

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

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

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

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

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### MASSHEALTH UPDATES

#### **Questions from the MTF January 2012 Roundtable Forms:**

**If member has been denied MassHealth because she/he's already on MassHealth, will DES process the disability supplement form submitted on his/her behalf?**

Yes if the member is proven disabled they may get a different coverage type many times resulting in a richer benefit. Any change to a member's circumstances should be reported to MassHealth within 10 days. The member would not need to wait for a denial of benefits to submit the disability supplement form.

**If a Medicare beneficiary who is under age 65 wants to apply for MassHealth and Buy-In, should he complete the MBR or SMBR? If he should complete the MBR, how does MassHealth evaluate his asset eligibility?**

A person under 65 living in the community should complete the MBR. Assets are not considered for the under 65 year old Buy-In coverage. If the beneficiary is interested in Buy-In coverage only they can fill out the shortened buy-in application available on the MassHealth website at:

<http://www.mass.gov/eohhs/gov/departments/masshealth/applications-and-member-forms.html>

**What application do I need to get folks Standard coverage for my folks in Worcester State Hospital and Tewksbury State Hospital when their “03” closes terms?**

When a cat 3 closes a transitional review should have been mailed to the member. If they did not receive the review and their last application was more than a year ago, then an MBR (for under 65) or a SMBR (for over 65) should be completed.

**When a person is adopted and the name on the birth certificate is different what do you do? If for some reason the children’s are open and the mother’s are closed, should I do an ERV form to add the mother to the child case?**

The mother can be added as a case maintenance function. Generally a review does not need to be done to add a member onto a case.

**If a person is a US citizen and don’t have a way to prove it, what will happen? Will that person be put on HSN?**

MassHealth has set up processes to help assist applicants/members with citizenship and identity verification requirements. MassHealth does electronic data matching with the Massachusetts Registry of Motor Vehicles, and with the Massachusetts Registry of Vital Records and Statistics (to match on birth certifications). In recent months, MassHealth now does data matching with the Social Security Administration on citizenship and identity information. If MassHealth is not able to obtain verification through data matching, the member will be required to provide proof. In terms of type of coverage provided for non-U.S. citizens it would depend on the person’s income and immigration status.

**What are the reasons that a person can get their ID changed? Does member get notified?**

Assuming this is referring to a 12 digit MassHealth ID, the number can change if the name, sex, or date of birth was data entered incorrectly. If the number changes the member should get a new card mailed to them. MassHealth has recently created a team specifically dedicated to the resolution and prevention of the types of situations where more than one ID may exist for a member. If you spot these errors, please call MassHealth Customer Service at 1-800-241-2900.

**I’d like a better understanding of how MassHealth processes documents when received and why sometimes the same documents are requested again?**

The MTF convener team is working on a webinar that will explain the flow and process of paperwork when it is received at a MassHealth office.

**I find sometimes I cannot assist a client via phone. When I call MassHealth and was not the original person who assisted the client with the application, new information cannot be released to me. Can this be changed?**

You can get information and assist the member if they have signed a Permission to Share Form which is a HIPAA requirement form that must be in place before MassHealth can share information.

**Suggestion:**

**Putting the type of insurance on the MassHealth card would help when a client/patient asks what type of insurance. It's easier to explain instead of calling to find out. e.g.: MassHealth, Essential, or MassHealth Basic.**

Thank you for the suggestion. We will take it back.

**Suggestion:**

**Can questions asked today and their answers be posted on a MassHealth website so we don't have to wait till the next MTF to see the responses?**

The MTF website posts the Q&A document on the meeting material section of their website as soon as it is completed. Please look for it at <http://mahealthcaretrainingforum.ehs.state.ma.us/index.aspx>, click on the **meeting materials** tab located in the blue bar at the top of the page.

**Why is MassHealth requesting an Absent Parent Form for 2 parents that do not have an absent parent?**

Depending on how the question is answered on a review /application, the trigger mechanism could send one out. This should not be ignored so a call to the MEC is important.

**Due date for MassHealth application/documents on the requested statement is not clear, it can be looked at as being misinforming. Can the wording be changed to be more clear and specific as to when the application/documentation must be submitted by?**

When MassHealth is requesting information the due date is on the letter. Members need to be sure to read the entire letter as some can be very lengthy.

**When families with children on CMSP call CMSP with a change (correction) of address and they can't make the update, they are told to call MassHealth. Is this necessary?** Yes, as only MassHealth or the Customer Service can make the necessary change. If it is only the address in question other facilities such as a hospital or health center they access may make the change via the Virtual Gateway.

**Hardship waiver (pg 6 of handout); is this different than a medical hardship thru the Division of Health Care Finance and Policy (Health Safety Net)?**

If you are speaking of the "Hardship Waiver" for MassHealth premiums, yes it is different from the medical hardship waiver through the Division of Health Care Finance and Policy. The MassHealth premium billing hardship waiver can be obtained by calling MH Customer Service at 1-800-841-2900.

**Medical Security (pg 9 of handout) - If patient is collecting unemployment benefits, do they still need to apply for insurance through Unemployment or can they apply for MassHealth?**

The Massachusetts Department of Unemployment Assistance provides health insurance assistance through the Medical Security Program for residents of the Commonwealth who are receiving unemployment insurance benefits. Massachusetts is the only state in the nation to offer a health care plan for unemployment insurance claimants, by providing assistance with the cost of existing health insurance premiums or by covering the cost of actual medical expenses.

If you are eligible for unemployment insurance benefits in Massachusetts, you should find out if you and your family (spouse, any children up to their 26th birthday or disabled children regardless of age) may also be eligible for health insurance coverage under the Medical Security Program (MSP) by calling the Program at 1-800-908-8801. Individuals that have access to for MSP are not eligible for Commonwealth Care.

**Client working earns \$60K and gets child support, \$30K. Client provides health insurance for herself and 2 children. Co-pays expensive and 1 child has OCD; is there help for OCD child concerning Co-pays for therapist?**

MassHealth provides comprehensive health insurance coverage. The MassHealth member booklet provides details on benefits and eligibility criteria. The Member Booklet is posted on the MassHealth website at: <http://www.mass.gov/eohhs/docs/masshealth/appforms/member-booklet.pdf>. Most MassHealth benefits include behavioral health services. MassHealth members are subject to nominal co pays for prescription drugs and acute inpatient hospital stays only.

**I work for an elder services agency and we would like to have training on MassHealth overview/programs at our agency, whom should I contact?**

Please go to the MTF website; [www.masshealthmtf.org](http://www.masshealthmtf.org), click on the **Training Opportunities** tab at the top of the page, then, under **Training by Request**, click on the MassHealth Member Education **Request for In-Service** link. Print/fill out/fax form to the # indicated and someone from MassHealth Member Education will get back to you.

**If MassHealth recipient has “Premium Assistance”, will they be eligible for LTC Standard benefits?**

MassHealth Long Term Care (LTC) benefits would result in a member residing in an institutional setting such as a Nursing Home. These are very separate categories but the member hypothetically may be getting Premium Assistance and then become a nursing home case because of his medical condition and potentially qualify but one is not dependent on the other. MassHealth Long Term Care benefits have a MassHealth Standard coverage type.

**Please explain Intake (& fax #) plus Ongoing (& fax #). e.g. SC1’s clinical eligibility’s requested documents.** Please reference the phone/fax number on the correspondence the member receives as to where to return requested verifications. A job aid has also been created regarding where to send documentation. To access this job aid click on the below link:  
<http://www.mass.gov/eohhs/docs/masshealth/provider-services/mfcs-guide.pdf>

**Are there plans to train all MEC intake workers on how to process PACE applications?**

No, there are currently no plans to train new workers.

**If someone over 65 fails to send in their ERV, what is the timeframe to still submit an ERV vs. new application? 30 days?**

For members age 65 or older living in the community, or for members of any age needing long-term care services:

- If the case has been closed for **thirty days or less**, the member provides MassHealth with any required, outstanding verifications on the case. A new application or review form is not required to reopen the case.
- If the case has been closed for **more than 30 days**, a new SMBR is required.

**If a family has Premium Assistance and they complete the ERV to renew, do they also need to fill out the form from Family Assistance Department and employer complete again?**

No they do need to fill out another application for premium assistance unless their health insurance has changed.

**State taking over the SSI checks; is there a site where we can get more information?**

Yes information can be found at the Massachusetts SSI State Supplemental Program (SSP) Customer Service Call Center toll-free number 1-877-863-1128. The call center is available Monday – Friday 9am – 5 pm.

**If someone does not have insurance/MassHealth and goes for TAFDC, why can’t the worker file a MassHealth application rather than sending client somewhere else to do the application?**

In many cases when a person is eligible for TAFDC they also get automatic MassHealth Standard coverage. Some TAFDC offices have a supply of paper applications but they are not processed at that office if they are not TAFDC program related.

## **Questions from the January 2012 Meeting Evaluations:**

### **Could we get more information on the Medicaid estate recovery rules?**

Estate Recovery information is included in the MassHealth member booklet on page 24. The below link will bring you to the Member Booklet.

<http://www.mass.gov/eohhs/docs/masshealth/appforms/member-booklet.pdf>

For more information about estate recovery, see the MassHealth regulations at 130 CMR 501.013 and Chapter 118E of the Massachusetts General Laws.

### **For the MassHealth Premium Assistant payment program; can the individual initiate this by sending in the required forms, or does the referral to the program have to come from the MEC?**

If MassHealth decides you can get MassHealth Family Assistance, you can get coverage in one of two ways.

- Under premium assistance, MassHealth may pay part of your family's health-insurance premiums.
- If you do not have other health insurance, you may enroll your children in a health plan through MassHealth. For questions about MassHealth Premium Assistance you can call the Premium Assistance unit at 1-800-862-4840 and they will tell them if they need to communicate a change of information to the MEC.

If you are referring to MassHealth Premium Billing, in which a member is subject to monthly premium payments, questions can be answered by MassHealth Customer Service at 1-800-841-2900.

### **If a parent is collecting unemployment and signs up for Mass Health MSP and is court ordered to have insurance for his children shouldn't he add the children to the MSP application?**

MassHealth and MSP are two separate health insurance programs. The enforcement of health insurance coverage is not enforced by the MassHealth program. Usually the Department of Revenue issues and enforces the child support and health insurance responsibilities.

### **Is there any way we could PLEASE better instruct the workers at the MassHealth Customer Service phone number (1800-841-2900)?**

This has been taken back.

### **Recently we attended a SHINE training and were told that an over 65 disabled adult should complete a regular MBR to apply for MassHealth Commonwealth Health, is this correct?**

Yes that is correct, see below information which is on the instruction page of the MBR.

This application is for people who live in Massachusetts, are not living in or are about to go into a nursing home, and are under age 65. This application may also be used by people of any age who are parents of children under age 19, or who are adult relatives living with and taking care of children under age 19 when neither parent is living in the home, or who are disabled and work 40 or more hours a month or are currently working and have worked at least 240 hours in the six months immediately before the month of the MassHealth application.

### **Should Permission to share forms (PSIs) be mailed to MassHealth, or should they be faxed to the appropriate location?**

A job aid has also been created regarding where to send documentation. To access this job aid click on the below link:

<http://www.mass.gov/eohhs/docs/masshealth/provider-services/mfcs-guide.pdf>

### **What's being done to make it possible to get through when calling the MEC's?**

Members can call the automated 24/7 line 1-888-665-9993 or the Head of Household can use the [www.mass.gov/vg/selservice](http://www.mass.gov/vg/selservice) options to get case information. MassHealth is also doing administrative renewals as well as utilizing EDM to scan information received.

### **What's the turnaround now for new applications going to Central Processing Unit?**

New applications are being processed within the 45 day time frame or sooner.

### **What's the turnaround for ERV's?**

Ongoing case work is processed in the order that it is received. We are currently working on work received in January. There is a process in place at each MEC to prioritize emergencies.

### **Why does it seem to take 3 months for mailed or faxed in information (changes in income or address) to be processed?**

Ongoing case work is processed in the order that it is received. We are currently working on work received in January. There is a process in place at each MEC to prioritize emergencies.

### **Why does it take Long Term Care (LTC) applications 3-4 months to be approved?**

This is often because of other outstanding verifications or a pending disability evaluation

### **Why is MassHealth sending Absent Parent forms to families who don't have absent parents? Regarding backlog at the short term unit in Revere. They are responding at approximately 35 days from submission as of the beginning of January. How will this impact other providers? Also; is there a plan in place at MassHealth to resolve the backlog?**

If there is no absent parent in a household the member needs to communicate this to MassHealth. To help alleviate some of the backlog issues, members can call the automated 24/7 line 1-888-665-9993 or the Head of Household can use the [www.mass.gov/vg/selservice](http://www.mass.gov/vg/selservice) options to get case information and make changes. MassHealth is also doing administrative renewals as well as utilizing EDM to scan information received.

### **Why is it when you fax in a PPA change, it takes more than three months to receive an updated Patient Paid Amount (PPA), (even when you speak with someone you believe is in Ongoing)?**

We ask that all faxes sent to MassHealth are with the fax coversheet with the barcode, and that all detail of the fax cover sheet is completed in full. This will ensure EDM indexing processes are able to move smoothly.

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## **MEDICARE 101**

### **✚ Questions from the MTF January 2012 Roundtable Forms:**

#### **Does Medicare cover elective tubal ligation?**

From the National Coverage Determinations Manual:

**230.3 - Sterilization**

**(Rev. 1, 10-03-03)**

**CIM 35-11**

## A. Covered Conditions

- Payment may be made only where sterilization is a necessary part of the treatment of an illness or injury, e.g., removal of a uterus because of a tumor or removal of diseased ovaries.
- Sterilization of a mentally retarded beneficiary is covered if it is a necessary part of the treatment of an illness or injury, (bilateral oophorectomy), or bilateral orchidectomy in a case of cancer of the prostate. The contractor denies claims when the pathological evidence of the necessity to perform any such procedures to treat an illness or injury is absent; and
- Monitor such surgeries closely and obtain the information needed to determine whether in fact the surgery was performed as a means of treating an illness or injury or only to achieve sterilization.

## B. Noncovered Conditions

- Elective hysterectomy, tubal ligation, and vasectomy, if the stated reason for these procedures is sterilization;
- A sterilization that is performed because a physician believes another pregnancy would endanger the overall general health of the woman is not considered to be reasonable and necessary for the diagnosis or treatment of illness or injury within the meaning of §1862(a) (1) of the Act. The same conclusion would apply where the sterilization is performed only as a measure to prevent the possible development of, or effect on, a mental condition should the individual become pregnant; and sterilization of a mentally retarded person where the purpose is to prevent conception, rather than the treatment of an illness or injury.

### **If a patient exhausts their hospital days and the hospital stay is now covered by MassHealth, can the Skilled Nursing Facility (SNF) use the hospital stay as a qualifying stay?**

If the patient was in an acute care hospital Medicare processes the whole Medicare claim from admission to discharge even if Mass Health pays some of it because the Medicare benefit was exhausted, so the SNF should report the hospital stay on their claim like any other qualifying stay.

Requirements of a qualifying stay:

A: Post hospital Skilled Nursing Facility (SNF) care is covered by Medicare only if a beneficiary meets the following requirements:

- Has been hospitalized in a participating or qualified hospital for a medically necessary inpatient hospital care for at least 3 consecutive calendar days, not counting the date of discharge; and
- Has been discharged from the hospital in or after the month he/she attained age 65, or in a month, which he/she was entitled to hospital insurance benefits on the basis of disability or end-stage renal disease.
- The beneficiary must be in need of post hospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of discharge from the hospital.

In addition, the beneficiary must meet the level of care requirements.

### **At what age would I apply for retirement? I plan on working until age 67.**

The Social Security Administration administers retirement benefits and provides helpful information on their website at <http://www.ssa.gov> to help you decide.

- Retirement Planner at <http://www.ssa.gov/pubs/10147.html>
- "Retirement Information For Medicare Beneficiaries" fact sheet, <http://www.ssa.gov/pubs/10529.html>
- Check the [Retirement Estimator](http://www.ssa.gov/planners/calculators.htm) at <http://www.ssa.gov/planners/calculators.htm> to see how different retirement dates will affect your benefit amount

**What is the planned percent charge over what number of days for patient vs. CMS portion of the responsibility for mental health claims to get 20%-80%?**

While Medicare has reimbursed for all other outpatient medical services at 80%, with the patient responsible for the other 20%, outpatient mental health treatment was at 50% but that is changing so that by 2014, the rate for outpatient mental health treatment will be the same as other outpatient medical services. In 2012, the reimbursement rate is 60%; in 2013 it will be 65 %; and, in 2014, it will be the full 80%. Mental health evaluations have always had 20 % coinsurance. Detailed information on billing is at <https://www.cms.gov/Transmittals/Downloads/R114BP.pdf>.

**Re: Referring and Ordering Issue; how formal is the referral process which necessitates a provider (including behavioral health) enrolling with Medicare? Verbal referral vs. written? Other criteria?**

When there is an ordering and/or referring provider identified on a Medicare Claim (Box 17, CMS 1500-08-0) CMS requires that individual to be enrolled as a Medicare provider. To expedite this requirement for provider types likely to order and/or refer but unlikely to bill Medicare directly for their services (VA physicians, residents, etc) CMS created a special enrollment form, CMS 855O. The requirement does not distinguish by referral method (verbal versus written).

**Can an individual in a US Territory such as the Virgin Islands who did not pay into Medicare through their working years still buy into Medicare?**

Yes. Any person in the US Territories who wants to buy Medicare Parts A or B can do it the same way as in the States - by paying a monthly premium. Medicare enrollment rules are the same. The only difference for the territories concerns enrollment in Part B in Puerto Rico - those individuals are not automatically enrolled in Part B and would need to take action to enroll if they wanted it.

**Is there a process for out of state Medicare provider to get expedited credentialing for QMB only?**

A Medicare provider has to be enrolled by the Medicare Administrative Contractor serving the jurisdiction in which the provider renders services so a provider can be “out of state” but still within the jurisdiction. There is no expedited credentialing based on beneficiary type(s), such as QMB. The most expeditious enrollment process is “On Line PECOS” at <https://pecos.cms.hhs.gov>.

MassHealth does not have an expedited process for QMB providers, but there are limited enrollment requirements compared to other provider types. The MassHealth Regulations on QMB and Out of State Providers can be found at <http://www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-allprovider.pdf>.

For an Out of State Provider to be considered for application, they must meet the qualifications for an emergency service. Supporting documentation would include a claim for emergency services.

To enroll in MassHealth, a provider has two options:

1. Submit application online at the link below. Online application requires that additional documentation be submitted:
  - a. QMB Provider Contract
  - b. Federally Required Disclosure Form
  - c. Massachusetts W9
  - d. Electronic Funds Transfer
  - e. Trading Partner Agreement
  - f. National Provider Identification Supplement Form
  - g. Data Collection Form

Or



2. Contact the MassHealth Customer Service – 800-841-2900. All required documents will be mailed.  
<https://newmmis-portal.ehs.state.ma.us/EHSPProviderPortal/appmanager/provider/desktop>.

**Health and Human Services** Mass.gov

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**MassHealth Provider Online Service Center**

The Provider Online Service Center gives you the tools to effectively manage your business with MassHealth electronically. Use these services to enroll as a MassHealth provider, manage your profile information, and submit and retrieve transactions.

Enter data directly and modify individual transactions (ie. claims submission, eligibility verification, MMQ, Prior Authorization, Pre-Admission Screening, Referrals, and EHR Incentive Program).

View your notifications, contracts, reports, metrics, and financial data. Download most MassHealth forms and publications.

You will need a Username and password to access many of the services listed on the left. If you are currently a MassHealth provider but do not know your Username and password, please contact the Customer Service Center at 1-800-841-2900.

Registered User? Would like to enroll as a provider? Need more information?

[Login](#) [Enroll Now](#) [FAQs](#)

**If a person never paid into Medicare, (this person was a fisherman) is he eligible for any type of Medicare?**

Individuals usually become eligible for Medicare Part A premium-free by paying into Medicare over their working life for at least “40 credits,” (you earn one credit for every \$920 you earn; you can earn 4 credits a year), however individuals age 65 and over and certain persons with disabilities who have not paid into Medicare can obtain Part A coverage by paying a monthly premium set according to a statutory formula. This premium is \$451 for 2012. They also must be U.S. citizens or legal permanent residents who have been in the United States for 5 continuous years or more.

Those who have paid into Medicare but have between 30 and 39 “credits” may buy into Part A at a reduced monthly premium rate which is \$248 for 2012.

If you don’t sign up for Part A when you’re first eligible, you may have to pay a penalty equal to 10% of the Part A premium, unless you’re eligible for a Special Enrollment P. The 10% premium penalty applies no matter how long you delay Part A enrollment. You will have to pay the premium penalty for twice the number of years you could have had Part A, but didn’t sign up. For example, if you delay enrollment for

2 years, you must pay the 10% premium penalty for 4 years. If you don't sign up for Part B when you're first eligible, you may have to pay a penalty on your Part B premium also. For each 12-month period you delay enrollment in Part B, you will have to pay an extra 10% of the Part B premium, unless you qualify for a Special Enrollment Period. In most cases, you will have to pay that penalty every month for as long as you have Part B. For more information, see "Understanding Medicare Enrollment Periods" at <http://www.medicare.gov/Publications/Pubs/pdf/11219.pdf>  
Low-income programs may be able to help pay costs if you meet the income and asset levels.

### **Donut Hole status i.e. soon reach available on letter or internet?**

#### **Donut Hole status is tracked**

When a person gets prescription drugs through a Medicare drug plan during their coverage gap (the "donut hole"), the plan tracks and calculates the person's out-of-pocket costs automatically. People with Medicare will get an "Explanation of Benefits" (EOB) from their plan in the mail every month that they use their plan's services. The EOB will show how much they have spent for the year and how close they are to reaching the plan's coverage gap. The person with Medicare should always use their Medicare drug plan card, even during the coverage gap. This will allow them to buy their prescription drugs at the drug plan's discounted rates. Note: Only Medicare-covered drugs on their plan's formulary will count toward their out-of-pocket costs (unless the plan has granted them an exception for a drug it doesn't usually cover).

### **For someone on MassHealth, on several medications, who qualify for state Buy-In (QMB) benefit; would MassHealth pay any part of this?**

#### **Becomes eligible for Medicare as DAC beneficiary**

MassHealth pays for Medicare benefits for individuals on QMB. For those eligible for Medicare and Medicaid, prescription coverage is from Medicare.

Here are definitions of the various programs:

#### **1. Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only)**

These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

**2. QMBs with full Medicaid (QMB Plus)** - These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.

#### **3. Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only)**

These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.

#### **4. SLMBs with full Medicaid (SLMB Plus)**

These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not in exceed twice the limit for SSI eligibility, and are eligible for full

Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits. FFP equals FMAP.

#### **5. Qualified Disabled and Working Individuals (QDWIs)**

These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. FFP equals FMAP.

#### **6. Qualifying Individuals (1) (QI-1s)**

This group is effective 1/1/98 - 12/31/02. There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of at least 120% FPL, but less than 135% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP at 100%.

#### **7. Medicaid Only Dual Eligible's (Non QMB, SLMB, QDWI, QI-1, or QI-2)**

These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1, or QI-2. Typically, these individuals need to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability. Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

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## **AFFORDABLE HEALTH CARE (ACA) UPDATES**

### **Questions from the MTF January 2012 Meeting Evaluations:**

**What happens if the Affordable Care Act is overturned by the Supreme Court i.e. what does that mean for all the work that is currently being done by MA in advance of 2014?**

Massachusetts is actively working towards ACA implementation. We cannot answer this since no hearings or decisions have been made and cannot speculate on this.

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

## Questions from the MTF January 2012 Roundtable Forms:

### **Can the ABS form be included on the Virtual Gateway?**

This is a great idea. We have taken it back to MassHealth.

### **Do we have to write name of head of household and social security number or I.D. number on every page of the Annual Review (E-Fax)?**

No.

### **Do you have an estimated timeframe by when EDM will clear up the back log at the MEC's?**

MassHealth has made the backlog reductions among its very top priorities. We have implemented internal steps that we expect will gradually bring down the backlog over the next several months. We greatly appreciate your patience during this time period!

**Howard mentioned issue with family members under same MassHealth ID. We have a participant with 2 MassHealth ID's are you aware of this issue with other beneficiaries?** As mentioned at the January sessions, MassHealth has recently created a team specifically dedicated to the resolution and prevention of these types of situations. If you spot these errors, please call MassHealth Customer Service at 1-800-241-2900.

### **How do you by-pass Virtual Gateway field requirements for income when HOH is caretaker relative who is not applying?**

It is up to MassHealth to determine if caretaker relative income is countable. For this reason, information should not be by-passed on the application form.

### **If on a Virtual Gateway, someone is NOT sure about amount of income, is it better to put in \$1.00 as a red flag or for them to give their best guess**

If one doesn't have the pay stubs put an amount closest to what the applicant tells you and MassHealth will send out the verification checklist for the pay information and any other information necessary to determine the case.

### **Over 65 send signature pages to Taunton but fax the verifications to the CPU? Just to make sure that only LTC Intake applications go to the Tewksbury MEC.**

This is correct! Thanks for confirming. If you're ever in doubt on where to send materials when and using which cover sheet, please refer to the job aid at:

<http://www.mass.gov/eohhs/docs/masshealth/provider-services/mfcs-guide.pdf>

### **Receipt of new Virtual Gateway application does not show in MAP for some time. Why? When I asked about it and I was told it gets updated when the application is ready to be processed. Why? It used to show by the next day. What happened?**

This is most likely due to the temporary situation we've been discussing with you about where MassHealth is experiencing periodic delays in processing some items due to the extraordinary number of applications and supporting documents we have been receiving daily. The delay in reviewing and processing some applications is most likely why you are seeing a delay in what MAP is showing. MassHealth has already taken steps to remedy this, and we expect you will begin to see improvements in turnaround times soon. In addition, MAP now allows you to see a list of all documents MassHealth received, the date it was received, and whether it was processed yet or not.

### **Residency question; Do not include infants born in MA who have not left the state?**

Need clarification. Infants who are born in Massachusetts and have not left the state and have no intention of leaving the state meet the residency rules.

**Whatever happened to eligibility notices in MAP? Some cases are not shown.**

Thank you for this question. To assist in resolving it, we would need to see specific examples so we can pinpoint the issue. Feel free to send, securely, examples of this problem to the MTF staff, and they will be sure to forward to Howard, Joseph, Bob, and et. al.

**When a couple is applying for MassHealth, do they need two applications or one?**

Please click here for a job aid that will hopefully help you figure this question out:

<http://www.mass.gov/eohhs/docs/vg/common-intake/family-group-job-aid.pdf>

**SC1 BOX 19, MassHealth Requested pay date; would this be the same as Admit date?**

Not necessarily. Many times the pay date requested would not be the same as the admit date, for example if the member had other insurance that could cover some time in the nursing home before MassHealth would be begin to pay then the dates would not be the same.

Howard mentioned issue with family members under same MassHealth ID. We have a participant with 2 MassHealth ID's are you aware of this issue with other beneficiaries? As mentioned at the January sessions, MassHealth has recently created a team specifically dedicated to the resolution and prevention of these types of situations. If you spot these errors, please call MassHealth Customer Service at 1-800-241-2900.

**When are we going to be able to do ERV's on the Gateway?**

Stay tuned. This is being discussed at MassHealth.

**✚ Questions from the MTF January 2012 Meeting Evaluations:**

**Approximately how long does it take for an Eligibility Review Application, once received by you, to show in MAP that it has been received?**

With the new My Account Page document list feature, you should now be able to see that it was received, and whether it was processed or not yet.

**During the Virtual Gateway presentation, Howard mentioned that we should not do our own or coworkers MassHealth applications but instead bring it to a supervisor, I am the only person in my organization that has a Virtual Gateway login for MassHealth enrollment; what do I do in that situation?**

Where you are the only VG user at your organization, you would probably have little choice but to download a paper application from the MassHealth web site and submit it on your own.

**Why is it that when you have patients sign the PSI so that you can look at MAP you sometimes still can't view it in MAP at all later?**

The only cases for which you can view MAP information are those who have signed the VG PSIs. This issue results from one of two reasons: PSI's other than ones preprinted by the VG must include, in order for you to be able to access MAP, your organization's Virtual Gateway number. Note that this is NOT your organization's MassHealth Provider Number. That is something completely different. If you do not remember or know your VG organization number, please call VG Customer Service at 1-800-421-0938 and they can help. The second cause of this issue can be that the PSI was not entered yet into MA21 by MassHealth. This is directly related to the backlog we are experiencing due to the high number of documents received daily. MassHealth has taken steps to reduce this backload and expedite processing of documents, so we expect you will see less of this issue going forward.

## MASSHEALTH PROVIDER BILLING AND SERVICE

### **Questions from the MTF January 2012 Roundtable Forms:**

#### **When is MassHealth going to accept modifiers 25.59?**

Any MassHealth changes or updates regarding modifiers will be communicated via Transmittals Letters or Bulletins.

#### **Will you provide onsite training for provider groups?**

CST has provided virtual room, onsite and workshop training including sessions after certain MTF meetings.

#### **When trying to bill MassHealth secondary to Medicare through DDE, we enter the Medicare payment and get the following message:**

**“The sum of all line level payments amount less any claim level adjustment amounts must balance to claim level payment amount for the matched payment. Please correct and submit.”**

The provider billed amount on the service line entered on the Procedure tab should balance to the sum of the service line payer paid amount and service line HIPAA adjustment amounts entered on the Procedure tab.

#### **Under the COB Reasons Detail, what code do you enter “Reason”?**

The HIPAA adjustment reason codes should be entered in this field.

#### **I submitted a batch file and got batch received confirmation # but when I checked later over the next 5 days, I never got accepted report 997.**

In 5010 providers should be looking for an accepted or rejected 999 as 997 is the 4010 format. If a provider does not receive this acknowledgement, then the provider should contact EDI team at CST.

#### **Does everyone have to send test 5010 file if software vendor completed and passed testing?**

No

#### **Our billing system (Matrix) was recently updated and is now requiring an alpha numeric code for our other insurance claims (e.g. our 150 code items) is this necessary?**

Providers should refer to both the MassHealth companion guide (available on the 5010 website) and their software vendor.

#### **Matrix/Eprenis is now substituting the 1G for UPIN with a 1D. Will the claim pay on POSC if we ask the software vendor to leave the field off the claims?**

Providers should refer to both the MassHealth companion guide (available on the 5010 website) and their software vendor.

#### **Where do I find information on the elimination of the MMQ and use of the Federal Regulation score?**

It is our understanding that this was discussed at a recent Mass Senior Care Association (MSCA) meeting. Please refer back to MSCA for details.

#### **Do we use the paper claims address to have claims over 1 year adjusted?**

Claims that are over the 1 year filing deadline should be going to Final Deadline Appeals.

**Claim for service date 9/6/11 submitted to Neighborhood Health MCO, the claim paid but was then retraced due to eligibility information being updated. (Client is now on MassHealth Standard). I was told to do a 90-day waiver but when I submitted claim through DDE, it paid. Is this due to the date the MassHealth Eligibility was updated?**

Without claim specifics it is not possible to answer why this claim paid

**90 Day Waiver, FSA appeals now available for online submission, is this mandatory or optional? The provider bulletin 220 and 221 indicates “May” be submitted electronically.**

Online appeals submission through DDE is currently optional.

**Timeframe on billing appeals online with documentation, instead of paper appeals.**

The appeals timeline procedures have not changed.

**If original claim billed paper can we bill appeal paper or does it have to go online?**

Currently the appeal can be billed either way.

**Does everything go electronic as of 1/1/12?**

Please refer All Provider Bulletin 223.

**When billing a Skilled Nursing Facility (SNF) claim with attachment for delayed eligibility once denied for billing deadline exceeded, do we send the claim electronically for the 851 and if so what is the reason code we use?**

Appeals can be sent electronically through DDE on the POSC. Please refer to All Provider Bulletin 220 for submission guidelines.

**Can we bill a patient that made us aware of eligibility after the 90 day filing time?**

No

**How can we get paid if another PCP’s office won’t give us our time referral?**

Referrals should be obtained prior to providing service to avoid this issue.

**If a patient who seeks service doesn’t have insurance on the day of service and we see the patient and assist them with insurance application. The patient gets retro-eligibility but not to the initial date of application (or service), who will be responsible for the bill?**

The member is responsible.

**Can I get updates MassHealth Billing Information?**

Yes, go to [www.mass.gov/masshealth/5010](http://www.mass.gov/masshealth/5010) and [www.mass.gov/masshealth](http://www.mass.gov/masshealth) for updates.

**On the DME guidelines, it may have monthly totals, i.e. Absorbent Products 248 a month. Does the PA override this? If we need to give out (due to package) less than 248 but one month we could give out 300.**

No. The payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions.

**If patient has premium assistance program (Sr.) and HSN secondary, before we bill HSN, Do we need to bill MCD and get the denial?**

Please refer to MassHealth provider manual subchapter 1 section 130 CMR 450.105(B) (1) regarding premium assistance coverage.

**Retro eligibility/MCO members – Do we expect a resolution soon?**

Please refer to the contact listed in the message text regarding retro-eligibility issues.

**National Correct Coding Initiative (NCCI) edit/Mental Health Centers – any plans to lift this edit? – Timeframe?**

Any MassHealth changes or updates regarding modifiers will be communicated via Transmittals Letters or Bulletins.

**Claim sent 9/22/11, computer says it was accepted but when I check on Virtual Gateway, says, not in system.**

In 5010 providers should be looking for an accepted or rejected 999. If a provider does not receive this acknowledgement, then the provider should contact EDI team at CST.

**We submit our MassHealth claims through ZirMed and there is presently a 5010 submission issue that is preventing claims to process at MassHealth. Can we DDE these claims?**

Yes

**Can I submit paper 90 day waivers?**

Currently the appeal can be billed either way.

**Eligibility was checked on date of service and patient listed as having standard coverage. Claim was denied, patient enrolled in MCD. Tracking numbers list no MCO from the date of service when eligibility was checked. When eligibility is checked, currently for date of service, patient is listed enrolled in MCO. Customer Service stated there is nothing that can be done.**

Please refer to the MCO contact listed in the message text regarding eligibility issues.

**When we are attempting to void online, we receive an ERROR CODE 400.**

Providers with specific DDE entry issues should contact CST directly for assistance.

**When entering a secondary inpatient claim, we have been getting the following error message: The sum of all claim level COB adjustment amount and claim level COB payments must balance to the claim level charged amount. They ARE balanced.**

**Claim Billed Amount Balancing** - For Inpatient and Skilled Nursing Facility room and board claims, for each payer reported in the claim, the sum of the payer paid amount and HIPAA adjustment amounts entered on the **Coordination of Benefits** tab should balance to the **Total Charges** entered on the **Billing and Services** tab.

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## HEALTH SAFETY NET

### **Questions from the MTF January 2012 Roundtable Forms:**

**Will HSN ever be payable to private practices? We are “next door” to the hospital and we get many of their HSN patients from referral?**

By statute (MGL Chapter 118G, Section 36,

<http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter118G/Section36>), the HSN is only able make payments to acute hospitals and community health centers.

**How patient can prove that he/she has reached their HSN partial deductible?**



Providers are responsible for tracking a patient's progress toward meeting their HSN partial deductible if the patient has no other family members and uses only one facility. Patients are responsible for tracking their own bills if more than one member of the family is using HSN services, or if patients are using more than one medical facility to receive their care.

Patients may demonstrate that they have met their deductible by presenting bills that indicate that they and/or their family members have incurred medical expenses in excess of the deductible amount. Expenses exceeding the deductible amount must be incurred, but not necessarily paid, before the patient's services may be billed to the HSN.

**Please help us to understand EAEDC and how it relates to HSN.**

The HSN acts as a secondary payer to EAEDC only in cases where the EAEDC patient's eligibility is non-temporary. EVS currently displays a message indicating that a patient is eligible for HSN Secondary even when the patient has temporary EAEDC eligibility. The HSN is aware of this issue will work to correct this in the future. In the meantime, claims should not be submitted to the HSN in cases where EVS indicates that an individual has temporary EAEDC eligibility.

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