Massachusetts Health Care Training Forum
April 2011 Questions & Answers

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

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

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

MASSHEALTH UPDATES

Further guidance will be forthcoming concerning questions related to the visitor section of the application.

Questions from the MTF April 2011 Roundtable Forms:

What is considered an absent parent exactly?

If a parent does not live in the home with a child then the parent is considered absent. Children who were adopted by a single parent or who have a parent who is deceased or unknown are not considered to have absent parents. Details on absent parent can be found on page 5 and Supplement B of the Medical Benefit Request application.

Can we still send MH Buy-In applications to Tewksbury or must they be sent according to address?

Buy-In applications are being processed by all 4 MassHealth Enrollment Centers effective 3-1-11.

Case: Family with three children with mental behavioral and emotional health needs; was voluntarily enrolled with DCF and given MassHealth Standard. DCF notified family they were closing the case in 30 days. Family applied for MassHealth and was denied because MBR

processed before DCF closed them out so family denied benefit. What should family do now to ensure continuity of care for children?
Without knowing the specifics of this case, the general rule of thumb is to file an MBR as soon as possible. MH can possibly give up to 10 days of retroactive coverage.

What is the connection between MassHealth and DOR (Child Support)?
MassHealth obtains information regarding child support and health insurance from absent parents in order to assist in determining coverage.

I'm having a problem with receiving more than one MassHealth letter on same dates for same consumer. It's confusing which is most updated.
Check My Account Page (MAP) to see the latest notice issued.

Where can I find a list of MassHealth Audiologists?
Contact MassHealth Customer Service at 1-800-841-2900 and a list or providers in the callers' area can be provided.

On review forms; last sections about people who need help proving their citizenship only fill out if there's a new member in the household. We would assume the person who's being reviewed already proved their citizenship.
If MassHealth needs verification they will send a request letter.

Consumer moved to MA from FLA in March 2011, applied for MassHealth 2 weeks ago. She has FL Medicaid. During pending process, if consumer gets ill or admitted to ER, will FL Medicaid be covered or MassHealth (retroactive)?
Individuals receiving benefits from another state are not eligible for MassHealth. It is the person's responsibility to report to Florida Medicaid that they have moved and to ensure their case is closed since they are no longer a Florida resident. The person may be eligible for MH once they become a resident here if all other eligibility requirements are met. In cases under 65, MassHealth can often go retroactive 10 days from the date the application was received by MassHealth.

When a patient does not return their verifications with 60 days, do they need to complete a new VGW or just send in the missing verifications?
The individual should send in missing information; a new application would need to be done if an application was filed over a year ago.

Is there a gap in the system because too many members are getting letter of termination for not sending the review forms? The members state they never received one.
MassHealth is not aware of any gap or missing review forms.

As an OB/GYN specialist who is called to the hospital to see a patient for a problem, the hospital does not get a referral for us. How do we get a referral for a patient we have never seen to bill?
All providers are responsible for obtaining referrals for the services they provide to MassHealth members. This may mean that the servicing practitioner will have to contact the member's PCC in order to request a referral, if one has not proactively been issued. For those individuals that serve in outpatient hospital settings, more than one referral may need to be issued by the primary care physician (one to the hospital and one to the individual servicing practitioner) if the individual servicing the patient is not contracted and employed by the hospital.

What is eligible retroactive start date of applications?
Most MassHealth coverage types can give 10 days of retro coverage, applicants over 65 get up to 90 days of retro coverage.

What happens when a MH member gets into an MCO that there doctor does not take?
Call 1-800-841-2900 to switch to another doctor.

MassHealth Essential, can they pick an MCO/PCC?
Essential members can choose either.

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Questions from the MTF April 2011 Meeting Evaluations:

Back log - the back log at ma health, we were told that we are not to refax information, in the past many of us re-faxed because we were not sure ma heath received the information and we wanted to make sure it was received, so going forward we will not refax, however, will you except our fax confirmation if MH says they did not received it?
Yes

How can we find out more about who the Outreach & Benefit Enrollment Grantees are in our area?
To learn more about the EOHHS outreach grant program or to obtain a list of the outreach grantees visit: **www.outreachgrants.org**

I forgot to ask about the question about employed or college student question on MER/TRANS (SP) form. Because the applicant is over 65 years old; does the applicant have to answer this question?
All questions should be answered**.**

I was confused as to if we have to continue to ask applicants for their Birth Certificates when doing a VG Application. Do we or don't we? Why all of sudden is the Local MEC asking me to provide Birth Certificates and Identity for applicants over 65 yrs. of age? Is this because they could not locate these patient's in the Social Security System?
As a general rule of thumb, any verification that is available should be submitted with the application. In most cases MassHealth can match with SS to verify citizenship and identity. If further verification is needed a request will be sent. Including verifications with the application will cut back on the time necessary to process the application while awaiting the documentation.

This question is for MassHealth in regards to absent parent. How do we treat a parent who lives outside of United States or outside of Massachusetts?
No matter where the absent parent lives all known information should be provided in Supplement B of the application.

What are the asset limitations for the following programs: QMB, SLMB & QI-1?
It's $6680 for an Individual and $10,020 for a couple.

What is the process for newborn babies who DSS will take over? example: When DSS takes over the newborn because of mom situation, their MassHealth starts when the 51A is filed and

they take over; that leaves the day of birth and sometimes an extra day that are not cover by MassHealth. What would be the process to get those days covered? For those two days the hospital is responsible for the child can we do an application on behalf of the hospital and make the financial counselor the ERD?
DSS internal process should go to DSS (DCF) agency for answer.

When someone has long-term care and their condition is not changing, how can this person eligibility be questioned?
MassHealth is required to review cases annually. MassHealth is also committed to finding ways to reduce the administrative burden for members, providers and eligibility staff. MassHealth populations with stable circumstances are currently being identified and analyzed to determine if they meet criteria for a more streamlined method for renewing their eligibility. MassHealth receives income and insurance information directly from the Social Security Administration to automatically verify both Social Security income and Medicare insurance. Therefore, members receiving Social Security as their sole source of income and Medicare are populations with stable circumstances that can benefit from a streamlined eligibility review process. In April 2010, MassHealth successfully implemented an administrative annual review process for approximately 13,500 members who reside in a nursing facility. These members are sent an eligibility review form and a letter that informs them that they will remain enrolled and only need to complete and return the form if they have changes to report. MassHealth is exploring possible other population that we could use a similar administrative annual review process.

Resident was discharged in MMIS (in error) by MMQ Nurse, because he was on Medicare. This took him out of the facility.(Not coded to Keystone anymore) We have sent in new SC1 to get him coded to us and called several times and we are having a hard time getting the Resident coded to us so we can bill. Who can we contact directly so we can get our Residents coded to us? It is not only our facility that is having a problem it is many facilities. The individual MEC'S Long term care ongoing units complete the SC-1 changes so the providers need to call whichever MEC their facility deals with.

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Health Connector

Questions from the MTF April 2011 Roundtable Forms:

Please explain the difference between Commonwealth Care vs. CommonHealth Care. Briefly explain the eligibility differences between MassHealth and Commonwealth Connector?
A description of MassHealth coverage types, including CommonHealth, and the Health Connector's subsidized Commonwealth Care can be found in the member booklet. You can view the member booklet at the following web link:
http://www.mass.gov/?pageID=eohhs2modulechunk&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eeohhs2&b=terminalcontent&f=masshealth_consumer_member_application-member-forms&csid=Eeohhs2

Individuals who are seeking health insurance can also do a preliminary screening to determine if they might be eligible for state health insurance benefits from this web page.
https://service.hhs.state.ma.us/ierhome/LandingPage.do?method=displayConsumerHomePage&pageSwitch=HOME

What is the difference between Type 1 and Type 2 members?

A Plan Type is a scope of health benefits that is available to a group of eligible Commonwealth Care individuals based on their income. Each Plan Type has a certain list of health benefits and copayments. Commonwealth Care has three Plan types:

- Plan Type 1 is available to eligible individuals whose income is below 100% FPL
- Plan Type 2 is available to eligible individuals whose income is greater than 100% FPL but at or below 200% FPL.
- Plan Type 3 is available to eligible individuals whose income is greater than 200% FPL but at or below 300% FPL

Individuals who are eligible for Plan Type 1 benefits are not subject to a monthly premium. Learn more about the different plan types, benefits and copayment structure at the Health Connector website at www.MAhealthconnector.org.

Questions from the MTF April 2011 Meeting Evaluations:

Information about the Bridge Program was not discussed at the forum from the Connector. Many members from our program will be affected if this program will be closed. Will the Bridge program continues after June, 2011? What we need to do as an organization to help to avoid this to happen?
Commonwealth Care Bridge information will be shared at the next upcoming MTF quarterly forums.

More detailed information on Transition of Care Support i.e. weekly meetings and incoming new members with Limited Choice.
Transition of care meetings are held between Connector Staff and their respective MCO liaisons. The intent of these sessions is to ensure that members experience minimal disruption as health plan changes take effect July 1, 2011.

Effective July 1, 2011, eligible Plan Type 1 enrollees who do not have any previous MCO history (180 days) with either MassHealth or Commonwealth Care will have a limited choice of health plans. Most areas will have a choice between two plans – either CeltiCare or Network Health. Individuals living in the following service areas are only eligible to enroll in one plan:

Service Area	Available Health Plan
Greenfield	CeltiCare
Northampton	CeltiCare
Pittsfield	Network Health

Would the Connector consider using an ID and password instead of having a patient have an individual e-mail address to be able to enroll? Not everyone has access to e-mail address.
Commonwealth Care members who would like to use the member web portal are not required to have an email address.

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Virtual Gateway

Questions from MTF April 2011 Roundtable Forms:

When MassHealth eligibility is checked and the result says "more than one member found", can the system allow us to go in and retrieve the patient you're looking for so that we do not have to call Customer Service? This would save time.

We understand why you would want to do this. However, the reason for the message "more than one member found" is to protect the privacy of the individual who is not your patient or client in the event that My Account Page cannot distinguish among several individuals all having the same name and/or identifying numbers. If MAP or other systems were to list all of the individuals with the same identifying information it found for your search, a risk exists that information would be viewed for those not your clients in an attempt to find the person with the same name, etc., that is your client.

Why can't reviews be done electronically – would save time and paper?

MassHealth completely agrees with you. As you know, Streamlined Renewals – online annual review – has been available on the Virtual Gateway for Commonwealth Care members the past 3 years. In addition, it is our goal to eventually develop an electronic Virtual Gateway Eligibility Review capability for all programs and members. Resource limitations have prevented us from developing it sooner, but we are currently exploring it. We will keep you informed of the latest developments and appreciate your patience!

Why don't you put a check box on the VG application that states this is an eligibility review? Wouldn't it be easier to handle as much as possible electronically?

This is an interesting idea. However, the issue that prevents us from doing it is that annual reviews, must, for a given member, be submitted only during a specified time period. The member himself needs to be notified by MassHealth that his "review period" has started and that it will expire on a given date thereafter. Placing a checkbox on the VG would allow reviews to be sent at any time of the year – even those periods of time falling outside of the member's specific review period. However, MassHealth is currently exploring electronic Virtual Gateway Eligibility Review capability for all programs and members - we will keep you posted on our progress.

Is there a way that we can check the status of an applicant that is recently released from incarceration on line without having to call and check if they were approved and for what coverage?

Currently, we have a MassHealth Pilot Program with the Dept. of Corrections which begins the application process for MassHealth 60 days before they leave incarceration. A facility can use My Account Page and or EVS to check status on anyone whether applying or on the program.

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Health Safety Net

Questions from April 2011 Meeting Roundtable Question Forms:

What happens when a second HSN deductible is assessed as the result of a redetermination? i.e. deductible $1900.00 effective 10/1/10 and deductible $1800.00 effective 3/5/11 = deductible of $3700.00 for the year.

If a patient with an HSN partial deductible has an income change in the middle of the year, it is possible that their deductible amount will change. When this happens, the new deductible amount replaces the old deductible amount for the remainder of the year; the amounts do not get added

together. In the above example, after the redetermination, the patient would still be responsible for paying only $1,800 services received between 10/1/10 and 9/30/11. Amounts paid between 10/1/10 and 3/4/11 would apply to the $1,800 deductible requirement in effect beginning on 3/5/11.

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MassHealth Billing and Provider Services

Questions from April 2011 Meeting Roundtable Question Forms:

When a claim for 2 payers (COB) is submitted thru POSC (DDE), when would MassHealth require a copy of the primary EOB?

When submitting coordination of benefits claims through DDE (or through an 837 transaction), a copy of the primary EOB is never needed. In order to convey the EOB details, you must directly enter them into the appropriate tabs and fields in the DDE interface. For additional information related to submitting Direct Data Entry (DDE) Coordination of Benefits (COB) transactions, please consider attending the July MassHealth DDE COB trainings. Details about these trainings can be found at www.masshealthmtf.org under the *Highlights* section on the right side of the web site.

Will DDE for COB claims get any easier? (Very time consuming for Providers compared to paper).
No changes are expected with the DDE interface. However, continued engagement of the DDE system, specifically with the COB panels, facilitates a familiarity with the system and contributes to an ease of use that most likely will not be present during initial periods of engagement.

For clients attending an Adult Day Health facility, eligibility checks are done via the POSC. We look for "Standard Health" status to determine clients' eligibility and ultimately provider reimbursement of services. In the "List of Other Insurances" section, if a client has another insurance (HMO, MCO, etc.), we are told we must bill "other" insurance first, get a denial letter, then submit to MassHealth. Why? Adult Day Care Services are NEVER paid by these "Other Insurances".
Since each member's situation may be different based on their other insurance and their MassHealth coverage type, providers should first consult Subchapter 1-3 of their provider manual regarding MassHealth eligibility and coverage. The provider should always check with the other insurance's policy and payment as it should never be assumed whether payment is made or not. The provider can then contact MassHealth customer service if there are any additional questions regarding billing MassHealth.

Issues with MCO's and POSC discrepancies
The MassHealth EVS system is always the system of record.

Some providers only have new provider numbers', they do not have the legacy number required for billing.
MassHealth no longer issues 7 digit provider IDs upon enrollment by a new provider; only 9 digit Provider IDs with an alpha character serving as the 10th digit are issued.

Partial Voids – Can they be done online?
Partial voids cannot be done at MassHealth. In order to void a claim, the provider must void the entire claim and re-bill only those lines that do not need to be voided. However, there is an indirect

way to accomplish the same purpose. If a provider adjusts their original claim and omits the lines that they would like voided from the original claim, then the omitted lines will essentially be voided and only the remaining lines will adjudicate.

Why do R/A crossovers for Home Health (which is billed under Medicare A) have Medicare 'B' reimbursement information on top?
An example would be needed in order to address this information. If you have further questions regarding this, please contact MassHealth Customer Service at 800-841-2900 or providersupport@mahealth.net.

Status of final appeals
The appeal unit currently has an inventory of claims. Should you have a question about an appeal you submitted you can contact fdeappeals@state.ma.us or connect with them at 617-847-3115.

Version 5010
MassHealth is working towards implementation of 5010 on January 1, 2012. Please visit www.mass.gov/masshealth/5010 for more information on this initiative.

ICD-10 Codes
MassHealth began the ICD-10 planning effort in October 2010 and 5010 implementation is the priority now leading up to 1/1/2012 go live date. During the **next few years** the coding language will be transitioned from the current ICD-9 version to a new set of codes, ICD-10, for diagnoses and procedures. An assessment will be performed on MMIS and on interfaces between MMIS and its supporting systems. Business processes review and analysis will be needed, and a transition plan from ICD-9 to ICD-10 will be developed that will include Commonwealth trading partners.

When a patient is referred to us, and has used Physical Therapy, Occupational Therapy or Speech visits elsewhere, how much time do we have to get a (retro) prior authorization? Most times we don't know until we get denied.
Effective for dates of service on or after January 1, 2005, after 20 PT visits, 20 OT visits, or 35 ST visits, within a rolling 12-month period, you will need to request prior authorization from MassHealth for additional therapy visits of that type during that 12-month period.
Please note: The MassHealth managed care organizations (MCOs) (Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Network Health, and Neighborhood Health Plan), Senior Care Options (SCO), and Program of All-inclusive Care for the Elderly (PACE) may have prior-authorization policies that differ from the MassHealth policy described above. MassHealth members enrolled in these MCOs are subject to the prior-authorization policies of their health plan.

Are there acceptance (277) reports for submitted claim files?
Yes. Please note that provider must be setup up in MMIS system for 276/277.

I have a Standard MassHealth client with an MCO. Client signed up with Adult Foster Care in the fall of 2010 and a MH Customer Service Rep. is working on a "glitch". We have not yet been paid for services through 12/31/10.
The provider should call CST to follow up on identified MMIS issues.

Questions from MTF April 2011 Meeting Evaluations (Electronic):

I'm unable to find the job aid for COB carrier codes for resubmitting on VG. Any policies about what can be billed to Patients who are unable to find in Provider Manual as directed?

Third Party Liability Carrier Codes can be found in Appendix C of the MassHealth Provider Manual found on www.mass.gov/masshealthpubs. Click on Provider Library then on MassHealth Provider Manuals and then on your provider specific manual. Appendix C should be found within that link.

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