Massachusetts Health Care Training Forum
January 2013 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. The Questions and Answers are provided within this document.

**** Please Be Advised – The answers to these questions speak in general terms and are not intended to be case specific****

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

MTF Questions and Answers
MassHealth Updates
Virtual Gateway Updates
Health Safety Net
Community Health Network Areas (CHNAs)
ACA and Exchange Learning Series
MassHealth Billing and Provider Services

MASSHEALTH UPDATES

Questions from the MTF January 2013 Roundtable Forms:

Are faxes received after 5pm processed? We heard they are not if it is after 5pm or on Saturday.
They are received in the office but not processed until an enrollment worker is present and can work on them.

Can a full time student get any help from MassHealth? Paying $2500.00 is a lot of money for them?
If a Full Time college student is not eligible for MassHealth they can get insurance through their college and if eligible also receive the HSN.

Can the eligibility review form, when completed, be brought to a financial counselor at a hospital to be submitted through the Virtual Gateway or do they have to be mailed?
Right now the review form must be mailed. The new Health Insurance Exchange Integrated Eligibility System will include functionality to do online renewals.

Does the list give codes and prices? How is the prices broken down, is it one whole fee for the visit or broken down by codes?
Coding and fees can be found by contacting provider support at 1-800-841-2900.

Does MassHealth process applications in the order they were received or do they just go by whatever order work for them? I've seen a few applications that were submitted much later than some but got approved before the ones submitted first.
In general applications are processed in the order received. Some applications are prioritized due to pregnancy or other medically needy reasons.

Duals; what is the "readiness review?"
Review of ICO's to make sure they can handle the population and have network adequacy.

Does CommonHealth have a lifetime cap on any services? How does this cap affect schools utilizing MassHealth?
Covered services can be found by contacting provider support at 1-800-841-2900.

Eligibility responses from MassHealth are received in English when application was filled out in Spanish. Spanish was also selected as primary language. Has happened several times. Why?
There a language indicators on the application forms. If Spanish was checked as the primary language then the notice will go out in that language. The member should be sure to check the correct indicator on the form. A member can always call customer service to update their case with this information.

For those who recently applied and were denied because their income was slightly over 300% FPL, will these applications be reprocessed after the new FPL takes effect in March? Do we need to resubmit new paperwork, or complete ERV?
MassHealth will not automatically reprocess recently denied applications; however the applicant does not have to do a new application or an ERV if the application was filed in the last 12 months. The member can contact MassHealth and have their case recalculated.

How does MassHealth assist homeless individuals with no address? What addresses are acceptable to use?
Addresses such as shelters, a relative's address, are examples of acceptable addresses MH uses.

How do I gain access and training for the Community Health Center (CHC) staff?
There are different trainings available. Request forms can be found at the MTF website http://www.masshealthmtf.org/

How do we set up training for MassHealth applications for both over and under 65?
If you are looking to access the Virtual Gateway you can call the Helpdesk at 1-800-421-0938 or a formal presentation can be accessed by going to the MTF website at http://www.masshealthmtf.org/ and complete the request for training.

How will the home and community based waiver, frail elder and spousal programs be impacted by HCR-ACA?
Generally the ACA impacts the health care reform population which does not include the above listed traditional populations. If however there is any change to the above population there will be program updates given at future MTF'S.

How will federal health reform/Affordable Care Act impact the dual eligible initiative?
The Affordable Care Act created the Medicare Medicaid Coordination Office (MMCO) within the Centers for Medicare and Medicaid Services (CMS). MMCO is Massachusetts's federal government partner in the dual eligible initiative

If an ERV is completed and the member has no legal status but provides a SSN, how do you determine eligibility? Do you consider this a fraud? What do you suggest for us to take as a next step?
If fraud is suspected then a call or referral can be made to the MassHealth program integrity unit.

I have not been on the website for behavioral (confidential) health codes, but do they cover contraceptive methods?
Covered services can be found by contacting provider support at 1-800-841-2900.

Is an enrollment in an ICO mandatory?
No. Enrollment in the Demonstration will be conducted through a voluntary, opt-out process. Individuals may choose whether to participate in the Demonstration and may choose a different ICO or opt out at any time. Changes in enrollment will always become effective on the first day of the following month.

Is MassHealth available for children whose parents receive MSP?
The Medical Security Plan should provide family coverage but if it is not available then the family may apply for MassHealth.

Is there an email contact for SC-1 Coding issues or questions?
No, sorry there is not one Central location for the processing of SC-1 coding. You must call the general Customer Service line 1-800-841-2900.

Local Veterans' agents are often giving families inaccurate information regarding MassHealth; can some outreach be done with the Veterans' agents?

We are currently working with the VA with hopes of coordinating the information. We are encouraging Veteran's agents to have folks call MH if they don't know the answer.

MassHealth eligibility has changed. Too many are now listing standard plus waiver. These are not in provider manual so what are they?
MassHealth Standard as the Waiver is an eligibility factor that allows an otherwise denied applicant to obtain MassHealth benefits.

On Notice of Birth form (NOB), if check PCC block, the gender block information disappears: why?
Thank you for raising this. We are looking into this at this time.

Patient has MassHealth standard with an assigned PCC but refuses o make an appointment with assigned PCC. We are a specialist clinic; what options exist to enable follow case? Insurance changed from commercial to MassHealth (no PCC) to MassHealth (with assigned PCC).
If a member does not like that particular physician then they do have the option of changing their primary care doctor at any time by calling 1-800-841-2900.

Patient is 18 years old, totally disabled, in a group home with severe autism; has medical benefits through parents with higher income e ; can he apply for MassHealth once he turns 19 to cover his prescriptions, co pays and deductibles?
Absolutely, at 19 a person may apply as their own entity for MassHealth.

Patients with Premium Assistance have Health Plan turned i.e. BC/BS. Have sent termination, information patient still in Premium Assistance (can be for months). What can a provider do for update?
Contact the Premium Assistance unit directly at 1-800-862-4840.

Regarding retro coverage, how far back does it go?
MassHealth under 65 generally gives 10 days of retroactive coverage with some exceptions. MassHealth over 65 can give up to 90 days of retroactive coverage. Complete policy rules can be found at www.mass.gov/masshealth.

TPL not updated in a timely manner
Contact the TPL unit directly at 1-888-628-7526 option #5.

Under the Integrated Care Organizations (ICO's) what happens to the clients' Medicare Part D plan (prescription drug plan)?
ICO will become the Part D plan and the services will be absorbed by the ICO as well as Medicare Parts A and B.

What will happen to existing Prior Authorizations when the Integrated Care Organizations (ICO's) implements?
There will be a 90 day window by which the new ICO will honor the existing PA the same way it has been handled and after the 90 day period the ICO will establish a new Care Plan with the member.

We are having difficulty finding primary care physicians that take MassHealth and are taking new clients. The list we have received from MassHealth has not been of any help. Do you have any suggestions?
The provider list is constantly changing. Please contact customer service for assistance.

We refer outpatients for dental procedures, many not covered by HSN or MassHealth. For patients with HSN primary, how does HSN cover patients at Non-CHC's? Can BU dental Tufts School bill HSN for dental services?
There are complete CHC listings that take HSN for dental service. They can be found at the www.mass.gov/chia website.

With the addition of questions Veterans' benefits will all CSR who may quality for veterans' health be needed for standard on FEW? Is there going to be any information to help elders in this transition?
MassHealth is working closing with the Veteran's Administration to achieve a data matching process which should help Veteran's and their dependents utilize available Veteran's benefits. As we get closer to finalizing the data matching process we will give updates.

When an applicant is unable to get health insurance from employer due to not working enough hours, although the company does offer insurance, when answering "Does company offer health insurance"; should I answer yes, or no?
The answer should be yes. The exceptions process will determine if the health insurance is available.

When will there be standardization around residency issues?
MassHealth regulations spell it out clearly:
503.002: Residence Requirements
As a condition of eligibility, an applicant or member must live in the Commonwealth with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence of fixed address.

What progress has been made to streamline transition from Skilled Nursing Facility (SNF) to HCBW MassHealth eligibility? Especially with the state's push to get people out of SNF's and back into the community?
Money Follows the Person is the program that is addressing the above question and issues. As program information becomes available program updates will be given.

Why does MassHealth send MCO enrollment notices to members who have a primary insurance in place?
A member does not have to enroll into MassHealth Managed Care if they have their own primary health insurance. This information is sent so the member is aware of choices available.

When a nursing home resident comes in with MassHealth and needs coverage after 20 days for Medicare Part A co insurance, the SC1 that I send in gets returned with a MassHealth application. Why?

An application is mailed when it is necessary to complete the proper enrollment into either long term care or community MassHealth. If you have specific questions call 1-888-665-9993 and they can assist you.

What phone number can we call to go directly to a Spanish speaking representative? We dial 2 for Spanish and always get English.
1-888-665-9993 and request an interpreter.

Which documents are absolutely needed for a review?
If a member has reported changes all along within 10 days, then they may need to only submit updated financial information such as pay stubs, income, or assets if over 65. If information is still needed, they will get a letter requesting it.

Why are so many copies of letters with the same information being mailed to facilities, members, and responsible parties?
When an action is taken on a case, the system sends out a letter of the change in eligibility. A copy of this letter is sent to everyone who has appropriate HIPAA forms on file as a contact on the case.

When MassHealth is needed for Medicare type A Co-Insurance and SC1 is sent in, they are returned for application.
This is a difficult question to answer without follow up information. To answer this question correctly it would have to be specific to the case.

When a member joins an Integrated Care Organization (ICO), what happens to their existing services and prior authorizations?
For the first 90 days, or until the ICO has completed a full assessment of the member's needs and worked with the member to develop a care plan, the ICO is required to cover the member's current services, including honoring any prior authorizations. Through the assessment and care planning process, the member will have opportunities to discuss his or her needs with the ICO and be involved in creating a care plan. The member is the center of the care planning process, and each care plan must reflect the enrollee's preferences and needs. If care planning process results in a change being made to the enrollee's current course of treatment, the ICO must provide written notice of those changes – and an opportunity to appeal the proposed modifications – no fewer than 10 days prior to implementation of the new care plan.

What providers will be available under ICOs? Will all ICOs have the same providers in their network, or will provider networks differ from one ICO to another?
All ICOs are required to contract with a broad range of medical, behavioral health, and long-term services and supports providers so that enrollees have adequate choices. But the individual providers that participate with each ICO may differ from one ICO to another. ICOs are being encouraged to contract with providers that are currently providing services to members eligible for the Demonstration.

Under the Integrated Care Organizations (ICOs), what happens to the client's Medicare Part D plan (prescription drug plan)?
A person who enrolls in an ICO will have their Medicare Part D drug coverage provided by the ICO. The person will no longer have a separate Part D plan.

Questions from the MTF January 2013 Evaluation

If a patient is unable to send their re-enrollment application in before the day its due on, how much longer does their application take to be processed? Are there special cases where the time it takes to hear back on eligibility could be changed depending on the person's case? I've had individuals that stated they've waited up to 3 months to hear back from MassHealth. Also, are these individuals covered by HSN at all till their eligibility status is confirmed for health insurance?
Reviews should always try to be done timely to avoid this situation but if it is done and an emergency arises then a call to MH Customer Service designating that there is an emergency can expedite the determination.

What is the difference between the one time PSI request and Long term PSI request to access the MAP page? Do we need to have the patient sign the one time PSI request?
Long term gives you a set timeframe, example: if you are working with someone and will be monitoring them for 2 years, let's say: you can designate the timeframe for 2years after which you will be taken off and not receive any more correspondence from MassHealth. One time is one time and can be tedious. PSI's should be signed.

What progress is being made to streamline MassHealth enrollees in SNFs to the HCBW to return them to the community? They need the Waiver to cover services to enable them to return to the community but MassHealth requires them to be in the community to be eligible for the Waiver. Do you see the problem here?
If the Doctor can give a letter for the Member to return to the community with proper services in place and a discharge date then the member or their representative should have them screened by the ASAP and get the letter and the screening with the discharge date to MassHealth this situation should be avoided.

VIRTUAL GATEWAY UPDATES

Questions from the MTF January 2013 Roundtable Forms:

Getting employee on Virtual Gateway, I have emailed 2 times to Virtual Gateway and have gotten no response.
Try calling the VG Customer Service Helpdesk at 1-800-421-0938; TTY: 617-847-6578

Will we be able to see PT-1 forms that have been faxed on MAP? Will we be able to determine the status?
Call automated line for status update.

Has there been any progress finding a solution for providers to use MAP to assist their clients? For example, the clients my organization serves are for the most part homebound.

The PSI process requirement does not support easy access to Virtual Gateway to determine documents needed.
Currently the PSI process in effect is the one MH is using but it is under advisement.

I work for a different organization (SDC). How can I get a new Virtual Gateway Account with new organization?
Call the Virtual Gateway Customer Service Helpdesk at 1-800-421-0938; TTY: 1-617-847-6578

When an applicant is unable to get health insurance from employer due to not working enough hours, although the company does offer insurance, when answering "Does company offer health insurance"; should I answer yes, or no?
You should answer yes as the MH Premium Assistance Unit may be able to help the person obtain the ESI and potentially pay part or the entire premium.

HEALTH SAFETY NET UPDATES

Questions from the MTF January 2013 Roundtable Forms:

Are confidential applications different for Community Health Center than hospitals? Is payment different?
The application process is the same for CHCs and Hospitals. Payments for services provided to confidential members follow the rules as payments for services provided to other HSN members. For HSN payment information, please refer to the regulation governing Health Safety Net Payments and Funding (114.6 CMR 14.00) located at http://www.mass.gov/eohhs/gov/laws-regs/hhs/regs.html

Are there new denials and edits for the new HSNO Billing or are we going by the old edits?
The HSN 837I & 837P billing guides outline HSN specific requirements and edits.

Can HSN have more accurate/detailed information in the new system online? Clients need information at hand to know what's covered and what's not.
The HSN is working with MassHealth and the Connector to provide the best possible information under the new system.

Does a member need to have enrolled in a Commonwealth Care before HSN can pay for dental or medical services? If so, why is it that HSN which is available being denied because primary payer not billed first?
A patient determined eligible for Commonwealth Care receives 10 days of retroactive HSN eligibility and 90 days of HSN eligibility going forward from the date of application. If they enroll after the 90th day they will have HSN eligibility from the date of enrollment until coverage begins. If they are in one of these periods of HSN eligibility the HSN can be billed as the primary payer for eligible dental and medical services received at a Massachusetts acute hospital or community health center. Once the patient's Commonwealth Care coverage begins, eligible dental services not covered by the patients Commonwealth Care plan may be billed to the HSN without first billing Commonwealth Care plan. If you have questions about a denial please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us

Does Health Safety Net cover smoking cessation counseling?
The Health Safety Net Office will pay for smoking and tobacco use cessation counseling visit billed using code 99407 when the service is provided at a Massachusetts acute hospital or community health center. Eligible providers are physician, independent nurse practitioner, and independent nurse midwife.

Does Health Safety Net meet the requirements for Health Care Reform?
HSN is not an insurance program, and is not considered Minimum Creditable Coverage or Minimum Essential Coverage for tax purposes.

How do we know what items can be billed with 99 procedure codes? We have an item called Dynamic Realignment Orthosis and would like to know if it can be billed with a 99 code as it has no procedure code assigned to it. :
If there is a procedure that a provider is performing and there is no specific code for it, the 99 (unlisted code) from that family of codes would be billed and documentation should be sent to support that procedure. All Unlisted codes are suspended and reviewed for pricing.

How do we match HSN validation reports to files we submitted to MMIS?
The beginning of the HSN validation reports share the same naming convention as files submitted to MMIS.

How often should we expect payments from Health Safety Net?
The HSN processes payments on a monthly basis. The HSN payment schedule has not changed as a result of claims migration to MMIS.

HSN will cover co-pay, deductible and co-insurance for MCR member but will they cover the same if someone has BC 65? Does coverage go back 60 days retro from the time we submitted the application?
Yes, the HSN will pay for co-pays, deductibles, and coinsurance for individuals who are Medicare-eligible, regardless of the plan they are enrolled in. If the patient is eligible for HSN-only, Buy-In, or Senior Buy-In, they will receive six months of retroactive eligibility.

I don't see the 2013 BH codes on the HSN covered list; are these accepted for DOS's 1/1/13 and beyond?
Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us and provide specific examples regarding codes in question.

If a minor's under their parents MassHealth benefits, what is the impact when they apply for HSN under confidential?
If a minor who is eligible for MassHealth is determined eligible for HSN confidential, their MassHealth eligibility is not impacted. Services related to family planning and sexually transmitted diseases may be billed directly to the HSN.

If Commonwealth Care member enrolled on day 94, when would HSN retro start?

A patient who is eligible for Commonwealth Care does receives 10 days of retroactive eligibility before their date of application, and 90 days of HSN eligibility after their date of application. If they pass the 90 days, they lose their HSN eligibility. If they enroll in managed care at a later date, services provided during the 43-day period before their managed care coverage begins may also be billed to the HSN.

If patient has Medicare part A only, but the patient came in under part B service, do we need to bill MCR first and bill HSN second or do we bill as primary?
HSN is a secondary payer to Medicare so the Medicare should be billed prior to billing the HSN, even if the service is under non-covered part B.

In 2014 with ACA, what will HSN cover?
The HSN will continue to operate and serve low-income patients throughout the implementation of the ACA. As specific policy becomes clear we will continue to bring this information to providers and advocates.

Is the REF 2U segment required to indicate primary payer ID on secondary claims on HSNP files?
Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us and provide specific examples regarding claim loops/segments in question.

Need information on collecting bad debt re: Confidential
Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

Newborn, eligible mom doesn't finish app. what is cut-off to get HSN retro?
The HSN retro period depends on the program the patient is determined into. Patients with HSN only, MassHealth Limited, EAEDC, Prenatal, Healthy Start, CMSP, Buy-In, Senior Buy-In, and Family Assistance/Premium Assistance receive 6 months of retroactive HSN eligibility before their application date. For patients determined eligible for Commonwealth Care, MassHealth Basic, and MassHealth Essential, HSN is available starting 10 days before the date of application. Patients determined eligible for all other MassHealth programs (Standard, CommonHealth, and Family Assistance/Direct Coverage) receive 10 days of retroactive eligibility from MassHealth, and are not eligible for HSN retro.

"Not eligible but has retro HSN available". What does that mean?
For a patient who is determined into either HSN primary or HSN as secondary to: private insurance, Medicare, MassHealth Limited, EAEDC, Prenatal, Healthy Start, CMSP, MH Buy-In, and Family Assistance/Premium Assistance, the patient will receive 6 months of retroactive HSN eligibility, retroactive to the application date. During this 6-month period EVS displays an eligibility status of "Member not Eligible," but a restrictive message will indicate that HSN retro is available. EVS users must click on the date range next to the eligibility status in order to see the restrictive message.

Outliers; can we bill HSN after a primary insurance pays? Example: BMC, Network.
Providers should refer to the HSN billing update regarding the billing of outlier days. The update is located on the HSN website at http://www.mass.gov/chia/provider/client-eligibility/health-

safety-net/providers/hospitals/billing-updates.html. Additional questions should be forwarded to the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

Since HSN is part of MassHealth now, would we get an actual EOB from now on?
HSN administration is now structurally part of MassHealth and EOHHS, however the HSN continues as a non-Medicaid entity. HSN is not an insurance program and patients will not receive an EOB.

Since HSN medical claims are currently only getting processed by MassHealth edits, how are we to accurately work denials when the same claim may not get processed the same way by HSN?
The HSN processes different edits as part of its claims adjudication. For MMIS edits, providers should refer to their MMIS 835s & RAs. These reports are available on the POSC. HSN edits are reported via the HSN validation report that can downloaded from INET.

The interim payments, do they have the patient's name?
HSN interim payments which have taken place during the transition to MMIS have been based on historical claims volume rather than submitted claims.

When is HSN going to update the eligibility system and stop erroneous – Not eligible denials?
As part of the claim denial review process, the HSN reviews its eligibility logic on an ongoing basis.

When would the time frame be to start billing Health Safety Net Secondary?
Providers can bill HSN Secondary claims to MMIS at any time. Providers must comply with MMIS billing requirements in submitting HSN Secondary claims.

Why are dental retractions going back more than 6 months from the dates of service? Why are we receiving denial or retraction messages on remits that we can't find a clear explanation of on the CHIA website or MMIS website?
The HSN cannot address this question without reviewing specific claim examples. Providers should contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

Why doesn't HSN just create an appeals form instead of having each facility create their own?
The billing update of August 24, 2012 outlines the general format and process that all providers should follow regarding the submission of claim denial reviews.

Why are EAEDC temporary eligibility accounts all getting denied HSN?
The HSN pays for services for EAEDC members only when the EAEDC eligibility is non-temporary. If EVS indicates that the member's eligibility is temporary, the HSN will not pay for their services. Please review the HSN Claim Update from January 24, 2011 regarding EAEDC eligibility. Claim updates are located at http://www.mass.gov/chia/provider/client-eligibility/health-safety-net/providers/hospitals/billing-updates.html (Hospitals) and http://www.mass.gov/chia/provider/client-eligibility/health-safety-net/providers/chcs/hsn-claims-information-for-chcs-.html (Community Health Centers)

Why is it the responsibility of the hospitals to keep track of partial deductibles? It is very difficult for us to keep track of each member's deductible especially if the member is treated at a different hospital.
The HSN claims system is not currently equipped to track deductibles. However, patients who are treated by multiple providers are responsible for tracking their own deductibles and for demonstrating to each provider that when have met their HSN deductible. Providers are not expected to keep track of expenses incurred at other locations.

Will claims status be available on MMIS website to work denials?
DDE functionality for HSN claims processing is not available at this time. Functionality is scheduled to be reviewed during the next phase of HSN claims migration; however, a timeline has not been determined at this time.

Will HSN now be paying for codes that MassHealth pays that HSN did not previously pay? (IE: codes 90658 and 59025)
The HSN pays for services which are covered under MassHealth standard. If new codes are added to MassHealth standard coverage then the HSN will pay for these as well, when the services are provided and billed by a Massachusetts acute hospital or community health center. 90658 will be added, and 59025 is already an eligible service.

Will remittance advice change from INET to MMIS?
Claims and Remittance Advices from MMMIS should only be used for identification and correction of claim errors. Do not use these RAs for posting payment. HSN reports will remain in the same format and must continue to be downloaded from INET.

When will the HSN remits provided by MassHealth reflect Health Safety Net payment?
HSN continues to work with MassHealth and the MMIS system to create a more efficient process. We will provide updates on timelines to providers and advocates as they become available.
Will we be able to get training for hardship application?
In our online provider FAQ's we have details on the Medical Hardship process and application (http://www.mass.gov/chia/docs/p/hsn/provider-faq-hsn.pdf, section 3.4 Medical Hardship). If providers have questions regarding the use of this application through INET, contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

When billing an adjustment for a HSNP claim that has processed via an MMIS remit, do we use resubmission code 7 and the MMIS ICN#?
Providers should contact the CST at (800) 841-2900 or ProviderSupport@mahealth.net.

Questions from the MTF January 2013 Meeting Evaluations

I would like to learn more about the HSN program and how calculations are made especially when deductible is involved. Real examples would be beneficial.
For Health Safety Net - Partial patients with Family Income between 201% and 400% of the FPL, there is an annual Deductible equal to 40% of the difference between the applicant's Family Income

and 201% of the FPL. At hospitals, patients must incur expenses in excess of the deductible amount before the provider may submit claims for the patient services. At CHCs, patients are responsible for 20% of the payment amount for their services until they meet the deductible amount. **Example:** Assuming FPL for an individual in 2013 is $11,490
An individual patient with no family is determined eligible for HSN Partial with an income of 300% FPL, $34,470. The deductible is equal to 40% of the difference between their income and 201% of the FPL, $23,094.90, so the deductible would be equal to $4,550.04.

For Health Safety Net patients that have filled out an application for MassHealth, can we send a bill for Home Health Care to HSN even if is not a covered service or should we be just sending our claims to MassHealth?
HSN does not pay for Home Health Care services. These services cannot be billed to the HSN.

COMMUNITY HEALTH AREA NETWORKS (CHNAS)

Questions from the MTF January 2013 Roundtable Forms:

Explain how CHNA money is distributed (CHNA 16)?
When a hospital files for certain types of Determination of Need (DoN), they are required to distribute funding to the community for Community Health Initiatives (CHI). CHNAs, in addition to other partners work with the Office of Healthy Communities and the applicant to determine how the money is allocated. In some cases CHNAs receive the funding and they then distribute the funding through mini grants based on identified need and community priorities. Attached are the DoN Policies and Procedures (P&P) which detail the process.

How does your program benefit our organizations?
It enables greater partnership between DPH, health service providers and consumers, local ownership of community health problems and investment in their solutions, prevention and primary care based model of public health services, increased access to care and networking, increased partnership and collaboration among agencies, results oriented and community-based health status data becomes the focus and thus enabling efficiency and effectiveness in providing services to the consumers. Health planning grants to local organizations, project implementation and mini-grants available to partners of CHNA.

Why do each CHNA get different amount of dollars from Don?
Each DoN has a different Maximum Capital Expenditure (MCE) based on the cost of the particular project. Allocation to the community through CHNAs is 5% of that MCE. (see P&P), so the MCE amount determine the required contribution. These amounts are usually allocated over five years.
Example: MRI has a MCE of $2,000,000; the CHI would be $100,000 in total and distributed at $20,000 per year for five years.

Where and when are CHNA meetings held in the Southeast Region?
For a list of Community Health Network Areas (CHNAs) meeting(s) dates, times, locations, and contacts, please click on the link below.
http://healthimperatives.org/schc/community-health-network-areas-chna

What does the program do?
CHNA is committed to continuous improvement of health status focused on tracking area health status indicators and eliminating identified disparities. It is user friendly and consumer oriented. It's a mechanism to develop local solutions to local problems.

What is CHNA?
A Community Health Network Area, CHNA, is a local coalition of public, non-profit, and private sectors working together to build healthier communities in Massachusetts through community-based prevention planning and health promotion.

ACA & Exchange Learning Series

Questions from the MTF January 2013 Roundtable Forms:

How will current members be determined for eligibility for the ACA? Do they need to re-apply or will they be automatically transitioned in some way?
Transition planning is currently underway and will be shared through MTF when finalized. The goal is to make transition as seamless as possible for members.

How much money will MA save with ACA in place?
New federal commitments will save Massachusetts approximately $5 billion between 2014 and 2020.

How should we navigate insurance from other states that don't meet guidelines in Massachusetts?
Question: Part 1:
If a MA resident works in the MA office of an out-of-state/international company that provides health insurance that does not does not meet Mass. Minimum Creditable Coverage (MCC), is the employee subject to a penalty under the state's individual mandate today?

Yes, they could be. Massachusetts residents must be covered by insurance that meets Mass. Minimum Creditable Coverage (MCC) in order to fulfill the individual mandate and avoid a penalty. If the person has non-MCC compliant coverage, he/she could be liable for a penalty, unless he/she is exempt for reasons of affordability or hardship. (An official determination of affordability and any applicable penalty occurs at the time a person files his/her state income taxes.)

An out-of-state/international employer, however, can seek certification of its insurance plan(s) as MCC compliant, even though the insurance plan might not meet all the specific MCC regulations. For instance, plans that offer coverage that roughly approximates the benefits of MCC could

apply for certification. An employee covered by a health insurance plan certified by the Health Connector would meet his/her individual mandate requirement.

Question: Part 2:
If the Commonwealth retains the individual mandate as proposed and a MA residents works in the MA office of out-of-state/international company that offers health insurance that satisfies federal requirements, under the Affordable Care Act, but does not meet the Mass. MCC requirements, will the employee be subject to a penalty under the state's individual mandate?

Yes, they could be. A MA resident working in the MA office of an out-of-state/international company that provides insurance that meets federal ACA requirements, but not MCC requirements, will be subject to the Mass. individual mandate and could be subject to a penalty.

An out-of-state/international employer, however, will be able to seek certification of its insurance plan(s) as MCC compliant, even though the insurance plan might not meet all the specific MCC regulations. For instance, plans that offer coverage that roughly approximates the benefits of MCC could apply for certification. An employee covered by a health insurance plan certified by the Health Connector would meet his/her individual mandate requirement.

Questions from the MTF January 2013 Meeting Evaluations

I'd like more details on how the ACA differs from what we already have in Mass.
The Health Connector website includes a webpage called "Health Care Reform: Planning for national reform". This webpage includes FAQs and ppt. presentations with lots of details on how things will change under ACA. Weblink below:
https://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_viewID=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_docName=Exchange_Planning_content.htm&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_folderPath=/Health%20Care%20Reform/Exchange%20Planning/&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=com.vignette.cachetoken

Will those individuals who receive Medicare only have to reapply for plans using the HIX/IES
No.

MASSHEALTH PROVIDER BILLING AND SERVICES

Questions from the MTF January 2013 Roundtable Forms:

90 day waivers – MassHealth denies for timely filing due to the time frame from when the eligibility was checked and the time the bill was filed. There are multiple checks and should not go against the filing status because they can track the status check.

Initial claims must be received by MassHealth within 90 days of the service date unless there was retroactive coverage for the member. If that is the case, a 90 day waiver must be submitted with the appropriate documentation to support the request.

Acute hospital outpatients ER visit; arrives the 8th at 8pm and leaves the 9th at 10am. Regulations say to populate field #6 with start and end date. Should cell chares be on UB or 2 UB's?
Per the MassHealth Billing guide, providers must use a separate claim form for each date of service.

Do crossover claims need shoe forms and do shoe forms have an expiration date?
Crossovers do not require a shoe form.

Does MassHealth have advanced practice professionals billing guidelines/policies? For ex; can we use modifier SA?
Providers need to refer Subchapter 6 of their provider manual and subsequent bulletins and transmittal letters.

Early intervention codes T1015 have been denying for billed over allowed amount. Providers have been notified that these claims will be reprocessed by MassHealth, and to do nothing. To date, my claims are still not paid. Has payment started on these yet?
According to December 11, 2012 message text MassHealth will systematically reprocess previously adjudicated claims for T1015 denied due to edit 5930 on future remittance advices. No action is required on the part of the provider.

For ambulance/wheelchair billing on DDE: how many trips can we combine for ambulance billing? How many can we combine for wheelchair billing? I noticed if we combine wheelchair tips, only one trip paid other denied for duplicate.
For ambulance/wheelchair billing, please refer to Subchapter 6 of the MassHealth Transportation manual.

How are referrals working for MassHealth managed care members? Referral numbers are not being accepted by the portal and when the referral is not submitted the claim is denied. How should these be handled?
There are no known MMIS issues with PCC referrals. Providers with specific issues concerning claims with referral numbers should contact MassHealth Customer Service directly at 800-841-2900.

How far can MassHealth go back and recoup payment?
There is no specified timeframe for recoupments.

I am having difficulties with the MassHealth shoe form and hoping someone can go over this with me
The Shoe prescription form is on the MassHealth website and includes instructions on the second page. If you have additional questions, please contact MassHealth Customer Service at 800-841-2900.

MCR – MCD crossover – MCR uses 90827-IND-MH (Mental Health) 60 minute therapy. MCD does not use 90837 for MH but does use the H0004 for SA – How would that crossover?
Medicare Crossover payments for codes not covered by MassHealth will process in the same manner as they have in the past. There has been no change in the policy. If a procedure code is not covered by MassHealth, we will not make an additional payment. If the member is a QMB, MassHealth will pay the Medicare co-insurance and/or deductible for the member.

Member POSC eligibility states "standard plus frail elders HCBS waiver" and I'm didn't get paid for DME claims –
The Provider needs to contact CST to verify the member's coverage.

Once a claim has denied for no prior authorization, can retro authorization be obtained if a valid referral is in place? Is there a retroactive authorization appeal process? If so, where could we find it?
The Prior Authorization (PA) and the referral (PCC referral) are two separate processes. For PA, providers need to submit a PA request, please refer to 130 CMR 450.303 for additional information regarding Prior Authorizations requirements.

Starting in 2013, will MassHealth cover CPT vaccine administration codes 90460, etc. if billed on same DOS as on E&M code?
Yes, please refer to MassHealth All Provider Bulletin 230 December 2012.

We are opening a PCC – very new to us. We need to complete a MassHealth application when we have all needed paperwork. This will be a PCC application correct?
We can't link the nurses and doctors to HCTC yet because we don't have an account number correct? The nurse called customer service and was told he should have already had his number linked to HPTC? How if we don't have a PCC number?
All providers must first enroll with MassHealth as a Fee for Service (FFS) provider. Then you may be enrolled as a Primary Care Clinician (PCC) provider. There is a separate application for FFS and PCC. Both applications may be submitted at the same time. Practitioners cannot be linked to the group until it is enrolled.

We have started administering Edinburg Screenings on "Moms" of newborn patients. We are a Pediatrics facility, industry standard suggests utilizing 99420. It is being recognized by many carriers. Code 99420 appears in MassHealth's non-payable code list. What code would MassHealth suggest using when we administer this screening at the newborn, 1 month, 2 month and 4 month visit?
Procedure code 99420 is not a covered code for a Physician Pediatric facility. MassHealth providers must refer to the American Medical Association's Current Procedural Terminology (CPT) 2013 code book for the descriptions for the service codes when billing for services provided to MassHealth members.

We are a Skilled Nursing Facility (SNF) with a large outpatient rehabilitation MassHealth provider for SNF but not for outpatient rehabilitation (PT/OT/SLP). We have two inpatient(s) with UHC Insurance plus BCBS. We billed for rehabilitation (as MassHealth pays R&B). The primary insurance but have been told we don't have the functionality to

bill the co-insurance/deductible on MMIS. Also, we are not allowed to paper bill the co-insurance/deductible. So how do we get paid?

MMIS has job aids available on the NewMMIS website to assist providers on billing claims via DDE or the companion guides for billing COB to MassHealth.

We have a long term custodial patient – Insurance through father's employer. This insurance for many years will not authorize due to custodial has provided letter so that we do not have to bill insurer. Recent updates in TPL apparently flagged "other insurance" however; we have been being reimbursed up to last month. When I called Customer Service, they are telling me money may be recouped. How do I prevent this and how do I handle this case? (Patient does have Medicare also but he does not meet the criteria to bill).

TPL EDITS SETTING ON NURSING HOME CLAIMS

Nursing Facility providers are reminded that they must follow the billing guidelines in Bulletin 133, dated May 2012, as well as the guidelines published in Transmittal Letter NF 58, dated December 2011, when billing claims for members with Medicare, Medicare Advantage and/or other insurance coverage.

Claims denying for Edit 2528 - POTENTIAL MEDICARE A IN FIRST 100 DAYS, Edit 2556 – POTENTIAL MEDICARE C IN FIRST 100 DAYS or Edit 2557 – POTENTIAL PRIVATE INSURANCE IN FIRST 100 DAYS can be resolved by following the instructions in the above-mentioned publications. Go to www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/ and click on the links for Bulletins and Transmittal Letters. For questions, please contact MassHealth Customer Service at providersupport@mahealth.net or call 1-800-841-2900.

What is the timely filing limit for crossover claims, unpaid and partially paid and unpaid claims?

MassHealth has a Billing Timelines and Appeal procedures flyer on the MassHealth website. Please refer to http://www.mass.gov/eohhs/docs/masshealth/provider-services/flyer-billing-timelines-and-appeal-procedures.pdf

When newborn comes in for 1st appointment, account is set up with Mother's MassHealth I.D. # - Was told we can use Mother's I.D. for 60 days.

Providers have never been allowed to bill MassHealth for a newborn under the mother's MassHealth ID number. Providers must bill with the newborn MassHealth ID.

Why are customer service representatives (CSR) telling providers at Community Health Centers (CHC's) that they can bill modifier 25 and when a CHC bills with that modifier MassHealth denies the claim with invalid modifier. When you pull up the CHC billing manual modifier 25 is not on the list. Am I correct that modifier 25 is not applicable for CHC's?

CHCs should be billing the applicable services and modifiers as outlined in Subchapter 6 of their provider manual and/or outlined in subsequent bulletins such as All Provider Bulletin 227. NCCI establishes which modifiers are allowed with which procedures codes. MassHealth follows these guidelines. Be certain that the modifier is acceptable to the procedure before billing.

Would MassHealth consider making it possible for patients (many of whom are indigent and homeless) to access treatment for addiction with Subonone or Vivitrol without needing a referral? Behavioral Health Providers do not need a referral but medical providers, providing this care do. It is a huge barrier for many MassHealth patients. BMC has removed this barrier, as well as HNE Be Healthy.
If the member is enrolled in the PCC plan, a referral is required for all services except those outlined in the regulations or subsequent bulletin or transmittal letter. The purpose is so that the PCC understands all of the services the member is receiving and can appropriately manage their care.

Why do we have t bill MCR and other insurers for bed hold days to receive a denial to submit with claim when they do not cover bid holds?
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Questions from the MTF January 2013 Meeting Evaluations

POSC issues with patient eligibility. Bob said it was a billing issue-Barbara said it was gateway issue? Barbara stated there is too much info in system as to how the member is eligible for MassHealth and claim processing stops.
The Provider needs to contact CST to verify the member's coverage.

Since the Veterans Administration benefits must be exhausted before billing MassHealth, could someone research the VA regulations to see how long they have to produce a denial so that Mass Health can be billed?
The provider needs to contact the Veterans Administration directly regarding