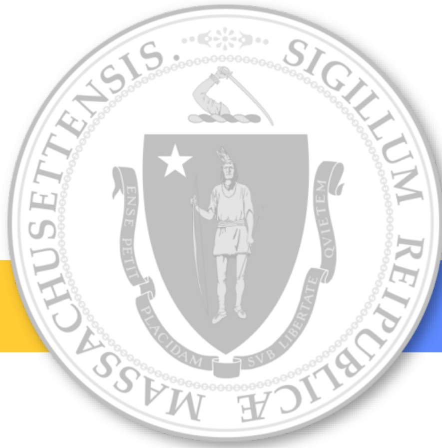
Provider Education and Communication



January/February 2020
MTF Afternoon session

Executive Office of Health & Human Services

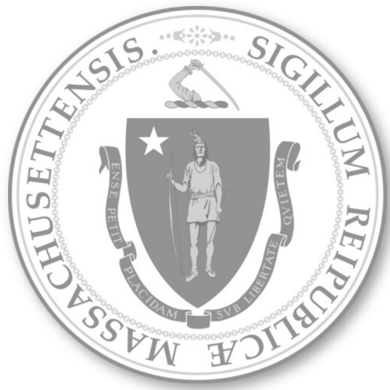
Welcome to MassHealth!

We are excited to have you as part of our provider community.

The purpose of this presentation is to deliver a high level overview of important MassHealth provider initiatives and current updates. Throughout presentation we have also included where provider resources and information pertaining to these topics are available on either Mass.gov or the Provider Online Service Center (POSC). Our goal is to ensure clear educational material to assist with incorporating each requirement into your respective organizations operational processes.

Agenda

- OLTSS Provider Services Overview - Optum
- Payment and Care Delivery Innovation (PCDI) Year 3 Update
- Ordering, Referring and Prescribing (ORP) Provider Update
- Technical Refresh Initiative (TPT)
- Provider Access Improvement Grant (PAIG)



MassHealth
Long-Term Services and Supports

Optum Provider Services Overview

Executive Office of Health & Human Services

Agenda

- Overview
- LTSS Provider Types
- Enrollment, Revalidation, and Training
- Provider Service Center
- Prior Authorization
- LTSS Provider Portal
- Hospice Enrollment Unit

Overview

- Optum is a vendor to MassHealth and provides comprehensive administrative and support services for MassHealth Long Term Services and Supports (LTSS) Providers.

- Key functions provided by Optum for LTSS providers include:
  - Enrollment & Revalidation
  - Education & Training
  - Provider Services
  - Prior Authorization
  - Program Integrity

- We also coordinate with Maximus for member issues in relation to LTSS providers.

LTSS Provider Types Serviced by Optum

Provider Type	Provider Type Description
PT 07	Ind. Therapists (PT/OT/ST)
PT 09	Nursing Facilities
PT 23	Speech and Hearing Centers
PT 24	Rehab Centers
PT 41	Durable Medical Equipment
PT 42	Oxy and Resp. Therapy Equipment
PT 43	Prosthetics
PT 47	Orthotics
PT 58	Fiscal Intermediary
PT 59	Personal Care Management

LTSS Provider Types Serviced by Optum

Provider Type	Provider Type Description
PT 60	Home Health Agency
PT 61	Ind. Nurse
PT 62	Adult Foster Care/Group Adult Foster Care
PT 63	Adult Day Health
PT 64	Day Habilitation
PT 66	Ind. Living Centers
PT 69	Hospice
PT 71	CRD Inpatient Hospital
PT 79	DME Competitive Bid
PT 82	CRD Outpatient Hospital
PT 97	Group Practice Therapists (PT/OT/ST)

Enrollment and Revalidation

- Enroll LTSS Provider Types into the MassHealth LTSS program
  - Ensures providers meet regulatory requirements for becoming a MassHealth contracted provider, including but not limited to:
    - Timely completion of their Federally Required Disclosure Form (FRDF)
    - Risk based screening and credentialing verifications
    - Completion of all applicable database checks, forms and supplemental forms, fingerprinting, site visits, etc.

- Complete revalidation of providers no less than every 5 years

- Process provider updates (e.g. contact information, portal access, license updates, legal address changes, etc.)

Education and Training

- Host education and training sessions for LTSS provider types specific to each type based on the following:
  - Provider specific regulations, prior authorization requirements (when applicable), billing and claims, and program integrity

- Conduct quarterly Quality Forums on current relative topics for LTSS Providers within MassHealth

- Provide education during each provider's call to the Provider Service Center, during site visits for enrollment, or during an audit

- Collaborate with Maximus on outreach efforts related to MassHealth initiatives including:
  - Ordering, Referring, and Prescribing Requirements
  - Technical Refresh
  - Duplicate Claims Submission

Provider Service Center

- The LTSS Provider Service Centers goal is to provide a first class experience for all callers seeking assistance
- The main areas of focus for the Service Center revolve around the following:
  - Claims research, education, and resolution
  - Nursing Facility/Long-term Care facility assistance with MMQ submission or level-of-care questions
  - Verification of previously provided services/Duplication of services
  - Financial Hardship requests
  - Member eligibility and benefit plan questions
  - Enrollment, Revalidation, and Training assistance
  - Prior authorization submission, updates, and questions
    - Clinical related questions are addressed in conjunction with PA reviewer

Prior Authorization

- As a condition of payment, certain provider types are required to submit a prior authorization request ***prior*** to rendering services

- These provider types are:

Adult Day Health	Rehabilitation Centers
Adult Foster Care	Speech and Hearing Centers
Durable Medical Equipment	Therapists (Outpatient PT/OT/ST)
Home Health Agencies	
Orthotics	
Oxygen and Respiratory Therapy Equipment	
Personal Care Management	
Prosthetics	

Prior Authorization

- Providers required to submit their prior authorizations can do so electronically through the LTSS Provider Portal, via fax, USPS mail, or the Provider Online Service Center (POSC)
- The following provider types use the LTSS Provider Portal for their PA submissions:

Adult Day Health	Oxygen and Respiratory Therapy Equipment
Adult Foster Care	Personal Care Management
Durable Medical Equipment	Prosthetics
Home Health Agencies	
Orthotics	
Outpatient Therapists (OT/PT/ST)	

❖ Special Programs (PT 98) may use Optum Prior Authorization for specific services

LTSS Provider Portal

- The LTSS Provider Portal provides the following capabilities to all LTSS Provider Types:
  - Enrollment with MassHealth
  - Completion of Revalidation
  - Submission and Review of Prior Authorizations
  - Resource hub for training materials used during training sessions
  - Access to MassHealth Provider Regulations
    - Includes links to mass.gov information and education
  - Provider specific job aids and additional resources

- Portal capabilities are available to providers on a 24/7 basis

- The LTSS Provider Portal can be accessed here: www.masshealthltss.com

Hospice Enrollment Unit

- Hospice providers are required to submit a Hospice Election Form (HOS-1) to enroll an eligible member into hospice
- As of November 18, 2019, Optum took over the processing of these forms
- Forms can be submitted via fax or USPS mail
- The form can be downloaded from the LTSS Provider Portal on the Hospice provider resource page or through a search on Mass.gov under Provider Forms

Questions

Contact Us for LTSS Provider Support

Need Help?

MassHealth LTSS Provider Service Center

Access specialized support from the MassHealth LTSS Provider Service Center toll-free at **1-844-368-5184**, **8 am to 6 pm ET**, Monday to Friday.

Email: support@MassHealthltss.com

OPTUM™

Payment and Care Delivery Innovation (PCDI) Year 3

Agenda

- Updates for 2020
  - Continuity of Care
  - Newborns
  - Program of Assertive Community Treatment (PACT)
  - Flex Services
  - CP Changes
    - Care Plan Requirements
    - EVS updates
- Provider Reminders
- Provider Resources

Continuity of Care (CoC) for Impacted Members

MassHealth is committed to working with all relevant parties to promote continuity of care for members who move into new plans. As part of the year 3 changes that went into effect on 1/1/20, 56 practices joined or moved between ACOs, and 36,642 members had an enrollment change to stay with those primary care providers. To support a successful transition, members have a 90 day continuity of care period to help prevent interruptions to care as members transition health plans.

- In most cases, members can continue to see their existing providers for 90 days, even if those providers are not in their new plan's network
- Providers who are not in the new plan's network can contact the new plan to make appropriate payment arrangements
- In some cases, the continuity of care period may be extended. For example, members who are pregnant can continue seeing their existing OB/GYN providers throughout their pregnancy and up to six weeks postpartum
- Focused efforts will be made for members with needs requiring specialized care, including but not limited to members who are pregnant, have autism spectrum disorder and receiving ABA services, receiving ongoing services such as dialysis, home health, chemotherapy, and/or radiation, receiving treatment for behavioral health or substance use, including Medication for Addiction Treatment (MAT) services
- We are asking all plans, providers, and assisters to reinforce this message and to ensure that members continue to receive all needed health care services during this transition
- Members can contact their new plan now to let them know of any ongoing treatments or scheduled appointments
- Providers are able to see new plan information in the MassHealth Eligibility Verification System (EVS) as of January 1, 2020. They can contact the new plan at that time for new authorization requests, or with any questions or concerns
- While ACOs are ultimately responsible for coordinating member's transition and service coordination into their new health plan, both MassHealth and ACOs will ensure protocols are in place for continuity of care issues that may arise

Newborn Policy Changes

Based on stakeholder feedback, the following interventions are designed to offer a better experience for MassHealth members and providers:

- Currently, referral requirements for the majority of common Newborn services have been removed in our system.
- In the case of Newborn claims that are denied by the MassHealth claims system due to missing referral, we are rerunning denied claims roughly quarterly and reprocessing to catch inappropriate denials for newborns.
- As of 1/1/20, MCO and Accountable Care Partnership Plan (ACPP or “Model A Plans”) should not be denying primary care claims for referral alone for first 30 days of life.
- As of 1/1/21, we intend to automatically enroll all newborns to MassHealth FFS for up to the first 45 days of life, so practices have a single authorization pathway for services for newborns until the family enrolls the newborn in a health plan.
- We are updating the Notification of Birth form to include a heath plan enrollment option – so families can pick their newborn’s enrollment, rather than having to wait to do the process once they leave the hospital or birthing center.
- If voluntary selection of a health plan is not made by the family, auto assignment will occur. We are updating the auto assignment processes to first try place members in the same health plan as any older siblings, rather than in parents plan.

Program of Assertive Community Treatment

As of 1/1/20, MassHealth has added Program of Assertive Community Treatment to the MassHealth benefit.

- Programs in the PACT model are intensive, community-based, and multi-disciplinary treatment, rehabilitation and support services for adults with severe and persistent mental illness, including BH and Medical care coordination, and 24/7 availability of support services for members

- Current rate is approximately $50 per day per member, higher rates for justice involved

Flex Services

Over the past year, MassHealth has worked with ACOs to develop Flex Services programs that will address Health Related Social Needs for their members. As of January 1, ACOs have launched Flex Services programs that seek to address members targeted Health Related Social Needs (HRSN) directly.

- Flex programs will focus on two domains – Nutrition Sustaining Supports and Tenancy Preservation Supports
  - Most programs focus nutritional support on medically tailored meal programs
  - Housing supports can come in the form of home modifications, or one time first, last and security to get into housing, or education on tenancy requirements/or supports to sustain and navigate housing
- ACO members must meet at least one targeted eligibility criterion to qualify for Flex
  - Complex physical or behavioral health need
  - assessed need for assistance with one or more Activities of Daily Living (ADLs)
  - Repeated ER use
  - Pregnant individuals and their children
- …and one risk factor: Homelessness or at risk of homelessness, or food insecurity
- Flex Services are not an entitlement or a covered service – not all eligible members are guaranteed to receive Flex Services.
- ACOs are required to determine that any flex supports are not duplicative of other federally funded supports that members are eligible for, and are a support of "last resort."

Providers are encouraged to reach out to ACO care coordination and management staff to inquire about the availability of flex services for members they believe may qualify for and benefit from these supports.

MassHealth Community Partners (CP) Program: Care Plan

CP Program Background Information:

Behavioral Health (BH) and Long-Term Services and Supports (LTSS) Community Partners (CPs) are community-based entities that work with ACOs and MCOs to provide care management and coordination to certain members. BH CPs provide supports to certain members with significant behavioral health needs, including serious mental illness and addiction. LTSS CPs provide supports to certain members with complex LTSS needs, such as children and adults with physical and developmental disabilities and brain injuries.

MassHealth members enrolled in an ACO or MCO may be eligible to participate in the CP program. CPs are not available to members enrolled in the Primary Care Clinician (PCC) Plan or in Mass Health's fee-for-service (FFS) program unless the member is affiliated with the Department of Mental Health's Adult Community Clinical Supports program. When members have other state agency or provider supports, CPs supplement and coordinate with those supports but do not duplicate the functions provided by them. **Please note that CPs are not a health plan.**

MassHealth requires ACOs and MCOs to provide Care Plans to members assigned to BH and LTSS CPs. For members assigned to a BH CP, the responsibility for developing the Care Plan is delegated to the CP. For members assigned to an LTSS CP, ACO/MCOs develop the Care Plan – with the input and sign off of Primary Care Providers. Such Care Plans must include the LTSS Care Plan delegated to the LTSS CP as an integrated component.

Beginning Jan 1, 2020, MassHealth has aligned the Care Plan requirements for CP assigned members in the LTSS, BH, ACO and MCO contracts. All entities are working towards implementing the changes and updates in 2020, which will be reviewed and approved by MassHealth.

Updates to Care Plan requirements for CP assigned members include:

- Requirements around person-centered care planning process
- Training requirements for staff completing Care Plans
- Minimum Elements of the Care Plans
- Care Plan timing, monitoring and updates
- Care Plan approval and distribution
- Use of comprehensive assessments for members changing health plans

MassHealth Community Partners (CP) Program: EVS Update

CP Program Enrollments Now Available on MassHealth's Eligibility Verification System (EVS): CP enrollments now appear on EVS as a managed care enrollment. Providers may check if members are enrolled in the CP Program by utilizing the EVS system. Please see examples below:

Welcome

Mass.Gov Home | State Agencies | State Online Services

MassHealth Provider Online Service Center

Member Information | Eligibility

Dates of Eligibility

Click on the Date Range to view Eligibility information for Member ID

	Date Range	Eligibility Status
➜	12/17/2019 12/17/2019	MASSHEALTH STANDARD

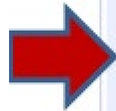
The information below refers to the **MASSHEALTH STANDARD** coverage for **12/17/2019** to **12/17/2019**.

Eligibility Restrictive Messages

Restrictive Messages: 991 / 991 CERTAIN HSN DENTAL SERVICES AVAILABLE AT COMMUNITY HEALTH CENTERS AND HOSPITAL-BASED HEALTH CENTERS.

List of Managed Care Data (for MCO/ACO)

Name	NPI	Phone	Date Range
BMC HEALTHNET PLAN COMMUNITY ALLIAN		(888) 566-0010	12/17/2019 12/17/2019



List of Managed Care Data (for CP)

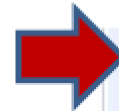
Name	NPI	Phone	Date Range
RIVERSIDE COMMUNITY PARTNERS	1780791467	(781) 619-5000	12/17/2019 12/17/2019

Member Payment Responsibility Detail

Patient Paid Amount | Patient Paid Amount Type

Spend Down Amount

Deductible Amount | Deductible Date



Managed Care Data (for CP) Details

Begin Date 12/16/2019 | End Date 12/16/2019

Name BEHAVIORAL HEALTH NETWORK INC

NPI 1134617210 | Phone (413) 242-0715

Restrictive Messages: 1649 / Member is receiving BH Community Partner care coordination services.

Member Payment Responsibility Detail

Patient Paid Amount | Patient Paid Amount Type

Spend Down Amount

Deductible Amount | Deductible Date

Co-pay Status | Co-pay Cap Status

Restrictive Messages

Questions?

Ordering, Referring and Prescribing Requirements (ORP)

Ordering, Referring & Prescribing (ORP) Requirements

- ACA Section 6401 (b)
- States must require:
  - All ordering or referring physicians and other professionals be enrolled under the State [Medicaid] Plan…as a participating provider; and
  - The NPI of any ordering or referring physician or other professional…be specified on any claim for payment that is based on an order or referral of the physician or other professional.
- State law requires that authorized ordering/referring/prescribing provider types must apply to enroll with MassHealth at least as a nonbilling provider in order to obtain and maintain state licensure, regardless of practice location (private practice, hospital, CHC, CMHC, etc.) The legislation applies to physician interns and residents but not other types of interns and residents.

ORP Requirements

The services below must be ordered, referred or prescribed. MassHealth is applying ORP requirements to fee for service, crossover (where Medicare requires ORP), third party liability, and Health Safety Net and Children’s Medical Security Plan claims but not to claims submitted to MassHealth contracted managed care entities.

- Any service that requires a PCC referral
- Adult Day Health
- Adult Foster Care
- Durable Medical Equipment
- Eyeglasses
- Group Adult Foster Care
- Home Health
- Independent Nurse
- Labs and Diagnostic Tests
- Medications
- Orthotics
- Oxygen/Respiratory Equipment
- Prosthetics
- Psychological Testing
- Therapy (PT, OT, ST)

ORP Requirements

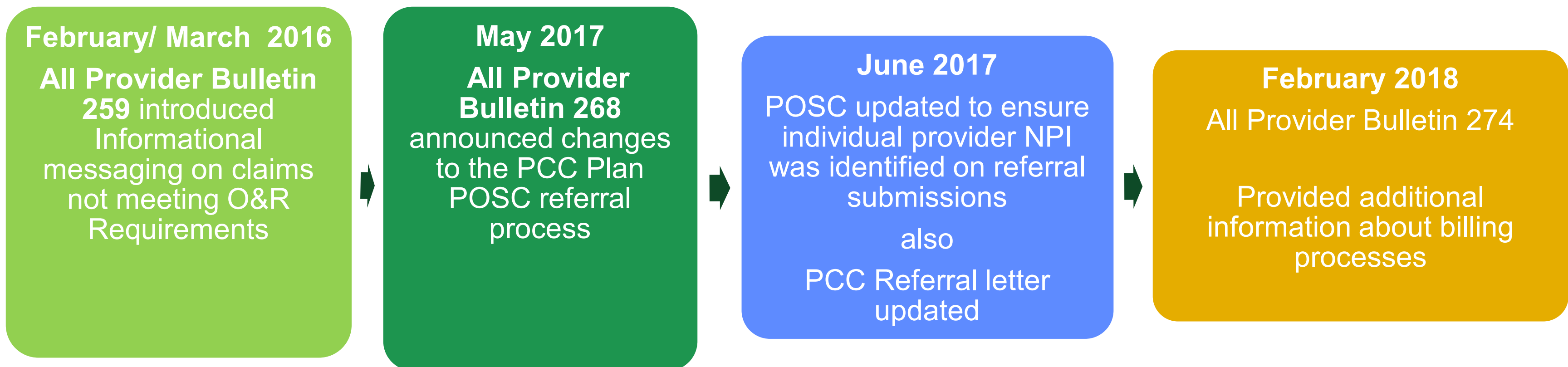
Provider Types (including interns and residents in those provider types) authorized to be included on a claim as the ordering, referring or prescribing provider and who must enroll as at least a nonbilling provider

- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist
- Dentist
- Licensed Independent Clinical Social Worker
- Certified Nurse Practitioner
- Optometrist
- Pharmacist (if authorized to prescribe)
- Physician
- Physician Assistant
- Podiatrist
- Psychiatric Clinical Nurse Specialist
- Psychologist

Fillable nonbilling provider applications and contracts are available on the MassHealth website: http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html

Implementation of ORP Billing Requirements

- When ORP is fully implemented, impacted claims submitted for payment to MassHealth must meet the following requirements:
  - The Individual ORP provider's NPI must be included on the claim
  - The NPI of the provider on the claim must be one of the ORP provider types
  - The ORP provider must be enrolled with MassHealth, at least as a nonbilling provider
- To assist providers to better prepare for these changes, MassHealth has been providing detailed information and education to providers for the last several years.



ORP Provider Education and Outreach Activities

- MassHealth has been using a variety of communication strategies and methods to share information with providers since 2015, which includes:

Resources and Information:

- Webinars
- Provider bulletins
- MassHealth website
- MassHealth regulations
- Message text (POSC)

Collaboration Strategies:

- Work with stakeholders to provide consistent messaging
- Work closely with Provider Associations
- Proactive outbound calls from MassHealth
- Knowledgeable MassHealth Provider Services staff, available to answer providers' questions as needed
- Working with respective provider licensing boards

Implementation of ORP Billing Requirements

MassHealth is implementing denials for not meeting the ORP billing requirements in several phases.

Phase 1 – for claims for services that require an order, referral or prescription

- The Individual ORP provider's NPI must be included on the claim
- The NPI of the provider on the claim must be one of the authorized ORP provider types

September 2019

All Provider Bulletin 286 posted with additional information about billing processes and including the schedule to begin denying claims

For dates of service on or after December 15, 2019

Impacted claims from Group 1 (individual non-LTSS) providers will deny if they do not include the NPI of an authorized ORP provider

For dates of service on or after February 15, 2020

Impacted claims from Group 2 (entity non-LTSS) providers will deny if they do not include the NPI of an authorized ORP provider

For dates of service on or after April 15, 2020

Impacted claims from Group 3 (LTSS) providers will deny if they do not include the NPI of an authorized ORP provider

Implementation of ORP Billing Requirements

Group 1 (individual non-LTSS) provider types – Phase 1 denials went into effect 12/15/19

- Audiologist
- Chiropractor
- Clinical Nurse Specialist
- Group practices of the types in this group
- Hearing Instrument Specialist
- Nurse Practitioner
- Ocularist
- Optician
- Optometrist
- Physician
- Podiatrist
- Psychologist
- QMB Only Providers

Implementation of ORP Billing Requirements

Group 2 (entity non-LTSS) provider types - Phase 1 denials go into effect 2/15/20

- Abortion/Sterilization Clinic
- Acute Inpatient Hospital
- Acute Outpatient Hospital
- Certified Independent Laboratory
- Community Health Center
- Early Intervention
- Family Planning Agency
- Hospital-licensed Health Center
- Independent Diagnostic Testing Facility
- Mental Health Center
- Pharmacy (for claims processed through MMIS
- Psychiatric Outpatient Hospital
- Renal Dialysis Center
- Substance Use Disorder Outpatient Hospital
- Volume Purchaser

Implementation of ORP Billing Requirements

Group 3 (LTSS) provider types - Phase 1 denials go into effect 4/15/20

- Adult Day Health
- Adult Foster Care
- Chronic Outpatient Hospital
- Competitive Bid Only (DMEPOS)
- Durable Medical Equipment
- Group Adult Foster Care
- Group Practice (Therapist)
- Home Health
- Independent Nurse
- Orthotics
- Oxygen and Respiratory Therapy
- Prosthetics
- Rehabilitation Center
- Speech and Hearing Center
- Therapist

For dates of service on or after 4/15/20, any/all impacted claims will be denied for failure to comply with the requirements of Phase 1

ORP Billing - Denial Edits on Remittance Advices (RAs)

MassHealth has been providing informational edits for impacted ORP claims to inform billing providers of claims that do not meet ordering, referring, and prescribing requirements.

Once the ORP requirements are fully implemented, *impacted claims will be denied* for these reasons if provider billing processes are not corrected:

The NPI of the ORP provider must be included on the claim:

- **835 Electronic Remittance Advice** (log into the POSC to see the applicable detailed edit from the list below)

HIPAA Claim Adjust Reason Code (CARC)	HIPAA Remark Adjust Reason Code (RARC)
206 – National Provider Identifier – missing	N265 – Missing/incomplete/invalid ordering provider primary identifier N286 – Missing/incomplete/invalid referring provider primary identifier

- **POSC version of the remittance advice**

1080 – Ordering Provider Required

1081 – NPI required for Ordering Provider

1200 – Referring Provider Required

1201 – NPI Required for Referring Provider – HDR

1202 – NPI Required for Referring Provider 2 – HDR*

1203 – NPI Required for Referring Provider – DTL *

1204 – NPI Required for Referring Provider 2 – DTL*

*According to federal guidance, Ordering and Referring rules do not require a secondary referring provider identifier on claims. However, there may be circumstances where the HIPAA V5010 Implementation Guide situationally requires a second referring provider identifier. In those circumstances, if the second referring provider's NPI is included on the claim, but that provider is not enrolled with MassHealth or is not an authorized ORP provider, relevant informational edits will be included on the remittance advice.

ORP Billing - Denial Edits on Remittance Advices (RAs)

- Billing provider types currently receiving large (500+) numbers of “NPI Missing” edits:

Group 1

- Chiropractor
- Group Practice – Physician
- Physician

Group 2

- Acute Outpatient Hospital
- Community Health Center
- Early Intervention
- Family Planning Agency
- Hospital Licensed Health Center
- Pharmacy (MMIS claims)
- Renal Dialysis Clinic
- Volume Purchaser

Group 3

- Adult Day Health
- Adult Foster Care
- Durable Medical Equipment
- Group Adult Foster Care
- Group Practice – Therapist

ORP Billing - Denial Edits on Remittance Advices (RAs)

The ORP provider must be in one of the eligible ORP provider types:

- **835 Electronic Remittance Advice** (log into the POSC to see the applicable detailed edit from the list below)

HIPAA Claim Adjust Reason Code (CARC)	HIPAA Remark Adjust Reason Code (RARC)
183 – The referring provider is not eligible to refer the service billed	N574 – Our records indicate the ordering/referring provider is of a is of a type/specialty that cannot order refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.
184 – The prescribing/ordering provider is not eligible to prescribe/order the service billed	N574 – Our records indicate the ordering/referring provider is of a type/specialty that cannot order refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.

- **POSC version of the remittance advice**

1085—Ordering Provider Not Authorized to Order Services

1217—Referring Provider Not Authorized to Refer - HDR

1218—Referring Provider 2 Not Authorized to Refer – HDR*

1219—Referring Provider Not Authorized to Refer - DTL

1220—Referring Provider 2 Not Authorized to Refer – DTL*

ORP Billing - Denial Edits on Remittance Advices (RAs)

- Billing provider types currently receiving large (500+) numbers of “NPI Not Authorized” edits:

Group 1
- Group Practice – Physician

Group 2
- Acute Outpatient Hospital
- Certified Independent Lab
- Community Health Center
- Early Intervention
- Family Planning

Group 3
- Adult Day Health

Note that MassHealth has discovered many **incorrect claim submissions** where **the NPI of the referring practice is being listed on the claim instead of NPI of the individual ORP provider**, resulting in “NPI not authorized” edits.

Implementation of ORP Billing Requirements

MassHealth is implementing denials for not meeting the ORP billing requirements in several phases.

Phase 2 – for claims for services that require an order, referral or prescription

- The NPI of the ORP provider is included on the claim but the ORP provider is not actively enrolled with MassHealth, at least as a nonbilling provider

August 15, 2020

Impacted claims from :

- Group 1 (individual non-LTSS) providers
- Group 2 (entity non-LTSS) providers
- Claims processed by the Pharmacy Online Processing System (POPS)

will deny if the ORP provider is not actively enrolled with MassHealth

November 15, 2020

Impacted claims from:

Group 3 (LTSS) providers

will deny if the ORP provider is not actively enrolled with MassHealth

For dates of service on or after November 15, 2020, any/all impacted claims will be denied if the claim does not meet all three ORP requirements

ORP Billing - Future Claim Denial Edits on Remittance Advices (RAs)

The ORP provider must be actively enrolled with MassHealth at least as a nonbilling provider:

- **835 Electronic Remittance Advice** (log into the POSC to see the applicable detailed edit from the list below)

HIPAA Claim Adjust Reason Code (CARC)	HIPAA Remark Adjust Reason Code (RARC)
183 – The referring provider is not eligible to refer the service billed 208 – National Provider Identified – Not matched.	N265 – Missing/incomplete/invalid ordering provider primary identifier N286 – Missing/incomplete/invalid referring provider primary identified

- **POSC version of the remittance advice**

1082—Ordering Provider NPI not on file	
1084—Ordering Provider not actively enrolled	
1205—Referring Provider NPI not on file – HDR	1213—Referring Provider not actively enrolled – HDR
1206—Referring Provider 2 NPI not on file – HDR*	1214—Referring Provider 2 not actively enrolled – HDR*
1207—Referring Provider NPI not on file – DTL	1215—Referring Provider not actively enrolled – DTL
1208—Referring Provider 2 NPI not on file – DTL*	1216—Referring Provider 2 not actively enrolled – DTL*

Billing providers that are receiving these edits should contact the ORP provider and/or the MassHealth CSC to request that the ORP provider enroll in MassHealth to avoid future claims denials.

ORP Provider Types and Enrollment Status as of January 10, 2020

*With detail regarding MassHealth Service Area Enrollment Saturation

Authorized ORP Provider Types	*MA Licensed & Business Addresses in MA, ME, NH,VT,CT,RI,NY	Total # of ORP Provider Types "Known" to MassHealth	Total % Enrolled or in Progress
Physician	31,219	34,937	112%
Optometrist	1,404	1,122	80%
Psychologist	5,608	4,864	87%
Podiatrist	462	408	88%
Nurse Midwife	489	411	84%
Dentist	6,518	4,463	68%
Nurse Practitioner (NP)	9,977	8,184	82%
Physician Assistant (PA)	3,723	3,675	99%
Certified Registered Nurse Anesthetists (CRNA)	1,114	1,190	107%
Clinical Nurse Specialist (CNS)	68	12	18%
Psychiatric Nurse Mental Health Specialist (PCNS)	622	302	49%
Pharmacist	62	96	155%
Licensed Independent Clinical Social Worker (LICSW)	14,051	11,801	84%
Total	**75,317**	**71,587**	**95%**

- Claims for the services that are ordered, referred, or prescribed by a clinician who is not one of the authorized ORP provider types listed above must include the NPI of the clinician's supervising physician (or other authorized ORP provider) on the claim.
- Note that pharmacy claims must include the individual NPI of the actual prescribing provider.

ORP Billing – Additional Note

- On 837I claims that require referrals, the referring provider is only required if different than the attending provider.
- Refer to MassHealth All Provider Bulletin 286 for more details and billing instructions related to ORP requirements.

POSC Provider Search Function

- In order to use the Provider Search Function you must be logged into the POSC. The Provider Search Option is in the left navigation list.
- Results will return PROVIDER NAME, ADDRESS, NPI and “ACTIVE Y” or “No active MassHealth providers found.”
- Please note that a response of ACTIVE Y does not definitively confirm that the provider is eligible to be an Ordering, Referring or Prescribing provider. For example, facilities and entities (e.g., hospitals, health centers, group practices) are not authorized ORP providers. Also, individual providers could be in a provider type that is not authorized to Order, Refer or Prescribe.

ORP Resources

- To learn more about **Ordering, Referring and Prescribing (ORP) (and to download Nonbilling Application),** visit the Provider ORP page at :
  www.mass.gov/the-aca-ordering-referring-and-prescribing-orp-requirements-for-masshealth-providers

- To register for a webinar for non-LTSS providers, please visit the **MassHealth Learning Management System** at :
  www.masshealthtraining.com

- An Ordering and Referring Guide for LTSS Providers is on the LTSS Provider Portal at:
  www.masshealthltss.com

- **Provider Updates Email Sign Up**

  To receive e-mail notification of updates to MassHealth provider manuals, including regulations, and new provider bulletins send an email to join-masshealth-provider-pubs@listserv.state.ma.us

- **Note:** Just send the blank e-mail as it's addressed. No text in the body or subject line is needed.

Questions?

Technical Refresh Initiative Phase 2

Technical Refresh

What Is Technical Refresh?

MassHealth will implement the Technical Refresh in the following phased approach and the Trading Partner Testing (TPT) timeline. Trading partners may upload test transactions to the TPT testing environment at any time during the corresponding TPT phase to **validate compliance**. **Testing for Phase II is mandatory.**

Phase	HIPAA Transactions	TPT Timeframe	Duration	GO LIVE
1	270/271	7/29/2019 – 9/20/2019	8 weeks	10/27/2019
2	837P, 837I, 276/277, 835	1/27/2020 – 3/27/2020	9 weeks	3/30/2020

Companion Guides

The HIPAA Companion Guides were updated and the 835 Companion Guide was updated in late-December 2019.

- Phase 1: *updated Companion Guides were published in June 2019*
- Phase 2: *updated 835 Companion Guide was published in late-December 2019*

Technical Refresh

Estimated Providers Expected to Test

Targeted timeframe to receive 1st test file: 1/27/20 – 2/21/20

Category	Expected To Test	Currently Scheduled to Test
Total providers currently submitting claims for large organizations	146	0
Total Vendors currently approved to submit claims on behalf of providers	141	104
Other Direct Submitters	568	9
Total	855	113

Technical Refresh – Phase II

TPT Information Sessions *(837I, 837P, 276/277, 835)*

MassHealth conducted a series of one hour information sessions to educate providers, Billing Intermediaries / Clearinghouses (BIs/CHs) and software vendors (SWVs) about the technical refresh and trading partner testing. There was a series of separate sessions scheduled for providers that submit transactions directly to MassHealth. MassHealth provided additional updates and information about testing, the timeline, and answered any questions received during the sessions. We conducted four sessions between 11/19/2019 – 12/12/2019.

Technical Refresh – TPT Office Hours

TPT Office Hours Schedule

MassHealth will conduct the sessions between 01/16/2020 – 03/26/2020.

Vendors

Date
1/16/2020
1/30/2020
2/13/2020
2/27/2020
3/12/2020
3/26/2020

Providers

Date
1/23/2020
2/6/2020
2/20/2020
3/5/2020
3/19/2020

Technical Refresh – Phase II

Testing Impact

Testing is mandatory for all trading partners that currently submit or receive via PRODUCTION the following HIPAA transactions:

- Health Care Claim Status Request and Response (276/277),
- Health Care Claim Payment/Advice (835)
- Health Care Claim: Institutional (837I) and Professional (837P), and
- HIPAA (999/TA1) Implementation Acknowledgment for Health Care Insurance

The scope of testing is limited to **compliance only**. It is required for electronic file submissions only. It includes system-to-system connections. Testing for DDE is not required. Trading Partners must participate in testing before the Implementation date to avoid any disruption in their workflow and possible financial impact downstream with claims submissions.

If trading partners do not successfully pass testing, files may not get processed in PRODUCTION on or after the Implementation date. In that case, vendors and direct submitters must use Direct Data Entry (DDE) in the Provider Online Service Center (POSC) to manually submit claims and check claim status – instead of submitting electronic files.

Technical Refresh – Phase II

Vendor List Updates

The Approved Vendor List will be updated to include attendance at training sessions and their testing status. It will be updated and posted periodically throughout Phase II TPT.

If your constituents authorized their vendor to submit claims and claim status and/or receive their remittance advice files, ask them to check their vendor's testing status online.

Here is the link to the latest update to the **MassHealth Approved Vendor List** on 12/03/2019: https://www.mass.gov/service-details/vendor-list

Technical Refresh – Phase II

We Need Your Help

Please share this important information with your constituents and review consequences of not testing. If they need assistance, please ask them to **immediately** contact EDI at ediTPT@mahealth.net.

1. Ensure that your constituents contact MassHealth EDI to schedule a test date, if they haven't already.

2. Ensure that your constituents monitor the Vendor List, check the status of their vendor(s)' testing, and outreach their vendor(s) if they do not see any progress.

3. Ensure that your constituents review information on the Technical Refresh web page https://www.mass.gov/masshealth-technical-refresh which includes the Companion Guides, Change Grid, and Reference Guide.

Technical Refresh – Phase II

We Need Your Help *(continued)*

Ensure that your constituents can perform the basic following claims submission, claims status verification and remittance advice workflow tasks as a direct submitter or that their vendors are able to on their behalf:

- Successfully submit claims (837) and claim status (276) HIPAA files
- Receive a 999 file for all 837 and 276 files submitted
- Review in the 999 file **all IK5 and all AK9 segments**. If there are any errors, they will need to submit a corrected file in order to receive the responses correctly
- Check their 277 response file before submitting a claim a second time, specifically for the Category Codes STC01-1 and STC01-2.
- Receive a response HIPAA file AND process it within their system without any issues. This includes 999/TA1, 277, 835.

Technical Refresh – Phase II

EDI Resources

- **MassHealth Customer Service Center – EDI Department**
  Email: **ediTPT@mahealth.net**
  Phone: 1-800-841-2900
- Webpage: **Technical Refresh**
  https://www.mass.gov/masshealth-technical-refresh
- **Companion Guides**
  https://www.mass.gov/lists/technical-refresh-companion-guides
- **Approved Vendor List**
  https://www.mass.gov/service-details/vendor-list
- Job Aid: **Upload Batch Claims – Upload Batch Files (837I, 837P, 276):**
  https://www.mass.gov/media/6971/download
- Job Aid: **Download Responses (999, 276, 835)**
  https://www.mass.gov/files/documents/2017/11/13/batch-claims-download.pdf
- POSC TPT: **Test Environment**
  https://mmis-portal-tptest.ehs.state.ma.us/EHSProviderPortal

Technical Refresh

EDI Resources *(continued)*

- Flyer: **999 Example**
  https://www.mass.gov/files/documents/2019/07/24/999-transaction-examples.pdf
- Flyer: **x12 Processing Example**
  https://www.mass.gov/files/documents/2019/07/18/x12-transaction-processing-pre-compliance-errors.pdf
- Flyer: **Change Grid: New HIPAA Translator Changes**
  https://www.mass.gov/doc/new-hipaa-translator-changes/download
- Flyer: **835 Example**
  https://www.mass.gov/doc/835-example-0/download
- **Quick Reference Guide**
  https://www.mass.gov/doc/technical-refresh-phase-2-quick-reference-guide-1/download
- FAQ: **TPT Frequently Asked Questions (FAQ)**
  https://www.mass.gov/info-details/additional-technical-refresh-transition-information#frequently-asked-questions-
- Flyer: **EVSpc/EVScall Transition Options**
  MassHealth will publish on the Technical Refresh webpage once available.

Technical Refresh – Phase II

Next Steps

Please advise your constituents to begin to prepare for Phase 2 by following this check-list.

- ☐ Download Companion Guides for Phase 2
- ☐ Review all of the EDI Resources, especially the following: *(slides #12 – 13)*
  - Webpage: Technical Refresh
  - Flyer: 999 Example
  - Flyer: x12 Processing Example
  - Flyer: Change Grid: New HIPAA Translator Changes
  - Flyer: 835 Example
  - Quick Reference Guide
- ☐ Assess impacts to their systems and accommodate the changes **immediately**
- ☐ Sign up for Office Hours and participate
- ☐ Submit first test file on their scheduled Test Date (between 1/27/2020 – 2/7/2020)
- ☐ If utilizing a vendor to submit claims (837I, 837P), claims status (276/277) or receive electronic remittance advice files (835s), coordinate testing

Questions?

Provider Access Improvement
GRANT PROGRAM (PAIGP)

2020 Cycle 2 MassHealth Provider Access Improvement Grant Program (PAIGP)

January /February 2020 MTF Afternoon session

Health Resources in Action, Inc.

PAIGP Overview

- The MassHealth Provider Access Improvement Grant Program (PAIGP) aims to help eligible MassHealth providers increase access to healthcare and improve outcomes for patients with disabilities, or for whom English is not a primary language, through the purchase of medical diagnostic equipment, communication devices, and other resources.
- The grants awarded through this program are intended to reduce the barriers that make it less likely for individuals with disabilities or for whom English is not a primary language to get routine and preventative medical care.
- The Massachusetts Executive Office of Health and Human Services (EOHHS) oversees PAIGP, which is funded via MassHealth's Section 1115 Demonstration.

PAIGP 2019 Update

- The 2019 Cycle 1 Provider Access Improvement Grant Program (PAIGP) expects to distribute just under $145,000 to eleven awardees.
- Grant funds awarded are being used for the purchase of:
  - Translation devices and software for non-English speaking individuals
  - Portable diagnostic equipment to enable providers to bring services to children, seniors, and individuals with disabilities
  - Medical equipment to increase the number of individuals who can be treated by providers who serve predominantly non-English speaking individuals
  - Modifications to provider office spaces to improve accessibility to individuals with disabilities (e.g., lifts, railings)

PAIGP 2020 Cycle 2 Preview

- The Request for Proposals (RFP) has been redesigned to expand the reach of the grant program
- Most notable changes:
  - **Grant amount** cap has been raised from $25,000 to **$75,000** per awardee
  - Provider matching funds requirement has been **eliminated**
  - **Eligibility requirements** have been revised to make the opportunity open to more MassHealth providers
  - Grant opportunity has been opened to MassHealth providers of **all sizes**, with preference given to applicants who employ fewer than 30 full-time employees

Launching 2020 PAIGP Cycle 2

- The 6-week application window will be opening in February.
- Interested potential applicants can visit the PAIGP website today at www.PAIGP.org to subscribe to receive email communications and announcements regarding the grant program.
- Advance communications to spark interest and raise awareness will begin about two weeks prior to the opening of the application window, followed by extensive outreach during the application window.
- HRiA will be presenting information about the grant program at four upcoming MassHealth Training Forums across the state.

Launching 2020 PAIGP Cycle 2

continued

- HRiA will conduct two live webinars during the application window and post recordings on the PAIGP website
  - **Informational webinar** to help potential applicants understand the grant program, the eligibility requirements, and the overall application process so that they can determine whether they would like to apply
  - **TA webinar** to provide assistance and guidance for applicants to enable them to submit a thorough and complete application
- There will be a Q&A window during which potential applicants may submit written questions. Responses will be posted on the PAIGP website.

Reach out to HRiA at PAIGP@hria.org if you have questions about this grant program and/or would like to help us spread the word.

Thank you!

Questions?