Massachusetts Health Care Training Forum
July 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

Questions from the MTF July 2011 Roundtable Forms:

What is the best way to report an emergency situation or change in income/work?
Call the MassHealth Enrollment Center at 1-888-666-9993

What is the MassHealth Customer Service phone number?
MassHealth Customer Service Center
1-800-841-2900
TTY: 1-800-497-4648

Is there a specific number a person should be calling for eligibility?
Call the MassHealth Enrollment Center at 1-888-666-9993

What is the MassHealth mailing address?
Effective April 22, 2011, the new mailing address for **non-LTC SMBR** applications, reviews and case maintenance for the Springfield, Taunton and Tewksbury MassHealth Enrollment Center is:
Taunton MassHealth Enrollment Center

P.O. Box 1231
Taunton MA 02780
Fax (508) 828-4611

Can a MassHealth patient be billed for non-covered services?
Call 1-800-841-2900 for Provider billing information.

When the "denied visitor" gets approved after verifying information, why doesn't the case go retro to application date?
Eligibility is determined on a case by case basis. Not all coverage types give retroactive eligibility. If information is not received timely this may also be a reason why there would be no retroactive coverage.

Explain Common Health Work requirement, does work before the date they stopped working count?
Disabled working adults must be employed at least 40 hours per month, or if employed less than 40 hours per month, have been employed at least 240 hours in the six-month period immediately preceding the month of receipt of the MBR or MassHealth's eligibility review.

How does a green card affect level of coverage for MassHealth for a lawfully admitted immigrant?
Generally date of entry and type of status determines what type of coverage individuals may be eligible for. For more detail see page 25 in the MassHealth member booklet or visit the MassHealth website for full details. www.mass.gov/masshealth

What will MassHealth Limited cover in the ER for non-life threatening problems?
MassHealth Limited does not cover non-life threatening conditions. See below provider regulation.
(G) MassHealth Limited.
Covered Services. For MassHealth Limited members (see 130 CMR 505.008 and 519.009), the MassHealth agency pays only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in
(a) Placing the member's health in serious jeopardy;
(b) Serious impairment to bodily functions; or
(c) Serious dysfunction of any bodily organ or part.

Could it be possible to attach the PSI to the eligibility review forms? As a member stops in to drop off the ERF, sometimes we don't approach them with the PSI because the member leaves too quickly. Most of the time we do get them signed but this would help all providers.
Permission to Share (PSI) forms can be downloaded from the MassHealth website.
They do not come with the ERV forms that are mailed to the members.

Members are often told by pharmacy's that they will only retro bill MassHealth if coverage is received within 14 days of purchase. Can they do that? If so, how does the member get reimbursed?
It is possible for the pharmacy to reimburse members for prescriptions in certain circumstances. The pharmacy should call 1-800-841-2900 for information on reimbursement procedures if they are unfamiliar with the process.

When a case in a "03" status for EAEDC, MassHealth tells them to go to DTA.
The case that is in a "03" status is pending approval or denial for cash benefits by DTA. The client has thirty days from the date of application to get their verifications into DTA. This client's eligibility will show in EVS as a "03" until a determination of approval or denial for cash

benefits has been made by DTA. During this time, if an individual declares he/she needs medical assistance, DTA will issue a temporary MassHealth card to the cardholder for use. The temporary MassHealth card shows dates of eligibility, service restrictions, and other insurance information. If a discrepancy occurs between information given on a temporary MassHealth card and by EVS, the information on the temporary card prevails. To be paid for a covered service that was provided based on information given on a temporary card; a provider must produce a copy of the temporary card, and have otherwise met all other prerequisites for payment.

Once the cash case is approved by DTA, MassHealth will send additional required paperwork for the client to fill out so that they can choose a primary care doctor. The information received will be used to determine the most comprehensive benefit the individual qualifies for. The individual **must** follow through with this paperwork given to them by MassHealth in order to receive the qualifying coverage.

Please clarify; Are we right in that in to get MassHealth Family Assistance you have to either have a child living with you, or have an employer who is enrolled in IP or have HIV?
MassHealth Family Assistance offers coverage to children, some working adults, and people who are HIV positive who cannot get MassHealth Standard or MassHealth CommonHealth. For more eligibility details on Family Assistance see page 12 in the MassHealth Member Booklet, or visit the MassHealth website. www.mass.gov/masshealth

I am having to trouble reporting Commonwealth Care Bridge members who are newly pregnant to the MEC's. What is the fastest way to report this change to see if they can be upgraded?
A Commonwealth Care Bridge member who is newly pregnant should report this change to the MassHealth Enrollment center. 1-888-665-9993.

Can the MEC's stop sending members to Quincy Medical Center to complete ERV's? We do not have a supply of the forms.
The ERV forms are system generated. If the member has lost their paper ERV they can contact the MassHealth Enrollment center to get another form. The member may then take the paper ERV to the medical center for help with completion of the form.

I have submitted Virtual Gateway application (both over 65 applicants) and they are in a pending status. When I called CPU, they did not receive them. I wondered if;
A: They should be resubmitted and
B: How do we obtain retroactivity back to original application?
The SMBR (Senior Medical Benefit Request) application form is processed at the local MassHealth Enrollment Center not the CPU. All SMBR's should be sent to the MEC'S for processing. Effective April 22, 2011, the new mailing address for non-LTC SMBR applications, reviews and case maintenance for the Springfield, Taunton, and Tewksbury:
MassHealth Enrollment Center is P.O. Box 1231 Taunton MA 02780.
SMBR (over 65) applications for the Revere MassHealth Enrollment are still being mailed to the Revere office.
REVERE MASSHEALTH ENROLLMENT CENTER
300 OCEAN AVE, SUITE 4000
REVERE, MA. 02151
Fax (508) 828-4611
SMBR applicants can have up to 90 days of retroactive coverage if they meet all eligibility requirements.

When a person has legal guardianship of a child, are they able to receive MassHealth services for child without MassHealth requesting their income?
There are specific factors that determine if the legal guardian's income will be considered in determining eligibility for a child. They include relationship of the legal guardian and if the legal guardian is applying for themselves.

What happens to the child coverage if the absent parent form is not returned? How about when the absent parent is in and out of the country?
Applicants and members are required to answer the absent parent questions for all children under age 19. If the absent parent information is not provided, MA21 will send a verification notice with an AP-1 form. Failure to complete and return the verification within the required time frame (60 days) will result in denial or termination of benefits for the custodial parent(s). Children under the age of 19 and pregnant women will not have their benefits denied or terminated if the only item not provided is the absent parent information. The applicant or member should have their permanent residence listed with the MassHealth office. This is where the form would be sent.

Can we consider e-filing an application on Virtual Gateway? Sort of the same process when one purchases anything at the store using a credit card, where the customer has to sign in the box to "ok" payment. This would save providers both paper & postage.
MassHealth is continually exploring ways to enhance systems to operate more efficiently. Thank you for that suggestion.

If a facility got audited by MassHealth and it was discovered that MassHealth over paid on some accounts, how does MassHealth recoup the money?
There is a process in place for MassHealth to recoup funds on overpaid accounts. The provider should call 1-800-841-2900 for details.

Can a member get a referral to see a MassHealth provider for a plan different than their own? Member has NHP wants to see specialized allergist who is not NHP but with another MassHealth plan
The member should call 1-800-841-2900 to get the correct referral procedure to obtain services outside of their MassHealth managed care plan.

I had a situation with a patient that was not being truthful during interview. I was told to alert the fraud line. I left 3 messages and nothing happened. No one has ever called me.
The correct procedure was followed in the above situation. The fraud unit will investigate on a case by case basis. The provider may or may not be contacted depending on the individual circumstance of the referral.

Is the bedside tool going to be updated? When?
You can use Medical Benefit Request (MBR) form, as a replacement for the "Bedside Tool". The current process is as follows; **Make photocopies of MBR for this purpose.**
Use MBR ONLY if patient is confined to bed and cannot meet with financial counselor AND you wish to submit an application on the VG for this patient. Use in the presence of your patient. Enter information you wrote on MBR onto Virtual Gateway Health Assistance online application. Mail to MassHealth the following: VG Cover Sheet you currently mail with signature pages and PSI's MBR. **Signature page ONLY–DO NOT MAIL ENTIRE MBR**–doing so will cause significant problems and delays.

Questions from the MTF July 2011 Meeting Evaluations:

Are the over 65 Gateway Applications taking longer to process because of all the changes at the Taunton MEC? Is there a better phone number for providers to use when following up with the Taunton MEC?

The Taunton MEC numbers have not changed. The contact information is
MASSHEALTH ENROLLMENT CENTER
21 SPRING ST, SUITE 4
TAUNTON, MA. 02780
1-800-242-1340
508-828-4600
The number for customer service is 1-888-665-9993. Continue to check MAP for notices.

Do we still send Electronic Document Management (EDM) - LTC SMBR's mail to MEC in Taunton 21 Spring St.?

All LTC intake applications and related verifications for the Taunton MEC should be sent by mail or fax to the address and fax number shown below. The P.O. Box 1231 has been designated for non LTC intake. This information will change on 9/24/11 when MassHealth integrates Revere and CPU into EDM.
Taunton MassHealth Enrollment Center
21 Spring St. Suite #4
Taunton, MA 02780
Fax: 508-828-4634

How does life insurance impact eligibility for Mass Health over 65? Can ownership of a life insurance policy be changed to make an elder eligible for LTC or Frail Elder Waiver?
The list of presenters is great, but can you add what positions these folks hold? Is it possible to get their contact information?

Below is the policy for life insurance:

(E) Cash-Surrender Value of Life-Insurance Policies.

(1) The cash-surrender value of a life-insurance policy is the amount of money, if any that the issuing company has agreed to pay the owner of the policy upon its cancellation. An individual may adjust the cash-surrender value of life insurance to meet the asset limit. The MassHealth agency will consider the cash-surrender-value amount an inaccessible asset during the adjustment period.

(2) If the total face value of all countable life-insurance policies owned by the applicant, member, or spouse exceeds $1,500, the total cash-surrender value of all policies held by that individual is countable. The MassHealth agency does not count the face value of burial insurance and the face value of life-insurance policies not having cash-surrender value (for instance, term insurance) in determining the total face value of life-insurance policies. Burial insurance is insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses, funeral expenses, or both of the insured.

The presenters contact information is available at the MTF meeting or can be obtained by request through the MTF email list serve

Back to Top

DEPARTMENT OF TRANSITIONAL ASSISTANCE

Questions from the MTF July 2011 Roundtable Forms:

Can you give me more details about college students and when they may be eligible for the Supplemental Nutrition Assistance Program (SNAP- formerly Food Stamp Program)?

A "student" is defined as being age 18 to 49 years of age; enrolled at least half-time in an institution of post-secondary education, a vocational or technical school at any level, a program that provides for completion of a secondary school diploma or the equivalent; or a school at any level for the physically or mentally handicapped.

A student shall be ineligible to participate in SNAP unless he or she meets one of the eligibility requirements:

(A) Be employed at least 20 hours per week or be employed for 20 hours per week averaged monthly and be paid for the employment, or, if self-employed, be employed for a minimum of 20 hours per week or be employed for 20 hours per week averaged monthly and receive weekly earnings at least equal to the federal minimum wage multiplied by 20 hours;	(B) Participate during the school year in a federally-funded work-study program (financed at least partially under Title IV-C of the Higher Education Act of 1965) or a state-funded work-study program; (C) Be responsible for the care of a dependent household member under the age of six; (D) Be a single parent enrolled full-time in an institution of higher education and responsible for the care of a dependent child under the age of 12 regardless of the availability of adequate child care.	(E) Be responsible for the care of a dependent household member who has reached the age of six but is under the age of 12 for whom adequate child care is not available to enable the student to attend school and work a minimum of 20 hours per week, or participate in a federally-funded or state-funded work-study program during the regular school year; (F) Be receiving TAFDC or AFDC;	(G) Be assigned to or placed in an institution of higher learning through: (1) A program under the Job Training Partnership Act (JTPA); (2) A program under Section 236 of the Trade Act of 1974; (3) An employment and training program under the Food and Nutrition Act; or (4) An employment and training program operated by a state or local government.

Does DTA still provide childcare vouchers for TAFDC clients?

DTA does not provide the child care voucher. We refer our clients to a childcare resource agency who can provide vouchers for daycare. Eligible clients must be participating and meeting certain DTA approved trainings/work program related activities or be employed in order to be referred.

Can someone on SNAP receive a childcare voucher?

For the SNAP program, we give a "child care deduction". The client only has to state how much they pay for daycare expenses and we will use this figure as a deduction from their overall gross pay reported. As for the voucher, they would have to go to their local childcare resource agency to inquire about how to obtain a voucher.

How is the car value taken into consideration for TAFDC? For SNAP?

Below describes the rules for car values for **TAFDC**:

- The first $10,000 of the **fair market value** *(fair market value is the price for which the vehicle will sell on the open market)* and the first $5,000 of **equity value** *(equity value is determined by subtracting the balance of any liens or legal encumbrances from the fair market value of the vehicle)* of ***one (1)*** vehicle owned by the household are non-countable.
- Any fair market value in excess of $10,000 is a countable asset.
- Any equity value in excess of $5,000 is a countable asset.
- If there is an excess in both the fair market value and the equity value, only the excess which is the **greater amount** shall be counted toward the asset limit.

  *(When the household owns **more than one vehicle**, the $10,000 fair market limit and the $5,000 equity limit shall be applied to the vehicle having the greatest fair market value, provided it is used primarily for the transportation of the household.*

  The full fair market value or the full equity value, whichever is greater, of each additional vehicle owned by the household (including vehicles that are used primarily for recreational purposes such as snowmobiles, boats, trailers, jeeps, vans and motorcycles) shall be countable.)

For **SNAP** the car in a "non-countable asset".

How long can someone stay on TAFDC?

Households that are nonexempt (nonexempt =mandated to work/youngest child in the household is 2 years of age) are eligible for TAFDC assistance for a maximum of a cumulative 24-months in a continuous 60-month period.

How can you tell if a case was considered "TMA" for 4-12 months?

For cases that are in a pending status the system of reference is EVS. For all other eligibility, providers should continue to check MMIS and My Account Page for eligibility information.

Can newborns be added to the TAFDC grant when the grantee is currently on the program?

A TAFDC assistance unit shall not be eligible for an increase in TAFDC assistance for a child born after the assistance unit's Family Cap date. This date is ten (10) months following the date that the Grantee first applies…

(ex: June Jones applies on 01/01/2011. She has one child age 2 and she is 4 months pregnant. She has the baby on May 1, 2011. This child is born before October 1, 2011, so she CAN add this child to her grant. If June has any other children after the October 1, 2011 date (her Cap Date), the children cannot be added to the grant.)

SNAP, TAFDC and EAEDC programs: Will rules apply for new immigrant eligibility 5-year bar? Will it affect the sponsor if they apply for these benefits?

See below:

- Noncitizens with LPR status are EAEDC eligible; no 5-year wait is required.
- PRUCOLs (Persons Residing Under the Color of Law) are eligible and this status is **not acceptable** in **SNAP** or **TAFDC**.

List of "ELIGIBLE" Noncitizen Status (for the EAEDC program)

The information below is directly from our Policy:

(A) Eligible Noncitizen Status

A noncitizen's eligibility for EAEDC depends on the section of the Immigration and Nationality Act (INA) under which the noncitizen is present in the United States, and meeting additional noncitizen requirements. Eligible noncitizen statuses for EAEDC are:

(1) Legal Permanent Resident - A noncitizen present in the U.S. as a legal permanent resident.

(2) Refugee - A noncitizen present in the U.S. as a refugee under section 207 of the INA.

(3) Asylee - A noncitizen present in the U.S. as an asylee under section 208 of the INA.

(4) Withholding of Deportation Noncitizen - A noncitizen whose deportation is being withheld under section 243(h) or 241(b)(3) of the INA.

(5) Parolee - A noncitizen present in the U.S. as a parolee under section 212(d)(5) of the INA whose parolee status was granted for a period of at least one year.

(6) Conditional Entrant - A noncitizen present in the U.S. as a conditional entrant under section 203(a)(7) of the INA as in effect prior to 4/1/80.

(7) PRUCOL: Permanently Residing Under Color of Law - A noncitizen permanently residing in the U.S. under color of law.

(8) Cuban/Haitian Entrant - A noncitizen present in the U.S. as a Cuban/Haitian Entrant as defined under section 501(e) of the Refugee Education Assistance Act of 1980 or under section 212(d)(5) of the INA.

(9) Amerasian - A noncitizen from Vietnam present in the U.S. as an Amerasian Immigrant as defined in section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1988.

(10) Victims of Severe Forms of Trafficking

A noncitizen who is present in the U.S. having been issued a letter of certification by the U.S. Department of Health and Human Services (HHS) as proof of the victim of severe form of trafficking status (as defined in the Trafficking Victims Protection Act of 2000).

Can a family with foster children apply for SNAP?

Families with foster children may apply for SNAP. They have the option of applying as follows:

- The foster child can be added with the household applying and the income received for the foster child will be counted for the household;
- The foster child does not have to be added to the households SNAP and the income received for the foster child is not counted for the household.

Should clients send in their first pay stub once they start working in order for their case to receive TMA?
Clients should always send in their first pay stub so that their case manager can enter it into our system. This will assure that if the case closes, the client can get all of the extended benefits that take place after it closes. If they do not do this step, the may not be entitled to certain extended benefits and will not be able to.

How do Emergency Aid to Elders, Disabled and Children (EAEDC) recipients access transportation assistance?
When the EAEDC applicant completes the application process becoming eligible for EAEDC, monthly stipend check and at that point will the applicant become eligible for MassHealth Basic. (See 505.006). Basic does provide emergency ambulance transportation. Please consult MassHealth Provider Regulations 130 CMR 450 for a listing of covered services, as well as 130 CMR 407 for information pertaining to transportation.

Back to Top

HEALTH CARE FOR ALL

Questions from the MTF July 2011 Roundtable Forms:

How can I enroll clients in private non-group insurance during open enrollment that does not have a social security number?
You can use a taxpayer ID number if the person does not have Social Security number. We have found that some insurers are stricter than others with this requirement.

On slide 5, (page 33) of the MTF handout, it mentions Small employer tax credit, Medicare Part D coverage gap or donut hole – 50% discount on brand name prescription drugs, No annual or lifetime limits on insurance benefits, No copayments for preventive services and $160 million in grants and demonstrations including "Money Follows the Person". Is this already in place in MA?
Yes, all of these are in place already, as part of the implementation of the Affordable Care Act. If you have specific questions about any of these, feel free to contact me at rosman@hcfama.org.

Back to Top

MASSHEALTH PROVIDER BILLING AND SERVICE

Questions from the MTF July 2011 Roundtable Forms:

I am getting error codes 6010 on my EOB, when I call they say it is a system error that is being worked on at the state level. Has this been resolved? What do I do with these claims?

If a provider has an escalation that is being researched, the provider can call CST to check on status. Providers can also check message text or POSC notices for additional information.

When will MassHealth recognize appropriate modifiers and payment with them?
Providers need to check Transmittal Letters for changes to regulations.

I was told that when a patient is covered by an MCO plan and our charges are denied, we may bill MassHealth. Would this apply for a no authorization denial due to a pending status? If so, how would we proceed to bill MassHealth?
Members who have a MCO plan need to have their claims submitted to the MCO. Providers should follow the guidelines of the specific MCO plan for claims submission.

A dentist wants to provide dental care to MassHealth covered kids in our OR. She is asking if we will be able to bill MassHealth and get paid. What do I tell her?
Providers with questions regarding providing care should contact CST to discuss specific issues.

I'm having trouble with photos 92250 and 4-line claims with 1-line not paid.
Providers should consult the Remittance Advice to review denial codes which will give more information regarding denials and payments. If additional assistance is needed, the provider can contact CST with the ICN and EOB code to for help with clarification.

TPL information is not updated for recipients with plans that do not cover our services (e.g. Health Safety Net).
Health Safety Net (HSN) is free care and only certain limited services are covered.

New survey billing rules; add on services (add on CPT codes) are being denied as MUE. Provider outreach representative explained only first code would be paid. Is there written guidance for codes that are not CCI our MUE and denied?
Providers need to refer to All Provider Bulletin 209

What do providers need to do, specifically to ensure they are ready for 5010 billing?
New MassHealth Web Page Lists 5010 Electronic Transactions Updates. MassHealth is continuing to add to the 5010 Web page with the latest 5010 information. Please check this page frequently (www.mass.gov/masshealth/5010) to stay informed about any 5010 updates.

Why are bilateral units split on prior authorizations when they are submitted on the same line?
Prior Authorization questions should be directed to the Prior Authorization unit. Please refer to Appendix A of the provider manual for the appropriate contact information.

Why does MassHealth only pay on one part of a claim? We bill for Medicaid Management and a procedure, MassHealth will only pay for one.
Providers should consult the Remittance Advice to review denial codes which will give more information regarding denials and payments. If additional assistance is needed, the provider can contact CST with the ICN and EOB code to for help with clarification.

We have several claims for skilled nursing room & board charges that were adjusted online after the one year file limit to correct the patient liability had changed and the entire payment was retracted by MassHealth.
Providers should not be adjusting claims over 1 year via the online system. Please refer to All Provider Bulletin 186 regarding Final Deadline appeals.

How come MassHealth does not pay for co-pays for secondary claims submitted to MassHealth?
Providers should consult the Remittance Advice to review denial codes which will give more information regarding denials and payments. For Third Party Payment limitations, please refer to 130 CMR 450.317 (Third-Party Liability: Payment Limitations on Claim Submission) in Subchapter 3 of the Provider Manual.

Regarding overpayments; we've sent in several void requests, some 3 times and they are not being recouped. Some are just for one treatment and one is a big recoup. Sent in 2010 as part of the "grace period" MassHealth did. Why aren't all my void requests being processed the first time they are sent?
Providers with specific issues should contact CST directly.

MassHealth included labs in the ATP building inappropriately. On the ones that have passed the filing limit, how does MassHealth want us to resubmit?
Providers with specific ATP issues should contact CST directly.

We are ambulance providers and many items are required that aren't on the basic billing guide. We are not able to direct enter new claims, no ICN number is issued, only an error message is received, and no claim is registered #.
Providers who are receiving errors while entering DDE claims which cannot be resolved should contact CST for assistance**.**

In MAP, patient has deductible and date. As time goes by, in MMIS the date changes and sometimes the deductible as well.
Providers should check MMIS eligibility using appropriate the date of service.

Questions from the MTF July 2011 Meeting Evaluations:

We are getting denials for the 99425 99426, I was told we can no longer use those codes and to review sub chapter 6. I was not able to find the new codes and would like to know what those are.
Providers should consult the Remittance Advice to review denial codes which will give more information regarding denials and payments. If additional assistance is needed, the provider can contact CST with the ICN and EOB code to for help with clarification.

I have difficulty with claims that were submitted by someone other than the primary care provider. How can these be resubmitted using the primary care 7 digit code so they will be paid? Submitting claims on newborns is somewhat challenging.
Providers should consult the Remittance Advice to review denial codes which will give more information regarding denials and payments. The primary care 7 digit code is no longer used. If a member belongs to the PCC program, then a referral needs to be entered into the POSC by the member's PCC.

Back to Top