Massachusetts Health Care Training Forum
July 2012 Questions & Answers

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

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

MASSHEALTH AND VIRTUAL GATEWAY UPDATES

Questions from the MTF July 2012 Roundtable Forms:

Patient's eligibility downgraded from Standard to EAEDC while in-house due to a prior application for cash assistance. Is there a way to have that reversed?
Re-apply for MassHealth via an MBR or Virtual Gateway supplying MassHealth with the current information of the patient's circumstances. Please note EAEDC benefit does include the MassHealth Basic coverage so the patient can still obtain certain medical benefits.

If a person under age 65 deemed SSDI eligible by federal standards leaves a facility and placed into community, how does MassHealth recognize that the person met their one time deductible?

An individual under 65 that is assessed a one-time deductible must send in medical receipts that have been paid or incurred during the deductible period. MassHealth will review the information to determine if the deductible has been met. Once the deductible is met, MassHealth's MA21 system will be updated to reflect this. If there is a discrepancy, the member should call the MassHealth Enrollment Center to resolve.

If nothing shows up "received" in MAP for 3-4 weeks, can we re-fax?

Call Customer Service first and see if they can "escalate" it.

How long does a mother have to add her newborn to MassHealth and to a plan before MassHealth puts the baby under the mothers plan and to make the plan effective the day the child was born?

We at MassHealth utilize the NOB (Notice of Birth) system which puts the child on MH back to the date of birth. The member should not have to initiate this. Please note we are currently making changes to this as well which should enhance the process.

If there is no information on a review past income, why must all the empty pages be sent? This seems unnecessary and just causes wasting paper. For example: already stated they are a citizen, the immigration pages are not needed; to children means no absent parent information was received or find out two months later that the documents sent were not received. The PSI's for reviews are still not being loaded.

The questions that are included on the eligibility review form are all possible information MassHealth requires from its entire membership. Depending on the individual's circumstances, not all questions will apply. Through the Affordable Care Act, the Commonwealth will be building a new Health Insurance Exchange Integrated Eligibility System (HIX/IES). The vision for the HIX/IES is to have the ability to create online and/or paper pre-populated eligibility review forms.

Some of our farm workers who need to report their babies have been born are unable to get through. Is there another number they can call? They speak Spanish; how are they accommodated when they call?

MassHealth Customer Service and MassHealth Enrollment Centers continue to receive high call volume. Because of this, callers will need to wait on the line and their call we be answered in the order it was received. MassHealth has customer service staff that speaks Spanish and will be able to accommodate their call.

If a client had MassHealth for a long time, is it not possible to update on line? Will that change?

There are only certain items that may be updated through the Virtual Gateway, My Account Page feature. These include things like address, and pregnancy. There will be many new changes and functionality forthcoming as a result of the Affordable Care Act. The Commonwealth is in the process of building a new Health Insurance Exchange Integrated Eligibility System (HIX/IES). This new system will have enhanced functionality for all users including members.

Patient is totally disabled, under 50, living in a group home. Why does she only have MassHealth and NO Medicare?

A person's Medicare is given through the Social Security Administration. If the person is drawing Social Security disability they have to wait two years before they receive Medicare.

Does CommonHealth work for over 65? My client was told yes by the MEC but never got approved and when we called the representative stated it did not.
Yes, MassHealth does have CommonHealth coverage for the over 65 population. The individual must be a "Working Disabled" adult in order to qualify.

If a client wants to update their family group and include the other parent of a child who does not want services and is not applying, do they still need to complete an ERV?
Yes.

What is the order of recovery by MassHealth when a home must be sold as a short sale? What is the priority of will? Can law firm be paid to prepare the MassHealth application from the sole of the property when doing a short sale?
For questions related to third party recovery, you should contact the MassHealth Third Party Recovery Unit at 1-800-462-1120.

Please clarify working letter: If client who is deemed disabled but is working 10 hours per week for a friend or a neighbor doing a menial chore i.e.; plant watering, grass mowing, dog walking, child pick up for a nominal fee. Is this enough to qualify them as "working disabled" adult?
Get a letter/statement from the person employing stating hours and wage.

What is the difference between ERV-5 and ERV-9 forms?
MasssHealth currently uses different ERV's for different situations, example, under 65 cases, 65 and over, children aging off the parent's case, etc.

Faxes often not received by workers; is mailing better?
With the Electronic Document Management system faxing is strongly encouraged. Mailing documents, like faxes, will also be scanned into the system but receiving faxes is a more efficient process for the Electronic Document Management workflow.

If cover letter with documents includes SSN, do we need to put SSN on every page?
To ensure that items are not lost every document should include the Head of Household information.

Can community applications be assigned so we can follow up with questions?
If you have questions you can contact the MassHealth Enrollment Center.

My question concerns the TPL unit. Are there new rules as to removing outdated insurance eligibility?
MassHealth always needs the most recent information on file to ensure eligibility is being determined accurately. If a member has a change in circumstances they need to report the change to MassHealth within 10 days by calling the MassHealth Enrollment Center. For specific questions concerning TPL call 1-800-462-1120.

Does the Taunton office accept "walk-ins" to complete an MBRF or Virtual Gateway application? I have heard mixed reviews, some have been successful and some have been turned away.

The MassHealth Enrollment Centers are available to assist folks with various needs and can help complete an MBR but they do not do the Virtual Gateway applications.

Please clarify doing an MBR for disabled individuals who are still working?
Complete the MBR as any other and make sure you complete the disability segment stating the person is or has a disabling condition. If a potential disability is indicated, a Disability Supplement will be generated to the member to be completed as part of the application.

Client has CommonHealth; over 65 disabled adult with closed case. Can you "reclaim" this status or separate applications? SMBR (not applying) and MBR (yes, applying).
Yes to the first question. The SMBR should be completed answering the disability questions included.

Is there an asset limit for those under 65 for MassHealth Traditional and Standard?
There is no asset limit for under 65 unless they need long term care coverage.

Is MassHealth Standard the same as MassHealth Traditional?
MassHealth Standard is a coverage type. MassHealth Traditional is the population over the age of 65 living in the community that can apply for health insurance benefits including MassHealth Standard coverage.

Does CommonHealth have asset limits?
No

Child has MassHealth via Department of Child and Youth and Families (DCYF) and the case is closing. How can they remain on MassHealth without gap in service?
File a MBR as soon as the (DCYF) closes. If eligible a child can get retroactive coverage back 10 days prior to the application date.

If member accesses MAP, can they escalate their MBR so the "pt must enroll" status can be avoided?
They can't escalate enrolling in a plan through MAP but they can enroll by call MassHealth Customer Service at 1-800-841-2900 to enroll in a health plan.

Receiving letters terminating patient stating that patient is in correctional facility
MassHealth is only available when a member resides in the community. If they become incarcerated they will receive a termination letter. If there is a discrepancy the member should contact the MassHealth Enrollment Center.

What is the process to expedite a MassHealth Application?
There is not an available expedited process, however if the application is completed in it's entirety and sent in with all necessary verifications it will be processed much more quickly.

I work in homeless clinic; if I establish a MAP account, for a patient on clinic computer, do I need to do a PSI?
Yes a PSI needs to be signed by the member allowing MassHealth to share information about their case with you.

If faxing a MassHealth Application would it be better to fax application, proof of identity and citizenship separately?
Fax together

Please explain Commonwealth Care with MassHealth Limited.
While Commonwealth Care members are waiting to enroll in a managed care plan they will receive Limited coverage and HSN (if eligible) until they enroll.

Why are changes not being made in the system?
Plans are underway to revise and enhance the application process due to the requirements of the ACA (Affordable Care Act). Future MTF meetings will highlights these revisions quarterly until final completion expected in January 2014.

Regarding absent parent information: Mother applies with maiden name, does not list TPL Checking insurance verification shows mother on TPL with last name of subscriber. What flags are raised? How will it affect the MassHealth determination for mom or babies?
MassHealth uses many factors to determine eligibility. In the above case MassHealth will look at family size, income, insurance and other factors. An investigation may be done by the integrity unit if necessary to determine the correct eligibility.

What do you do when a person doesn't want to submit information about all household members (ex: married, living separately)?
Advise members of their responsibilities of completing accurate and truthful information. A referral to the integrity unit may also be appropriate.

CommonHealth – disabled working adults; can they do any kind of work even if just informal working for family?
They must verify their earning and hours worked accurately to determine if they qualify as a working disabled adult.

What is the difference between MassHealth Standard and MassHealth CommonHealth?
CommonHealth coverage is given to eligible disabled adults, working disabled adults and disabled children. Standard coverage is given to many other categorically eligible individuals.
See MassHealth regulations for full details. 130 CMR 505.002 and 519.002

Questions from the MTF July 2012 Evaluation

Is it possible to generate a monthly list, by institution, of the patients coming up for renewal in two months time?
No but members and providers can check MAP to see when the next renewal is due.

Would appreciate knowing the process for the Virtual Gateway, as some applications go right thru & others hang up for a long time.
One way to escalate a VG is to file it accurately and completely and send in all required verifications.

Does MassHealth automatically generate a Disability Evaluation Services (DES) to the individual when the question "do you have a disability, injury or illness is checked yes?
Yes MassHealth will send a disability supplement to an individual who indicates a disability. Disability supplements can be also downloaded from the MassHealth website.

Back to Top

VIRTUAL GATEWAY

Questions from the MTF July 2012 Roundtable Forms:

Can a professional with PSI set up self service account for member? If so, do you need a Virtual Gateway account? Is this for only community cases or LTC too?
For privacy purposes, the member-facing My Account Page functions available at **www.mass.gov/vg/selfservice** are designed specifically for member use only, just as the provider/organizational My Account Page version is available for providers and organizations only. As to your second question, all Virtual Gateway functions, whether for providers/organizations or members, do not, at this time, include MassHealth Long Term Care cases.

How do we access the Virtual Gateway Change Form?
The Change Form link is located at the top of your patient/client's My Account Page web page. If you do not see it, or you wish to learn more about the Virtual Gateway Change Form, please feel free to contact Virtual Gateway Customer Service at 1-800-421-0938.

Can we set up on MAP in the "document received" section the amount of pages that were faxed, that way we know that all of the document was faxed to CPU/MEC were indeed received instead of guessing.
This is a very interesting idea. We will take it back. Thanks!

Are two separate accounts needed to use the Virtual Gateway and MAP?
No. Access to both the Common Intake application and My Account Page are ordinarily allowed from the same account. If you are experiencing difficulty with this, or would like to learn more, feel free to call Virtual Gateway Customer Service at 1-800-421-0938.

Questions from the MTF July 2012 Meeting Evaluations

Will there ever be a time when a Long Term Application can be done on the Virtual Gateway?
This is something MassHealth would very much like to do, and we are currently examining ways to do it, given existing resources. Stay tuned for more details. We appreciate your patience.

Back to Top

MASSHEALTH TRANSPORTATION PROGRAM

Questions from the MTF July 2012 Roundtable Forms:

Once PT-1 is approved, what is the turnaround time for the Regional Transit Authority (RTA) to have the information?
All PT-1 approvals are transmitted to the Regional Transit Authority the evening they are approved.

We were told that MassHealth no longer reimburses for transportation. Is this correct?
MassHealth members may be reimbursed for the cost of public transportation expenses only. However, in exceptional circumstances as described in regulation 130 CMR 407.431(C) a member may be reimbursed for direct transportation expenses.

The logistics are very involved from Martha's Vineyard. If someone is ill or has limited mobility, it is difficult to get on and off a ferry so it is more practical to take a care from home directly on ferry to medical appointment on main land instead of doing PT-1 and just getting picked up in Woods Hole.
MassHealth can reimburse a member if there is an exceptional circumstance where the member's transportation needs are beyond what can be provided through the transportation brokers. These cases are reviewed on a case-by-case basis.

Please verify the reimbursement of public transportation.
MassHealth members may be reimbursed for the cost of public transportation expenses only. However, in exceptional circumstances as described in regulation 130 CMR 407.431 (C) a member may be reimbursed for direct transportation expenses

If a patient has an asthma attack, they call transportation by ambulance; can they fill out the PT-1 form to require payment?
PT-1 forms are for non-emergency and for curb-to-curb service provided by the member's Regional Transit Authority (RTA).

If medical necessity form signed by physician, can you get transportation services without going through the PT-1 form process?
Medical necessity forms are only used for all non emergency ambulance trips and for chair vans trips for members in Long Term Care (LTC).

What order of reasons do you look for in approving PT-1?
The PT-1 form is reviewed for:

- An eligible MassHealth category of assistance (MassHealth Standard, or MassHealth CommonHealth)
- Prescribing and treating provider participation with MassHealth, or a MassHealth Managed Care Organization (MCO)
- Locality restrictions: Locality is defined as the city/town the member resides in and immediately adjacent communities. If not, the provider must list medical reasons/justification as to why the services cannot be received locally, or at a closer facility
- If the medical services received listed in Section 4 of the PT-1 form is a MassHealth covered service
- Is there a specific physical or mental disability prohibiting the use of public transportation listed in Section 6 of the PT-1 form
- Is the form signed by an appropriate party? (MD, RNC, RNP, etc.)

How can someone being approved for PT-1 for one but not for another? If the reason it was approved was for "medical reason" but are prohibited any use of public transportation?

Each destination of a PT-1 form is reviewed for locality (the city or town a member resides in, and immediately adjacent communities) restrictions. Section 3 provides opportunity to demonstrate medical reasons/justification as to why the services cannot be received with locality, or at a closer facility. Each PT-1 form for facilities outside of locality must provide this information.

MA state law requires that patients being transported on a Section 12 go in an ambulance. This is a non-emergency and ambulance. This is a non-emergency not covered by many coverage types. We get calls for these patients because they get bills after we get a denial. Is there any way around this?
Unfortunately, only valid aid categories will be reimbursed for these trips.

Questions from the MTF July 2012 Meeting Evaluations

How does MassHealth Transportation work when someone has a managed care senior plan, MassHealth coverage, and requires ambulance transport due to weight bearing status and amount of stairs in the building?
If the member is enrolled with a Senior Care Option (SCO) all transportation services are provided by the SCO. Please check the SCO for the approval process.

If a member does not have a medical condition but does not drive and there is no public transportation in her town, or there is no provider taking MassHealth near her, can we create a PT-1 for that person?
Yes

Back to Top

WORKERS' COMPENSATION PROGRAM

Questions from the MTF July 2012 Roundtable Forms:

When Workers' Compensation denies a claim, how do we send letter to Health Safety Net (HSN)? (When sent out, HSN first, secondary is industrial). HSNF
Any time a workers' compensation insurer denies a claim, it must be done in writing. That would be either in the form of a letter or by way of a DIA Form 104 – Insurer's Notice of Denial. Please note the insurer never sends these notices solely to the employer. The employee is always notified directly. If an employer tells the employee they received notice of the denial. That is not sufficient.

If a bona fide denial has been received, the injured worker should provide a copy to the health care provider. The health care provider can then notify the health insurer (Health Safety Net) that the health insurance will need to cover the loss.

Need more education for providers to document better work related injuries
We need to understand better how MassHealth is being denied by unscrupulous employers
Outreach to Metro West area.
The DIA plans to conduct robust outreach efforts to educate our partners in the healthcare industry concentrating on the initial points of contact that workers have with providers. We also

plan to conduct similar outreach to workers centers that service traditionally low wage and unrepresented workers.

Back to Top

HEALTH CONNECTOR UPDATES

Questions from the MTF July 2012 Roundtable Forms:

Suggestion: Need credit card machine for Commonwealth Care enrollment
The Commonwealth Care program does not currently accept credit card payment. Individuals can make a one-time payment online using a checking or savings account via MAhealthconnector.org.

We have a client with a small business on Commonwealth Choice. He pays over $10k per year for his family's insurance plan. He completed a MassHealth application to determine whether he could be eligible for Commonwealth Care. If he is, could he cancel the Commonwealth Choice health plan and get health insurance through Commonwealth Care?
Below is some information about the eligibility requirements of the Commonwealth Care program. If someone is determined eligible, they can enroll in Commonwealth Care and then cancel their commercial or "unsubsidized" Commonwealth Choice plan.

Commonwealth Care is a health insurance program **for adults, 19 and older**, who do not have access to insurance and meet certain eligibility requirements. If an individual is paying the full premium for a commercial health insurance plan in the non-group market and they meet the requirements below, they may be eligible to enroll.

- the family's income before taxes is below 300% of the federal poverty level.
- they are uninsured,
- they are a U.S. citizen/national, qualified alien, or alien with special status,
- they are age 19 or older (*persons under age 19 may be eligible for MassHealth benefits.)

Does Commonwealth Care or Commonwealth Choice mandate individual coverage for children?
Commonwealth Care is a "subsidized" health insurance program **for adults, 19 and older**, who do not have access to insurance and meet certain eligibility requirements. It does not offer insurance plans for children. Through **Commonwealth Choice**, Individuals, Families and Small Businesses can purchase commercial "unsubsidized" health insurance plans. Massachusetts residents 18 and older must carry health insurance that meets the minimum standards set by the Health Connector. Massachusetts tax filers who are considered able to afford a health plan need to enroll in one or pay tax penalties.

Are all members of Commonwealth Care, Commonwealth Choice confined to hospital, or community health center for their services? If not, does provider need to be a member of their plans?
If an individual is a member of a Commonwealth Care or a Commonwealth Choice plan, they are able to get services from any provider within their plan's network – for example a specific doctor or

specialist. Each health plan also contracts with specific hospitals. To get more information about a specific provider network, members should visit MAhealthconnector.org.

If new employee is offered insurance by the employer, can she just enroll herself, not for her whole family? Can her husband remain on Commonwealth Care and her daughter with MassHealth?
Commonwealth Care is available to **for adults, 19 and older**, who meet the eligibility requirements and do not have access to other subsidized health insurance. One example of having access to subsidized insurance is when health insurance is available through an employer or a spouse's employer.

What should we do if a member is assigned a Primary Care Provider (PCP) that is not a contracted provider with their health plan?
Commonwealth Care members can check the Provider Directory that is available online at MAhealthconnector.org to review the provider directory and find a PCP that is accepting new patients. They can also call the Commonwealth Care Member Service Center or their health plan directly for assistance**.**

Back to Top

AFFORDABLE CARE ACT (ACA) UPDATE

Questions from the MTF July 2012 Roundtable Forms:

Will Affordable Care Act require mandated coverage for children?
The ACA provides coverage for all populations – including individuals and families.

How will the Affordable Care Act/MassHealth insurance system be affected if ACA is repealed in the fall by republican legislature? What is the implementation status?
Massachusetts is actively involved in implementing ACA. Many of the provisions have already taken effect since the passage of ACA in 2010. We have many more exciting programs in the works in partnership with the ACA that will advance Massachusetts' nation-leading efforts to provide affordable and accessible care.

How will the Affordable Care Act (ACA), make American Sign Language (ASL) accessible to rising population?
The ACA has specific requirements around ensuring information is accessible and available in alternate formats. The new Health Insurance Exchange Integrated Eligibility System that is being developed will include alternative formats for accessibility.

Will Affordable Care Act eliminate the multiple confusing types of coverage i.e. HSN, Limited Basic, CommonHealth, etc.?

Yes – the coverage configuration vision under ACA will be more simplified with significantly less coverage types beginning in 2014. The notices will also be improved for readability and easier to understand.

ACA provider screening fee and side visit implementation; what is the best way to get information?

Thank you for your question. We have taken this back for consideration for future topic. You can also contact MassHealth customer service and inquire with provider relations.

Back to Top

MASSHEALTH PROVIDER BILLING AND SERVICE

Questions from the MTF July 2012 Roundtable Forms:

Member was cancelled, reinstated 3 months later, and issued incorrect insurance (HSN? Network Health?); claims denied. What should I do so I will get paid "after 90 days"? Date of Service 3/2012 to current.
Claims over 90 days due to retro eligibility should be sent to 90 day Waiver Unit.

Is the revaluation fee for federal tribe(s)?
MassHealth is not charging a fee for revalidation.

If a patient has secondary MassHealth and the primary insurance company is no longer paying, do you need a prior authorization (PA) when the 20 visits are exhausted? (physical therapy, occupational therapy, or speech therapy).
A prior authorization is needed when the therapy visits have exceeded the maximum allowed without a PA. Please note that the number of visits differs based on the type of therapy. Providers should refer to the Therapist manual for detailed information.

What is the appropriate way for notifying MassHealth of dually eligible patient eligibility changes? I was presented with a Medicare B policy termination that was faxed to Third Party Liability (TPL) unit. Upon follow up, notified TPL does not handle Medicare changes
Mail or fax the insurance information to:
(Please enclose copies of written evidence, if possible.)
MassHealth
Medicare Unit
The Schraffts Center
529 Main Street, 3rd Floor
Charlestown, MA 02129
617-886-8133 (fax)
Listed in Appendix A of the provider manual

Does MassHealth offer onsite billing training to hospital staff?
Training requests can be directed to CST either via phone 1-800-841-2900 or email providersupport@mahealth.net

Who has charged the application fee? Is it per facility/provider per application by site? Per doctor's per provider/facility
Individual physicians and non-physician practitioners are exempt from the application fee. The fee will be charged per provider ID/service location. Providers can refer to the "Information about National Health Care Reform (Affordable Care Act) link" on the MassHealth website

(www.mass.gov/masshealth). Click "Provider Application Fees" for detailed information regarding the application fee.

If no change, does MassHealth do automatic revalidation or does provider still need to submit information?
Providers will need to respond to the revalidation and provide/confirm the information.

NCCI Edits – 7/1/12 forward, modifier 59 will be able to be used. Will MMIS accept it or do we have to submit documentation and have it reviewed? Will modifier 59 be accepted no electronic submission?
For dates of service starting July 1, 2012, MassHealth will begin allowing certain modifiers for affected providers. Please refer to All Provider Bulletin 227 for additional information.

When patient is receiving therapy whether physical therapy, occupational therapy, etc, and exhausts the 20 visits on the initial PCC referral and a prior authorization is needed for continued services, (patient currently not eligible for additional 20). Is another PCC referral needed to go with the prior authorization (if the patient is still not eligible for the 20 or 35 visits? The patient is still working within the rolling year.
PCC referral and Prior authorization requirements are separate service authorizations and the specific conditions of each need to be followed.

I tried to submit a final deadline appeal through POSC but the date of service is over 1 year and I don't have the option to resubmit the claim because it's too old. Is this option to submit through portal unavailable or am I going through this process incorrectly?
Final Deadline Appeals can be submitted through the portal using DDE. Please refer to claims job aids, All Provider Bulletins 221 and 225 to ensure that the process is being appropriately followed.

Can we use modifiers on claims (ex: modifier 25) on office visits with cast or injections? Will both get paid?
Please refer to All Provider Bulletin 227 regarding recent modifier changes.

What technology/software will be utilized for CCI edits?
MMIS

NCCI appeals – Could you give a review timeframe? Are they still being processed?
Yes they are being reviewed. Providers with specific NCCI appeal questions can contact CST

MCO's are notifying us 1-2 years later that the patient is not eligible, taking funds back. Why is MassHealth sending such late notices? MCO's get this from you correct?
The take backs are from the MCOs providers should contact the MCO directly.

We are the billing intermediary for a special MassHealth, provider type 98, when we have claim denials who can we call?
Contact MassHealth Customer Service (CST) at 1-800-841-2900

Who is responsible for paying a medical claim that has psych diagnosis on it? Medicaid states MassHealth Basic Health Plan (MBHP) and MBHP states Medical or MassHealth. Patient is not in distinct psych unit and is being treated "medically" not for behavioral health. We have several cases of this and neither has paid.

Provider should contact CST directly for specific claim billing questions

Back to Top

HEALTH SAFETY NET

Questions from the MTF July 2012 Roundtable Forms:

Members don't seem to understand what Health Safety Net (HSN) covers and does not cover. Is there a way to better educate the HSN population?
Information on covered benefits is available on our website. For hospitals, the Health Safety Net covers the same list of codes that MassHealth covers. For Community Health Centers, a full list of covered procedure codes can be found here: http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/chcs/payment-information-for-chcs.html

How do we confirm if we passed the test period for MMIS transition?
Providers should receive an email from the MassHealth CST indicating that they have passed testing. Once this email is received, providers should contact the HSN and request to go live with MMIS claims migration. All providers are required to go live with MMIS claims migration on October 1, 2012.

Will the HSN claim denial review process remain the same after HSN claims are submitted to MMIS?
Information regarding the HSN's claim denial review process can be found at http://www.mass.gov/eohhs/docs/dhcfp/p/hsn/2012-08-24-hsn-claim-update.pdf

Providers should refer to the 837I & 837P Billing Guides which outline MMIS requirements governing 90 day waiver and final deadline appeal procedures. Billing guides can be found at http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/hospitals/hsn-claims-information-for-hospitals.html

Claim denial review procedures for 837D claims will remain the same as these claims will continue to be processed at the Division of Health Care Finance and Policy.

Can we verify HSN claims on MMIS; if so can we correct them on-line?
Providers can verify claims on the POSC via submissions of a batch 276 query. Direct Data Entry is not available for HSN claims processing at this time.

MMIS says the patient has Health Safety Net (HSN), we bill the claim and HSN denies saying the patient is not eligible?
Providers should contact the HSN Help Desk at (800) 609-7232 or dhcfphelpdesk@state.ma.us. Help desk staff will review the claim and follow up with the provider.

If someone has HSN while Commonwealth Care eligible, then loses his Commonwealth Care because they didn't enroll; will they take away the HSN money from the hospital that was used to pay for bills during the time they had HSN before they lost their HSN because they didn't enroll in Commonwealth Care?

The Health Safety Net covers Commonwealth Care eligible patients for up to 90 days after their date of application, and between the day that they enroll in managed care and the day that managed care coverage begins. During this time, claims can be submitted to the HSN. If a patient does not enroll within 90 days from their date of application, they are considered ineligible and the Health Safety Net can no longer be billed for services going forward. Claims which are paid for services provided within the 90 day period will not be retracted due to the patient failing to enroll.

When we submit our claim to MMIS, can we continue to use CPT code or use T code like MassHealth?

Unless otherwise noted in the HSN Billing Guides (located at: http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/hospitals/hsn-claims-information-for-hospitals.html), providers should follow MassHealth's companion guide and billing requirements.

Members with Commonwealth Care - unenrolled, call and enrolled with commonwealth care. There is a retro HSN but when members try to access the pharmacy they are told they don't have coverage. This is an ongoing issue; what should we do? We have been told many different things.

Providers should contact the Health Safety Net Eligibility Line at 877-910-2100. Help desk staff will review eligibility and follow up with the provider.

Benefits exhausted billing procedures. Outlier billing needs to be done in order to get the HSN portion processed but MCD tends to pay the outlier instead of denying as expected.

Providers should refer to the HSN Claim Update which outlines requirements for billing of outlier days. Claim Update can be found at: http://www.mass.gov/eohhs/docs/dhcfp/p/hsn/administrative-days-outlier-and-split-eligibity-reporting-20110125.pdf

What do we have to do to submit special circumstances application for confidential teens?

Special Circumstance Applications for Confidential Teens, Battered and Abused, and Medical Hardship are completed using the Division of Health Care Finance and Policy INET application. Providers must be signed up for INET before they can access the application. Providers should contact the Division's Help Desk at 800-609-7232 or dhcfphelpdesk@state.ma.us for additional information and instruction.

Back to Top