach their full retirement age until they start receiving their benefits or until they reach age 70. The percentage varies depending on the year of birth.

**What happens if you have not been married but were with your partner for many years or got married only a few years before divorce/separation/death?**
Social Security follows the laws of the state where the worker was residing at the time of death or the place where the worker is residing when the spouse applies for benefits. In order for a common law marriage to be valid, it must have been contracted in a state where common-law marriages are recognized. Many states do not honor common-law marriages, so you should check local laws. However, most states (even those in which a man and woman could not enter into a valid common-law marriage) will generally recognize a common-law marriage validly entered into in another state. Again, check local laws.

**Does a Disabled Adult Child (DAC) beneficiary always have a "C" code even if collection under own record as well?**
These letter codes identify the individual receiving benefits. "A" is assigned to the primary claimant (wage earner on own record) and "**C"** is for a child beneficiary.

**Are there any exceptions to 2-year waiting period for Disabled Adult Child (DAC) beneficiaries?**
Before age 65, a beneficiary is eligible for Medicare hospital insurance if he or she:

- Gets Social Security disability benefits and has amyotrophic lateral sclerosis (Lou Gehrig's) disease; or
- Has been a Social Security disability beneficiary for 24 months; or
- Has worked long enough in a federal, state or local government job and meets the requirements of the Social Security disability program.

**Can a Disabled Adult Child (DAC) beneficiary switch to a benefit of higher record without filing a claim?**

A child entitled to child's benefits on the earnings record of a living worker is entitled to a monthly benefit effective with the first month the child meets throughout the entire month, provided the parent or representative filed an application for that month.

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## HEALTH SAFETY NET CLAIMS UPDATE

### Questions from the MTF April 2012 Roundtable Forms:

**The new billing through MMIS for bad debt claims seems very cumbersome. Will we actually be submitting the claim twice or will you be processing the claim with the assigned number? If patient has a bad debt claim in the future, will they be assigned a new number or do we have to keep this number on file?**
For bad debt claims where an MMIS ID is present, providers should code the id on the claim. If an MMIS ID is not present, providers will have to submit the claim twice as the initial submission will be used by the Division/MMIS for assignment of an MMIS ID that will be reported to providers via INET. The assigned MMIS ID should be used for future submissions.

**Is the RA in the same format or changing? Will it pay in the same time frame?**
The Health Safety Net (HSN) Remittance Advice will remain the same (CSV format) and will continue to be downloaded by providers via INET. The HSN payment cycle will also remain the same.

**During the waiting period, how should we submit our claims to MMIS – old claims or new, please advise.**
Providers cannot submit HSN claims to MMIS until July 1, 2012 (at the earliest) or until they are ready to migrate to MMIS (no later than October 1, 2012). New claims (never submitted to the HSN) should be submitted to MMIS as original claims. Old claims (submitted to HSN but not paid) should be submitted to MMIS as original claims. Old claims (submitted to HSN AND paid) should be submitted to MMIS as an adjustment or void.

**Please go over the billing rules for confidential and bad debt HSN claims.**
Providers should refer to the 837I & 837P billing guides (link below) that outline HSN specific requirements pertinent to MMIS claims migration.
http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/hospitals/hsn-claims-information-for-hospitals.html

**Will current appeals process change? Who will review and approve appeals?**
Providers should refer to the 837I & 837P billing guides (link below) that outline HSN specific requirements pertinent to MMIS claims migration.
http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/hospitals/hsn-claims-information-for-hospitals.html

**For appealed claims that are currently approved for payment, will payment occur during interim period? Will this payment be in addition to amount paid according to interim payment methodology?**

Claims submitted for review and approved for payment during the interim period will be paid during the interim period. Payment will be in addition to the interim payment amounts.

**What will be turnaround time for denials and rejections for claims submitted on MMIS? Will we be able to check claim status through MMIS?**
Claim processing and reporting periods will be the same as they are for MassHealth claims submitted to MMIS. Providers should note that Direct Data Entry (DDE) will not be in place for HSN claims processing on July 1, 2012.

**Will HSN remits be set up to post automatically?**
The Health Safety Net (HSN) Remittance Advice will remain the same (CSV format) and will continue to be downloaded by providers via INET.

**Temporary EAEDC fix - any time frame for the issues where it shows Health Safety Net when it shouldn't?**
The HSN is aware of this issue. The timeframe for resolution has not yet been determined.
**Will deductible still be our responsibility to track or will it be automated?**
HSN providers will remain be responsible for tracking HSN deductibles when a patient has no other family members using HSN services, and uses services at only one facility. Patients will remain responsible for tracking their own bills if more than one member of the family is using HSN services, or if patients are using more than one medical facility to receive their care.

**Can community health centers bill Health Safety Net for minimal visits to a non-licensed provider? For example; a pregnancy test and options for counseling by a medical assistant. Currently, we can't bill MassHealth or other insurers for non-licensed providers.**
The HSN follows MassHealth's billing rules regarding provider licensing requirements. A list of providers eligible to bill the HSN for each category of community health center services is available in 114.6 CMR 13.00, the HSN Eligible Services regulation (http://www.mass.gov/eohhs/docs/dhcfp/g/regs/114-6-13.pdf) in section 13.03(4)(c).

**Is Health Safety Net ever going to use a clearing house?**
HSN 837D claims must be submitted via INET and cannot be submitted through a clearinghouse.

**Is the HSN MMIS provider number the same as MMIS I.D., used for MassHealth?**
Providers will be assigned separate provider IDs and service locations to use for their HSN claims.

**I am having trouble with my vendor being able to talk to Health Safety net help desk. Called helpdesk two weeks ago; they took a message and no return phone call.**
If a vendor is not on file with the Division as being affiliated with a provider, the Help Desk cannot provide any information. Providers should contact the Help Desk directly to confirm that required documentation has been provided outlining their relationship with a specific vendor and contacts.

**Isn't my vendor still on file from the original form I sent in years ago?**
Providers should contact the Help Desk directly to confirm that required documentation has been provided outlining their relationship with a specific vendor and contacts.

**If someone recovers a lost hospital bill from a date of service prior to enrollment in Commonwealth Care managed care and they have now enrolled, how far back will the retro HSN eligibility cover?**

When an applicant is determined eligible for Commonwealth Care, HSN eligibility begins 10 days prior to their application date and lasts for up to 90 days after their date of application in order to allow them time to enroll in a managed care plan. If enrollment occurs after the end of this 90-day period, the HSN is also available between the date of managed care enrollment and the date that managed care coverage begins.

**Will acceptance and rejection still be received the same way via internet?**
Providers should refer to the 837I & 837P billing guides (link below) that outline HSN specific requirements pertinent to MMIS claims migration.
http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/hospitals/hsn-claims-information-for-hospitals.html

**Will claims status be available on MMIS?**
Providers should refer to the 837I & 837P billing guides (link below) that outline HSN specific requirements pertinent to MMIS claims migration.
http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/hospitals/hsn-claims-information-for-hospitals.html

**Will payment still be only once a month on internet?**
The Health Safety Net (HSN) Remittance Advice will remain the same (.csv format) and will continue to be downloaded by providers via INET. The HSN payment cycle will also remain the same.

**Billing HSN as a secondary on MMIS?**
Providers should refer to the 837I & 837P billing guides (link below) that outline HSN specific requirements pertinent to MMIS claims migration.
http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/hospitals/hsn-claims-information-for-hospitals.html

**Is there a website, link or list serve tool available for updates or information regarding the HSN policy changes? Transfer to MMIS, etc.**
For HSN claims migration to MMIS, providers should refer to the 837I & 837P billing guides (link below) that outline HSN specific requirements pertinent to MMIS claims migration.
http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/hospitals/hsn-claims-information-for-hospitals.html

**For policy changes, providers should refer to HSN regulations (link below)**
http://www.mass.gov/eohhs/gov/departments/hcf/regulations.html#114_6_13

**Patient has HSN and had dentures done at 2 different facilities. How do we know if HSN has paid in the past? Do you have a system in place to track?**
The HSN is not able to report to providers when a patient has received a service at another facility. Providers should make every effort to ascertain if care has been provided and avoid to bill only for appropriate services.

**If there is a partial with deductible, how do we know if clients have met their deductible?**

If the patient is receiving care at a single site and no other family members are receiving HSN services, that provider should track the patient's deductible for services received at that site. If the patient is receiving care at multiple sites or has multiple family members receiving care, it is the responsibility of the patient to track their own deductible.

**How do you show how much someone's deductible is? Is the client responsible for proof of paid deductible amount?**
The HSN deductible amount will usually appear in EVS. If it does not, providers with a PSI can view the patient's deductible amount in the patient's determination letter in MAP. Providers who are unable to identify a patient's deductible amount may call the HSN Help Desk for assistance at 877-910-2100.
If the patient is receiving care at a single site and no other family members are receiving HSN services, that provider should track the patient's deductible for services received at that site. If the patient is receiving care at multiple sites or has multiple family members receiving care, it is the responsibility of the patient to track their own deductible.

**If we call HSN with an issue with a client, would they be able to help us?**
Yes, the HSN have a dedicated Help Desk to handle claims related to customer support (866-697-6080) and general eligibility questions (877-910-2100).

**What is retro HSN?**
A patient eligible for HSN Primary, HSN Partial, MassHealth Limited, Prenatal, Healthy Start, Buy-In Senior, Buy-in, EAEDC, or CMSP receives retroactive HSN eligibility beginning 6 months prior to the application date. Eligible services provided during the six-month retroactive period may be billed to the HSN.

**What if it's a non-covered procedure? Can we bill HSN? Is it considered contractual?**
If a claim is denied by a primary insurer because it is for a procedure that is not covered by the primary insurer, the claim may be billed to the HSN as long as it is for an HSN eligible service.

**Is "utility" necessary to get claims to pass?**
The HSN does not require a utility in order to get claims to pass. This may be a vendor requirement.

## Questions from the MTF April 2012 Meeting Evaluations:

**My understanding is that we as an organization are going to be issued a HSN PROVIDER ID /SERVICE what method of delivery will this be done?**
MMIS will issue Health Safety Net (HSN) provider ids. Provider ids will be emailed directly to providers by the HSN. Distribution of ids is scheduled for the week of May 21 or May 28. MMIS will copy over providers' security / access setup for these new ids so providers will not have to do this.

**Also on the MMIS there is no choice of anything indicating TEST is that going to be available or would MMIS know according to the ID provided that this is a test claim batch?**
Trading partner testing (TPT) will begin on or about June 20, 2012. The test environment used by providers for MMIS 5010 claims conversion will also be utilized for HSN claims migration. MMIS will be forwarding a link to providers that will connect them with the test system.

**When a patient is approved for Commonwealth Care, but needed to enroll in plan to receive benefits, EVS states benefit for HSN could go back the 90 days. When I called HSN they told me that I could just use the information shown in MAP to demonstrate the patient is eligible for the HSN benefit. Is this true?**

The start date shown in MAP can be used to estimate a patient's eligibility period. When someone is determined eligible for Commonwealth Care, HSN eligibility begins on the start date seen in MAP, and lasts for up to 100 days in order to allow time for the patient to select and enroll in a plan.

**Is there more information available that would help us to comprehend the HSN claims migration process?**

The Division is working collaboratively with the Massachusetts Hospital Association and the Massachusetts League of Community Health Centers regarding the HSN claims migration project. If you are a hospital or community health center provider, you can follow up with your respective provider association or contact the Division at dhcfphelpdesk@state.ma.us. Please note that claims migration only pertains to HSN providers including hospitals, hospital licensed and community health centers.

**I know that HSN coverage is acceptable in the Community Health Centers and services are limited to Specialist Services. I want to know if there is any referral specialist directory that we can use to know what is covered under this assistance.**

The Health Safety Net will pay for eligible services provided under an acute hospital or a community health center's license. The HSN does not require referrals to see specialists, but the HSN only pays for services are billed by a hospital or CHC. There is no directory listing of HSN specialist physicians. An individual hospital or CHC would need to provide information regarding what specialty services they can provide.

**HSN covered code lists for hospitals are available online at:**
http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/hospitals/hsn-claims-information-for-hospitals.html

**The CHC covered code list is available at:**
http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/chcs/payment-information-for-chcs.html

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## VIRTUAL GATEWAY/ELECTRONIC DOCUMENT MANAGEMENT (EDM) UPDATES

### Questions from the MTF April 2012 Roundtable Forms:

**I mail Permission to Share Information forms for all of my clients once a year. Why doesn't Virtual Gateway My Account Page recognize that the PSI is on file? Do I need to send another?**

No; you do not need to send an additional PSI. Rather, please let MassHealth know of an example or two of clients whom the VG does not recognize, and MassHealth will work with you to try to resolve the issue. Specific cases are the best way for MassHealth to attempt to assist you. Thanks for your patience!

**Patients are receiving the annual review to be completed, but there is no record of it having been sent on MAP.**

In order for MassHealth to assist on this question, they will need specific case examples. Feel free to provide those to MassHealth. Without being able to see the specific case on MA21, and see what transpired, it is very difficult to respond. Thanks for your patience!

**Will patients be able to change their own PCC and MD on the Virtual Gateway?**

This is a great idea. MassHealth has taken it back and will be reviewed. Thanks!

**Is it possible to add a field on Virtual Gateway to list the number of pages that were received when document was faxed in when using the correct cover sheet?**

This is a great idea. MassHealth has taken it back. Although we cannot guarantee it will be implemented, it will be reviewed carefully. Thanks!

**Can a physician's office do an enrollment or review for a patient? How time consuming is it and if we don't currently do this, how can we have access to the patient's status? We are a pediatric office and have trouble with newborn status.**

You are likely asking about access to the Virtual Gateway Common Application and My Account Page features. If so, please call the Virtual Gateway Customer Service line at 1-800-421-0938. They will be able to discuss with you options available for your practice and how to gain access to them, if you decide after speaking with them you wish to use those options.

**When faxing documents to MassHealth, please clarify which documents need whose social security number? Also, what if a member does not have a social security number?**

Your question has to do with our discussion at the April MTF sessions about how to make sure documents you mail or fax to MassHealth appear in the new My Account Page section showing all documents sent to MassHealth for a household.

For those documents to display, each document must include the Social Security Number (SSN) that matches the SSN of the household member that the document is about.

If the person does not have a Social Security number, AND the individual is a CURRENT Health program member, the Member's MassHealth ID No., Name and Date of Birth should be indicated instead. Note that this method ONLY applies to current members and not applicants.

So, all mailed or faxed documents need to have the applicable individual's identifying information as noted above on it for it to be shown. For example: If a birth certificate for a spouse were mailed or faxed (alone, with no other documents), it must have the SSN for that spouse on that document for it to be displayed in the MAP list.

**With documents, on MAP we're seeing occasionally in the new documents received section that a document is "processed" but in actuality is not. No determination letter has gone out, no notification date, no eligibility effective dates, etc. In addition, occasionally, we're finding that same situation is happening with a PSI form. It is shown as "processed", but I still can't access MAP.**

As to your first question: For some items received by MassHealth and entered into MA21 (triggering a "processed" in MA21), a determination and notice won't be generated until they do an overnight "cross-match" with certain databases, to verify the accuracy of the information submitted. This helps to maintain the integrity of the information submitted, which is a good thing, but may cause a slight gap between when "processed" pops up on MAP and when MA21 actually updates the eligibility determination results. This only happens for some types of submissions.

Regarding your PSI question, it is likely the following: Although it was entered into MA21 (processed), your Virtual Gateway Organization. No. (NOT your MassHealth provider number – that is something different) was probably, and accidentally, NOT entered into MA21. That number is needed for MAP to get permission from MA21 to show you the case. When you have situations like that please provide a specific situation to MassHealth and they will investigate. Thank you!

**When a patient has been approved for DMH only, does this cover only if the patient is hospitalized in a state facility? Do we have to do a new application in order to get the member upgraded so he/she can be covered for a psychiatric hospitalization in a private hospital?**

Yes - you are correct – "DMH only" coverage only covers DMH services. And yes, to get a person full MassHealth coverage an application would be required.

**If MAP states a patient was just currently terminated from coverage, and the last application date was well over a year ago and it states an Eligibility Review Verification form needs to be sent in, should we do the ERV or a new VG MassHealth application?**

Standard rule of thumb is if the last application date or review date is over one year then a new application is necessary.

**Can members go into MAP and how do they do that?**

Absolutely – we strongly encourage Heads of Households (those who actually signed the original application) who are currently receiving Health or DTA Cash / Food benefits to create a My Account Page account and use it frequently. Please see more information at www.mass.gov/vg/selfservice, and feel free to direct your clients/ patients who meet the two requirements above to that web page! Thanks for your question.

**Can providers complete ERV's on the Gateway?**

The not-so-great news is that currently, that option is not available except for households containing ALL Commonwealth Care members and where there have been minimal changes to the household during the past year. The GOOD news is that with the implementation of the Affordable Care Act in early 2014, there will likely be implemented an online yearly eligibility review tool. Stay tuned on timing and how it would work. Thanks for your patience!

**Can we add changing the date of birth as a change option on the VG?**

This is a great suggestion; I will take this back and review this.

**When the Head of Household is not currently receiving benefits (i.e.: Children have Family Assistance or CommonHealth) can he/she still access My Account Page?**
Unfortunately, for privacy reasons, the Head of Household must be receiving health benefits herself to be able to view household information on the Member-facing My Account Page version.

**Why can't a client access the Virtual Gateway's Member-facing My Account Page feature if he/she doesn't have Social Security number?**
This is required for security / legal reasons – to show that the person trying to gain entry to the Member-facing MAP version is the actual person. It is meant to protect members and MAP users.

**We have had about 4 clients come into our office just to check their MAP's and say that their application was processed at the Chelsea MEC with 24-48 hours. Is there a reason why they were processed immediately and others are waiting over 7 weeks? (Some of these clients did NOT need medical attention or have health issues.**
In order to answer this question, MassHealth would need (and appreciate) specific examples where this has occurred. Knowing the specific situation allows them to check MA21 to see why this was the case.

## Questions from the MTF April 2012 Meeting Evaluations:

**When using the Mail/Fax cover sheet does it automatically assign a bar code number to the top bar code? When I went to print one it did not assign a number to my sheet.**
The new generic mail/fax cover sheet, as well as the automatically generated VG cover sheet, does not automatically generate a brand new code each time you print them out. Instead, there's one dedicated code for the generic sheet, and a different dedicated one for the auto-generated VG sheet - just two possible codes, depending on the sheet you are using.

**It wasn't clear to me in the presentation about whose Social Security number MassHealth wants on verifications in order for them to appear on the new My Account "document received". They mentioned to put the persons SS number that the document is for. I wanted to know if we do that when we do an ERV or VG and are faxing all verifications at one time, OR just when we are faxing verifications after the fact for an application and it is a single VOI for a husband or BC for a child that perhaps was missing at time of submittal of application.**
Your question has to do with our discussion at the April MTF sessions about how to make sure documents you mail or fax to MassHealth appear in the new My Account Page documents received section. For those documents to display, each document must include the Social Security Number (SSN) that matches the SSN of the household member that the document is about. This applies for ANY document you send to MassHealth related to ANY applicant or member.

**On the Virtual Gateway, MassHealth Cover Sheet, There is not a space to fit the name of the organization and the contact information. Why?**
Unfortunately, you are correct. MassHealth is attempting to fix that. For now, try to fit that information on the form. Please write on your organization's name, sender and phone number. This is especially important in situations where you forget to click the VG "Submit" button, but fax MassHealth documents using the VG cover sheet. In that case, MassHealth cannot determine who

sent them to notify you that the application was never submitted. Valuable time can be lost if we cannot contact you / your organization.

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## MASSHEALTH PROVIDER BILLING AND SERVICE

### Questions from the MTF April 2012 Roundtable Forms:

**We are a MH and SA provider with I NPI and multiple sites and we were told to complete an application per site. Another provider also has multiple sites, but 2 NPI and the only had to do two applications based on NPI.**
Providers with specific provider application questions should contact CST directly and ask a provider enrollment specialist for assistance.

**Are all Medicare/MassHealth members' Qualified Medicare beneficiaries? I get RA's for claims that I'm not a contracted provider when MassHealth CommonHealth and Medicare are listed on eligibility.**
Yes

**If the claim is initially filed on paper, can I submit a corrected claim through POSC? Will it deny for field over the time limit?**
If the claim is initially billed on paper, you cannot use the buttons on the POSC claim status response to correct the claim. However, you can use the POSC to enter a new claim. The claim will not deny for being over the filing limit if the original claim was received within 90 days from the date of service. However, there are exceptions and providers should refer to subchapter 5 in their provider manual for the full details.

**On which website(s) can I find provider fee schedules and MassHealth fee schedules?**
This information can be found on the Division of Health Care Finance and Policy (DHCFP) website.

**Since we can submit 90-day waivers through POSC, how do we get to that option?**
Appeals can be sent electronically through DDE on the POSC. Please refer to All Provider Bulletin 220 for submission guidelines.

**When claims deny for manual pricing (drugs), I am attaching the invoice through DDE, and getting a suspend denial with ICN numbers starting with 5800000. Why is this happening? I was told I could submit on paper even though I do not have a paper waiver on file.**
This issue is being researched by the MMIS technical team.

**Since 5010 conversion, none of our secondary claims are going through. We do not have a paper claims waiver; are we going to be penalized for over the filing limit rejections? We also have primary claims that did not go through that denied for over the file we did 90-day waiver on these claims. Will filing be waived due to 5010 conversions issues?**
There is no timing limit waiver for 5010 conversion issues. Providers who are having issues should contact EDI at 1-800-841-2900, option 1, then option 8, then, option 3 for assistance.

**All our high end cardioloite drugs are in suspend and have been there for months. Any info as to why this is happening? Code example (A9500).**
If providers have claims that are in suspense beyond 60 days, they should contact CST.

**Is it possible to allow the system to void just one line, when it actually has 2 or 3 lines attached in the system? When doing a refund for MassHealth, sometimes there are three lines with the same date of service. However, it is only necessary to void just one line. The system only lets you do the entire amount.**
If providers need to void one line on a multiple line claim, they need to replace the claim and only remove the line that needs to be voided.

**For the patients that are receiving PT, OT, and speech on the same day and the claims are not paying due to NCII edits, we have been told to appeal. Can we talk more about what grounds are required to appeal and whether it would have to be billed with a 59 modifier?**
Providers should refer to All Provider Bulletin 225 for NCCI appeal information.

**With the False Claim Act, if we requested voids on paper and these payments were never retracted, should we do them again on DDE?**
DDE can be used to submit void requests.

**Regarding the cross over claims from Medicare; a problem since December. Claims are now past file limit; will MH reprocess these? Not showing up on-line, so we have no way of knowing if we should re-bill or hold off.**
Please refer recent message texts. These claims have been reprocessed.

**Does MassHealth have National Drug Code accepted codes? We are using WECs from vials/invoices, but MassHealth shows invalid NDCs.**
Please refer to NDC Q & A website:
http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/national-drug-code-ndc-requirements-for.html

**Where are the provider fee schedules/MassHealth fee schedules? What website?**
This information can be found on the Division of Health Care Finance and Policy (DHCFP) website.

**How do we find out how to do MassHealth secondary (after commercial insurance or MCR HMOs) electronically?**
Please refer to the Job aids available on the 5010 website: www.mass.gov/masshealth/5010

**How can we return Medicaid payments?**
The claim needs to be voided.

**How do we bill MassHealth Secondary electronically?**
Please refer to the Job aids available on the 5010 website: www.mass.gov/masshealth/5010

**Does the supervising physician need to be in the same building as the PA in order to bill for the PA's services?**
Please refer to Subchapter 4 of the physician manual.

**Is there any chance that more time can be given for fixing enrollment applications? (Now 10 days - ? 30 as other insurances?)**
No.

**When doing a single claim on DDE, only part of my claim is being paid; Ex: Enter visit 99211 or 99213 and I have supply (IVD). They only pay for visit. What I'm doing does not tell me why it is not paying for IVD.**
Please refer to 130 CMR 421.432 (D) in subchapter 4 of the Family Planning Manual.

**For provider credentialing; we have sent a fax requesting the welcome letter to be faxed and it is still not faxed. We have called numerous times. Is there an easier way? How can we get a roster?**
Yes. This information is available through the POSC under Manage Provider Information.

**What is the status of the system "defect" where the system has a problem processing our adjustments? As explained to us by MassHealth, it processes our attachment and stores it but it does not successfully create an adjusted claim. We receive a "bogus" ICN# that can no longer be found. This seems to occur with claims denied for 5927 NNCI conflict.**
This issue is being researched by the MMIS technical team.

**Is there a confirmed backlog for appeals processing? We have claims appealed to the NCCI address in November and December that have still not been adjudicated. When will the backlog be caught up?**
Providers that have inquiries regarding claims sent prior to January 1, 2012 can send a request to the address listed in All Provider Bulletin 209.

**Can you confirm that there is a 30 day time limit for appealing NCCI denials (5927)? I have received different responses from different people at MassHealth.**
All Provider Bulletin 209 states that "A provider must file its request for MassHealth agency review, accompanied by all supporting documentation, within 30 days of the date on the remittance advice on which the claim denial appears".

**We have recently gotten letters from MassHealth concerning an audit on adult day health. MassHealth is trying to take back money for transportations provided, paid out to 3rd party companies for days that have been denied for Hospital Preparedness Program (HPP) services. How do we get paid for these HPP services as well as keep from being penalized by taking the money for the transportation?**
Please refer to the contact person listed on the audit letter.

**When an individual provider completes section 2&3 of the medical necessity form and group is billing under group practice instead of individual provider, claims are being denied because we are not billing under individual provider even though provider is linked to our practice.**
Providers with specific claim denial issues should contact CST directly for assistance.

**Resubmit claim – We were given a suspend ICN# starting with 581 but it is not showing up in the system after having been assigned. Per Customer Service, MassHealth is aware of the issue. Why haven't providers been sent notification indicating there was an issue and that they were aware of it?**

This issue is being researched by the MMIS technical team. We will refer notification request to EOHHS.

**Claims are denied for invoice attachment. Attachments are not suspending? Why? Taxonomy is pulling on billing information.**
If the claim that requires an invoice is not suspending then the provider needs to confirm that they are clicking on the "Add/Upload" button to complete the attachment.

**We provide adult day health services. We have one client that needs transportation billing for MassHealth. I don't know how to enter the transportation in to the NewMMIS. Do I need addresses to and from?**
Adult Day Health providers do not need to fill out the address to and from fields.

## Questions from the April 2012 Meeting Evaluations:

**I am having an issue with claims (2009) that were processed under the old Medicaid claims system and were converted to the new MMIS system. In this transaction, the claims were reprocessed and the original payment was retracted due to a "known bug" system issue (No Revenue Code). I had been working with Maribel in Outreach since 2010, but since December 2011, my voice mail messages have not been responded to. I again reached out to Provider Services who responded that I would be contacted by Outreach; I have received no further follow up. Who can we contact to get assistance with this issue? Provider Services and Outreach have not been responsive in resolving this issue. Any guidance you could provide would be greatly appreciated.**
Please contact CST and have your issue escalated to the research person that was assisting you.

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