Massachusetts Health Care Training Forum
October 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. The Questions and Answers are provided within this document.

**** 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 UPDATES

Questions from the MTF October 2012 Roundtable Forms:

Can a provider office enroll newborns online or only hospitals?
At this point in time, this process is only for hospitals. The NOB-1 (Notification of Birth NOB-1) form is used to:

- process newborn MassHealth eligibility;
- provide hospitals with a mechanism for receiving a newborn member ID in order to submit claims;
- enroll newborns into MCOs; and
- track federally required birth weight and race information.

The MassHealth NOB-1 form is used by hospitals to facilitate eligibility determination and health-plan enrollment of newborns born to MassHealth- or Commonwealth Care-eligible women.

Will there be a fast lane renewal process for individuals soon? Many of my clients lose or do not understand some letters they receive and by the time I am pulled in, their coverage is cut.
MassHealth has implemented an Express Lane Renewal process which is a streamlined annual review process for families meeting certain criteria who are receiving both active MassHealth, Commonwealth Care, or Healthy Safety Net benefits and active Supplemental Nutrition Assistance Program (SNAP) Benefits.

MassHealth has also implemented an administrative review process which streamlines the annual redetermination of certain MassHealth members by using income and health insurance information available from federal files. This process is being used for certain members in nursing facilities, and certain elders and disabled adults receiving Social Security income and Medicare, as well as Kaileigh Mulligan children.

Regarding job update forms: How will seasonally employed members be handled? Previous quarter does not reflect current invoice. Ex: Summer workers 3rd quarter income not reflective of 4th and 2nd quarter income. Premiums will be unaffordable.
The new job update process is not used for all households. Households will be selected for this process if:

- their current verified gross income in the MA21 eligibility system is 300% FPL or lower;
- their current income on the DOR quarterly wage reporting file is 310% or higher; and
- they are not scheduled for an annual review within the next 30 days, are not pending verifications on their case, and are not homeless.

In providing proof of income, seasonal employed individuals can submit a letter from their employer stating wages and hours.

Will it be enough to write on fax cover sheet "Medical Necessity"?
If this is referring to submitting application or renewal paperwork, listing "medical necessity" information on the fax cover sheet should be followed up by contacting MassHealth Customer Service to explain medical services are needed.

If a family has family assistance and is getting premium assistance from employer health insurance, can the children also get secondary coverage for services not covered by their health insurance such as hearing aids?
MassHealth premium assistance coverage helps pay for the cost of the employer sponsored insurance. If the child has a potential disability, the family may want to consider filing an application for MassHealth indicating the potential disability. MassHealth provides coverage for disabled children and adults.

We had an application that was done at another facility according to the patients Mother while patient was a High Point Treatment Center. A dated letter had been sent to patient requesting proof of income. A letter from patient's employer s stating patient was 1099 employee showing amount of hours worked, and amount of income was faxed to MassHealth. A subsequent letter from the patient was faxed to MassHealth one week later. The patient indicated that he had been an inpatient at a hospital for two weeks prior to the first letter from the employer. The

patient also said he was no longer employed and had not worked since the admission. Per MA EVS, patient is now showing eligible to enroll in Commonwealth Care and HSN is available. HSN is not showing as effective for patient's admission. Shouldn't the HSN go back 10 days from the date the requested income information was received at MassHealth?
A member determined eligible for Commonwealth Care receives 10 days retroactive HSN eligibility to the date of application. In the case where required verifications are received more than 60 days from when they are requested, the eligibility begin date will be the date these verifications are received by MassHealth. If this member's admission date was three weeks prior to the verification letter from the member, HSN eligibility will begin on the date MassHealth received the member's faxed information. In this case, the retroactive period of 10 days from date of application does not apply.

We have a local Optometrist who says he accepts only MassHealth Standard, not MassHealth Family Assistance. Why is this?
MassHealth Family Assistance can either be direct coverage or premium assistance coverage. MassHealth Family Assistance Premium Assistance coverage would help pay towards the monthly premium of the family's health insurance coverage offered through their employer. Premium Assistance would not include medical benefit coverage, including vision care services.

MassHealth Limited is not always covering ambulance bills?
MassHealth Transportation regulations can be found at 130 CMR 407.000. Ambulance regulations can be found at 130 CMR 407.481. The regulations provide definitions as well as outline covered and non-covered services.

If a client is disabled with no income or benefits but owns a house, can she get MassHealth Standard? She had MassHealth Basic in the past but she may go to a residential program. What should I do?
Individuals under age 65 are not subject to an asset test. The individual will need to meet categorical and financial (countable income) criteria only.

If a client has mental disability, currently under Commonwealth Care by mistake because he may work one week but then he will be out of work for 3-6 months. Can he obtain MassHealth Standard all year?
MassHealth does not have an open enrollment period – individuals can apply at any time. MassHealth does provide coverage for children and adults with disabilities. The individual can apply for MassHealth with their current circumstances. If there is a change in circumstance, MassHealth will need to be notified within 10 days. Any updated information reported to MassHealth will be processed to update the case.

Cell phone numbers don't appear on any other page of gateway; how will that change?
The paper application and VG have been updated to include capturing this information in the Head of Household information.

If a person wins the lotto can they still apply for MassHealth? If no how long must she wait to apply?
We can never deny someone the ability to apply for MassHealth. If they won the lottery as a onetime payment we would only count that money in the month they won it. If on the other hand it is an annual installment we would divide that by 12 to get a monthly amount just as we do other income such as interest & dividends.

If mom has HSN only, what happens with Newborn insurance status?
The child would be born to a non-eligible MassHealth Mom and would have to go through the eligibility test to qualify.

If a person says they are a veteran, MassHealth denies them stating they have other health insurance offered; i.e.: TriCare. To get this insurance, they must be retired. Many hoops must be jumped through to get them coverage.
MassHealth doesn't deny for other insurance, they just become the payer of last resort. If it appears to MassHealth there is another benefit not applied for then the applicant may get a letter from their agent stating no eligibility for that particular program. Joseph

What is the difference between MassHealth Standard and Standard Plus?
MassHealth does not have a Standard Plus coverage type. MassHealth has the following coverage types:

MassHealth Standard
MassHealth CommonHealth
MassHealth Family Assistance
MassHealth Basic
MassHealth Essential
MassHealth Limited
Children's Medical Security Plan
Healthy Start Program
MassHealth Prenatal
To find out more about eligibility criteria and covered benefits you can go to the MassHealth Member Booklet:
http://www.mass.gov/eohhs/gov/departments/masshealth/applications-and-member-forms.html

Are there new income limits and how does it affect the waivers?
The current income standards and federal poverty level guidelines will not change until next year, 2013. When and if, the income standards change, so do the income standards for the waivers.

Is there and easier way to update beneficiaries address, name correction?
Addresses can be changed on MAP (My Account Page) or by contacting the MassHealth Enrollment Center.

Are third party recovery forms available for us to have bank copies? It would help expedite the application process.
Providers can contact MassHealth Customer Service at 1-800-841-290 to place orders to obtain applications and other MassHealth publications forms.

When client on MassHealth (under 65 community) and assigned to MCO loses standard due to income increase, and is assigned to Commonwealth Care; why not direct transfer and premium charge? Why do they need to enroll in commonwealth care? Seems like an extra step and distress.
When there is a program change from one agency to another, the prevailing agencies rules are followed. MassHealth MCO's cannot be transferred to Commonwealth Care and vice versa. Each program has different options and the members have the right to choose their health provider.

Address changes are happening we think because of food stamp applications but we don't want the address of the regional office but we want it to remain as the individuals address.
For questions related to food stamp applications, please contact the Massachusetts Department of Transitional Assistance.

Wait time on a call to Springfield office is extremely long. Is there any sign of this changing in the near future?
Additional enrollment staff has been hired at the MassHealth offices. This should alleviate wait times. Members should continue to use the 24/7 phone line and the Virtual Gateway self service options.

When doing an electronic application, in the section "personal relationship"; it does not have an option for fiancé, boyfriend/girlfriend. Hope its ok to put the partner under spouse.
If members are applying electronically or by Paper for MassHealth/Commonwealth Care/HSN benefits only they should apply separately if not married & no child in common.
The member should never choose spouse if they are not legally married. They should choose the option "unrelated".

I have received several complaints that clients are receiving their Eligibility Review Forms (ERV) late. I have witnessed the delivery date.
ERV forms are system generated and mailed to members annually. If there is a circumstance when the member does not receive the review form they can contact the MassHealth Enrollment Center and another form will be sent for completion

I understand MassHealth is working on services for veterans and that is why several veteran questions have been added to the application. There is also a Native American question on the application. Does this mean MassHealth is working on services for Native Americans as well or are there services already in place? If services are in place, what are they and can I find them online?
Native Americans and Alaskan Natives who are MassHealth beneficiaries are not subject to certain cost sharing.

Who can I contact at MassHealth when our agency runs into road blocks of transitioning people from long term to community waiver MassHealth?
Questions regarding transitioning members can be directed to the MassHealth Enrollment center at 1-888-665-9993.

I can understand that you can't disclose what document was received but is it possible to make an exception when just a PSI was received? We spent 40 minutes on the phone just to find this out about a member who believed they had done an application.
MassHealth has prioritized processing of these documents. 90% of PSIs are processed within 48 hours and can be viewed on MAP.

What is being done to streamline Long Term Care (LTC) to community waiver eligibility in regards to the state pushing to get people out of Skilled Nursing Facilities (SNF) with programs like Money follows the Person (MFP). Example: SNF resident needs waiver to come home but

MassHealth tells SNF business office that resident needs to be in community for 24hrs. before being eligible for waiver?
This process is being handled by MassHealth and the Executive Office of Elder Affairs. More information on the (MFP) initiative can be found at the MassHealth website.
www.mass.gov/masshealth

I was able to submit an application for an applicant who was only 18. I thought you had to be 19 to apply?
An 18 year old can file an application on their own if they are emancipated. They would need to have both parents absent, be pregnant, or have a dependent child of their own.

If a woman is applying for MassHealth, is separated from her husband (physically and financially), does she need to gather "ex-husbands" income verifications, even if he is not applying and they do not speak to each other?
No, the husband's income would not be counted if they do not live together; however alimony and or child support that the separated wife receives would be considered countable income.

What are examples of "support services" and "special circumstances" for MassHealth applications?
Some examples would be hearing or vision aids.

Do MA state veteran cash benefits count as income for purpose of MassHealth eligibility?
Some income is non countable for Veteran's. Below is the policy defining what is non countable.

Site Regulation
Veterans' aid and attendance benefits, unreimbursed medical expenses, housebound benefits, enhanced benefits ($90 Veterans' Administration pension to long-term-care-facility residents, including veterans and their childless surviving spouses who live in a state veterans' home), or Veterans' benefits that are based on need and are provided by municipalities to resident veterans.

Express lane – is it available for all MassHealth coverage types if client has SNAP?

- Express Lane renewal is a streamlined annual review process for families meeting certain criteria who are receiving both active MassHealth, Commonwealth Care, or Healthy Safety Net benefits and active Supplemental Nutrition Assistance Program (SNAP) benefits.

- Families selected for this process will receive a letter telling them that their eligibility has been reviewed electronically and, unless there are changes to report, they do not need to return the annual eligibility review form.

We have recently seen increases in inpatient admissions of patients from other states and countries. They have no coverage and claim to be moving to MA. It takes a long time to confirm MassHealth eligibility due to residency. Is there any way to expedite this process? Confirm eligibility? Will MassHealth approve retro to admission date or to date of confirmed residency?

The application forms have been designed to gather pertinent information in order to determine eligibility. If the eligibility criteria are met the member could get retroactive coverage. This will

depend on what type of coverage they are approved for and also if they have sent in documentation within required time frames.

Questions from the MTF October 2012 Evaluation

If someone is in an MCO now and is a "dual eligible" for the upcoming demonstration, will they move to an ICO or will they have both MCO and ICO services?
Information for the Dual Eligible program can be found at www.mass.gov/masshealth/duals

With the QHC, does this mean that certain coverage provided by MassHealth will be gone?
As part of the Affordable Care Act, Qualified Health Plans (QHP) will be available for purchase for an effective date of January 1, 2014. QHPs will be commercial insurance products available on the Health Connector website (that contain the Connector's seal of approval) for individuals to shop and purchase health plan coverage. These are similar to Commonwealth Choice products available for individual's to purchase through the Health Connector today. In 2014, Individuals that are not eligible for MassHealth, depending on their income, may be eligible for advance premium tax credits in helping purchase a QHP.

What is different between MassHealth members and Commonwealth Care members?
MassHealth is a state and federal program that pays for health care for qualified people living in Massachusetts with low and medium incomes. Even if you have other health insurance, you may be able to get MassHealth. If you qualify, MassHealth would be able to provide health care benefits directly or pay part or all of your health insurance premiums.

Commonwealth Care is a program administered by the Commonwealth Health Insurance Connector Authority ("the Health Connector") for certain adults who are not eligible for MassHealth. Commonwealth Care helps pay for health-insurance premiums for health plans that are approved by the Health Connector.

To read more about the programs, you can find information in the MassHealth Member Booklet at: http://www.mass.gov/eohhs/gov/departments/masshealth/applications-and-member-forms.html

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VIRTUAL GATEWAY UPDATES

Questions from the MTF October 2012 Roundtable Forms:

Can we incorporate Long Term Care (LTC) application on Virtual Gateway?
This is certainly something we would like to do as well. Stay tuned for future developments on this issue - we appreciate your patience.

How do we access the change form?
There is a link to the Change Form on the My Account Page. If you do not see it, please contact VG Customer Service at 1-800-421-0938.

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 the self service MAP option, only the member (must be Head of Household - the person who signed the application) can set up his or own access. All MAP functions show information for members under age 65, and those 65 and over living in the community. Long Term Care members are not currently shown in MAP.

Suggestion:
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 an excellent suggestion. We will take it back - however given limited resources and the number of current high priority projects in "the queue", it is unlikely it could be implemented easily in the near future.

Why am I not seeing notices in MAP?
We would be happy to work with you on resolving this issue but would need specific case examples.

Virtual Gateway and MAP do I have to set up two different accounts?
No - you need only set up one account. Please call VG Customer Service for assistance on setting up an account.

Virtual Gateway auto cover sheet indicates the MassHealth Enrollment address to send documents for over 65 when they are to be sent to Central Processing Unit (CPU)?
All Applications excluding Long Term Intake should be mailed to the Central Processing Unit (CPU).

Questions from the MTF October 2012 Meeting Evaluations

I am unable to view the 'documents received' section on MAP - what do I need to do in order to see that information?
Please call VG Customer Service at 1-800-421-0938 - they can assist with this issue.

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AFFORDABLE CARE ACT UPDATE

Questions from the MTF October 2012 Roundtable Forms:

How does is MassHealth / Affordable Care Act going to affect AFC families and billing?
MassHealth will continue to coordinate with sister state agencies on referred eligibility. The ACA updates provided at the MTFs cover the new changes on eligibility criteria and application and eligibility determination process.

To keep appraised of any provider billing changes, contact MassHealth Provide Services at 1-800-841-2900 ext. 2

Will dental benefits be better after Affordable Health Care Act?
Specific coverage is currently being defined. As information is finalized it will be shared with MTF.

Will streamline HIX/IES applications replace MBR/SMBR?
The Health Insurance Exchange (HIX) will allow consumers to shop for health insurance, apply for financial assistance, and enroll in private and public plans in on-line in real-time.
The integrated eligibility system (IES) will determine eligibility for the Medicaid and CHIP programs - either directly or by 'talking' to MA21 in real time. It will also determine eligibility for SHOP employers and employees, and more.

The HIX/IES online application will also be available in paper application, which will replace the current MBR. For the initial roll-out of the HIX/IES system, seniors will continue to apply by completing the SMBR.

What happens if Romney is elected and gets rid of the Affordable Health Care Act?
The Commonwealth is actively implementing the ACA.

Questions from the MTF October 2012 Meeting Evaluations

After I got back, I was wondering regarding the ACA presentation, how the HIX/IES will handle duel-enrollment for Medicare and MassHealth?
For the initial roll-out of the HIX/IES system, seniors will continue to apply by completing the SMBR.

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MEDICARE AND THE AFFORDABLE CARE ACT

Questions from the MTF October 2012 Roundtable Forms:

For someone on Medicare A&B who takes medication; do they have to take Medicare D?
If an individual wants coverage for outpatient prescription drugs, they would need to sign up for Part D. Parts A and B don't cover outpatient prescription drugs except in very limited circumstances.

Medicare Part B covers drugs only in these situations:

- "Incident to" a physician service, such as injectable/intravenous drugs considered by a Part B carrier as not usually self-administered
- If the drug needs to be administered via durable medical equipment covered by Medicare such as inhalation drugs, IV drugs requiring a pump for infusion, or insulin via infusion pump.

Medicare Part A covers drug only in these situations:

- If an individual is being covered by Medicare inpatient at a hospital or skilled nursing facility, the payment to hospitals and skilled nursing facilities generally will cover all drugs during a stay

- Drugs that are medically necessary for symptom control or pain relief if the individual is getting care under the Medicare hospice benefit

Patient with Medicare and Medicaid was in a car accident in the past. The patient came in for a sore throat. At first Medicare rejected the claim stating that the claim had to go to the car insurance first. Once it was resolved that Medicare was primary because the sore throat was not related to the car accident, Medicare paid the claim but did not send directly to Medicaid for secondary coverage. The claim required additional work in order for Medicaid to pay its share. How can this go smoother?

When Medicare becomes aware of an automobile accident, it is documented in a master file and claims submitted to Medicare for consideration suspend and get reviewed in order to determine if they are related to the motor vehicle accident.
If a claim for Medicare Secondary Payer (MSP) is incorrectly denied, the only way to correct the error is to reprocess the claim.

Medicare has cross-over agreements with insurers, including MassHealth, so that once Medicare makes primary payment on original claims, they are automatically forwarded to the supplemental insurer for consideration. However, that process is only for claims that go through the system correctly and primary payment issued the first time they are reviewed. Due to system restrictions, Medicare is unable to cross-over claims that were originally denied for MSP. The providers or beneficiaries must forward these claims to the supplemental insurer for secondary payment. Claims deny for MSP because records remain in the master file even after the cases get resolved because the parties involved fail to notify Medicare of settlements or exhaustion of Personal Injury Protection benefits.

Also, due to other reporting requirements, insurers are required to report to Medicare with information on automobile accidents that were previously closed. The process could go smoother and a large percentage of the denials could be prevented by insurers providing accurate information, including with specific codes and notes confirming that the claim is not related to an automobile accident. Medicare sends Medicare Summary Notices to beneficiaries that summarize all inpatient and outpatient claims information that has been processed by Medicare over a 90-day period. The Notices contain a customer service number that beneficiaries can call for assistance. However, if they do not get any satisfaction, they can call the CMS Regional Office public line for Medicare A/B issues: 617-565-4630.

What is a typical payment for Medicare Plan B?

The premium for most is $99.90/month in 2012. Medicaid offers programs to pay the premium for eligible low-income individuals. Individuals with higher incomes, starting at $85,000 for an individual, may pay higher premiums.

What is Medicare Part C?

Medicare Part C is a Medicare program offering health plan options approved by Medicare and run by private companies, including HMOs (health maintenance organizations) and PPOs (preferred provider organizations). Enrollees may have to use network doctors or hospitals. Medicare pays a certain amount for each member's care. Medicare Part C is now usually called Medicare Advantage.

If a person is retired, on spouse's health plan; do they have to elect Medicare Part D?
If the coverage is as good as Part D, called "creditable coverage," an individual may decide they do not need to get Part D. Many kinds of coverage may be creditable, including employer or retiree coverage. The employer is required to keep those enrolled updated that the coverage is creditable.
If the coverage however is not creditable or they do not have any drug coverage, and wish to enroll in Part D later, they would have a premium penalty of 1% added to their premium as long as they had Part D for every month eligible for Part D and not enrolled.

What is Medicare deductible for 2012? Are there 3 different deductibles?
The Part A (hospital insurance) deductible is $1,156; the Part B (medical insurance) deductible is $140; the Part C (Medicare Advantage) and D (prescription drug benefit) deductibles vary by plan.

Please explain how drug benefits will change. Example: Suboxone treatment for patients with straight Medicare. Will certain drugs be coming off the plan(s) which will affect patients? Will there be a list of drugs that will no longer be available?
Every year drug plans can change their formulary. To find out which plans cover a drug, enter the individual's zip code and the drug at https://www.medicare.gov/find-a-plan/questions/home.aspx.
You can also check with individual plans to find out what their formulary is.
Individuals on a plan will also get information about changes to the plan before the Open Enrollment Period.

I have a client who is now off SSI but still qualifies for Medicare. How is he billed for this?
If an individual is no longer receiving Social Security benefits, they will be billed quarterly. Those receiving Social Security benefits can have the premium deducted from the Social Security check.

Members who have Medicare from Puerto Rico are being told if they see provider in U.S. the Medicare in Puerto Rico will cover their services. Medicare (Puerto Rico) is HMO Plan and patients cannot get referral from primary. When bills are sent to Puerto Rico, claims are denied as (no referral from PCP). When they call to get Medicare changed to U.S. plan they are being told it will be charged on next day? Per Medicare Coordination of Benefits (COB) this could take weeks since they have to notify the primary Medicare to terminate that coverage
This issue would need to be investigated further. Please call the Regional Office public line for Medicare health plan issues: 617-565-1232. Please provide the individual's name, Medicare Health Insurance Claim number (HICN) and the name of the health plan.

The preventative services and the new ones are with no co pays, are they going to be covered 100%?
A full list of all preventive services, including eligibility and frequency is at http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf.
All but the "Welcome to Medicare" physical and some prostrate or colorectal cancer screenings have no co-pay and do not count towards the Part B deductible.

Who is going to keep track of troop expenses?
The health plan tracks the individual's True Out-of-Pocket expenses ((TrOOP).
TrOOP is used to determine if the individual reaches the coverage gap and when the individual gets out of the gap. The information is provided to the beneficiary on his statements from the plan.

Do we need any proof to meet the troop expenses?
The plans are required to keep track of TrOOP expenses. The individual may choose to keep their receipts in case there is a problem but it is not necessary.

If patient did not pay the Medicare Advantage plan premium for certain period of time, does that mean they will automatically go back to original Medicare?
The plan can disenroll the beneficiary, and if the plan does, the individual will revert to original Medicare.

Couple came in to office; wife will be on Medicare come Jan. 2013. Husband is disabled and is currently covered through wife's insurance. What will she have to do when she leaves her employers insurance? She is currently 65 and has not enrolled in Medicare.
The Initial Enrollment Period to sign up for Medicare is a 7-month window, starting the 3 months before the individual turns 65, the month they turn 65 and 3 months after. The Special Enrollment Period to sign up after the Initial Enrollment Period without penalty may be available in these situations:

- During the 8-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first, or
- An individual or his/her spouse (or family member if the beneficiary is disabled) are working, and the individual is covered by a group health plan through the employer or union based on that work

Unless the individual is eligible for the Special Enrollment period, if he/she does not enroll when they are initially eligible, they may have to pay the Part B penalty, which is 10% for each 12-month period eligible and not enrolled.
Finally, anyone can also sign up for Part A and/or Part B during the General Enrollment Period January 1–March 31 each year. However, coverage will not begin until July 1 of that year and they may be subject to the Part B penalty.

For one turning 65 who is still working and receiving insurance through his employer; does he still sign up for Medicare? Can he keep his employer's health insurance?
The individual can keep the employer's insurance and get Medicare. While working, the employer's insurance would pay primary and Medicare pay secondary. If they have retiree coverage, when the employee retires, Medicare would pay primary and the employer coverage secondary.
An individual can get Part A premium-free when he/she turns 65 if he/she is eligible to get Social Security or Railroad Retirement benefits even if the individual hasn't yet filed for them or if the individual or the individual's spouse had Medicare-covered government employment.
Since there are monthly premiums for Part B and/or D, an individual may want to delay enrolling until employment coverage ends.
A helpful publication on Understanding Medicare Enrollment Periods is available at http://www.medicare.gov/Pubs/pdf/11219.pdf

If a client's Medicare Part D is discontinued and they are not on LIS and they fail to actively choose a new plan during their open enrollment period, what happens? If they lose coverage but need it later, will they face a penalty at reenrollment?
Members of discontinued plans that are not on LIS may be eligible for a Special Enrollment Period from December 8 – February 28 to enroll without penalty.

If the individual enrolls later, they are subject to the penalty of 1% of the national base premium added to their premium for every month eligible but not enrolled.

What counseling services are available via new preventive services benefit?
The counseling services Medicare may cover at no cost are medical nutrition therapy for individuals with diabetes or kidney disease and counseling to help manage diabetes or kidney disease; and counseling from a qualified doctor or other Medicare-recognized practitioner who can help any individual using tobacco to stop using tobacco.

Other new counseling benefits are behavioral counseling for obesity and behavioral counseling interventions in primary care to reduce alcohol abuse, High Intensity Behavioral Counseling to prevent STIs and Intensive Behavioral Therapy for cardiovascular disease to Medicare beneficiaries
More detailed information here: http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf

Medicare Part B also pays 60% of the Medicare-approved amount for counseling or psychotherapy in a doctor's office setting and 80% of the Medicare-approved amount for visits to a doctor or other health care provider to diagnose or monitor or change prescriptions.
Medicare Part A covers 80% of the cost for inpatient mental health care in hospitals, including specialized psychiatric units and hospital.

How does a physician's office bill Part D for the shingles vaccine (Zostavax) administered to an individual on Medicare and Medicaid (dual eligible)?
The physician would need to call the Part D plan to make those arrangements, see Section 60.2 here: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf
MassHealth would not need to pay because it is covered under Part D.

Comment - Getting a letter about a plan terminating before getting the CMS letters about it are confusing to beneficiaries.
Medicare plans are required to send a letter to beneficiaries by October 2nd if they are not renewing. The letters from CMS are sent later as a reminder.

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MASSHEALTH PROVIDER BILLING AND SERVICES

Questions from the MTF October 2012 Roundtable Forms:

We have a substance abuse provider type for our inpatient unit. When a client steps down from detox to rehabilitation they have psychiatry visits. Are we able to bill these? I was told we need to have a mental health provider type. Does MassHealth consider rehabilitation all inclusive of these visits?
Providers need to refer to their specific provider manual for program regulations.

We have several claims with December dates of service that were never attached to a claim file due to a 5010 conversion issue. All claims have been captured and submitted, have denied for

timely filing, were submitted to 90 day waivers and have again denied. Is there another appeal option we could use prior to final deadline appeal? (Claims are not over 1 year old).
Providers need to follow 90 Day Waiver procedures outlined in All Provider Bulletin 220.

We currently have a waiver for paper claims submission. It will be expiring at the end of December. Can we apply for another waiver due to the issue of still working on this with a vendor?
Providers with waivers will need to reapply for the paper waiver. A notice should be sent to providers with more information.

Why is it so different to bill Adult Foster Care?? (AFC) client when they have waivers even though it says MassHealth Standard Plus?
Provider should contact CST directly for specific claim billing questions.

Should the use of modifier 25 with nebulizer treatments be a covered benefit?
All providers that bill for services under the various circumstances in which these modifiers apply, according to the CPT code book, will be able to use the modifiers for claims submission when medically appropriate. Please refer to All Provider Bulletin 227 for additional information.

Use of modifier 25 – Can this be used to bill well visit and sick visit on the same day? I.e. child comes for well visit and later comes in with leg injury.
All providers that bill for services under the various circumstances in which these modifiers apply, according to the CPT code book, will be able to use the modifiers for claims submission when medically appropriate. Please refer to All Provider Bulletin 227 for additional information.

Tobacco Cessation and Evaluation and Management (E+M), do these need a modifier?
All providers that bill for services under the various circumstances in which these modifiers apply, according to the CPT code book, will be able to use the modifiers for claims submission when medically appropriate. Please refer to All Provider Bulletin 227 for additional information.

To check MMIS to see if a claim has been paid, the date of service range doesn't include claim. Is there a reason for this?
Providers need to make sure that the claim status check includes the full date range of the claim and the appropriate billing provider is selected.

I would like to know why some eligibility on MMIS cannot be accessed by the social security number. Yet when it is accessed by name, DOB; the eligibility shows up.
There are no known issues regarding the member search using the social security number. Please check to see if the social security information being entered is correct. Providers can always call Customer Service if there are any questions regarding MMIS eligibility check.

MassHealth is not following CCI guidelines consistently. Ex: 25 modifier; some visits are paid with 24 modifier, others are not. Should we appeal denied claims or would it be a waste of time?
All providers that bill for services under the various circumstances in which these modifiers apply, according to the CPT code book, will be able to use the modifiers for claims submission when medically appropriate. Please refer to All Provider Bulletin 227 for additional information.

Why do we have to manually key 90 day waiver claims? Can't we submit claims electronically and have it in "pending" status for attachments?
Providers need to follow 90 Day Waiver procedures outlined in All Provider Bulletin 220 in order to send a 90 Day Waiver through DDE to MassHealth. 90 Day waivers cannot currently be sent via electronic batch files as 837 files cannot support attachments.

Why do I get these errors suspended claims?

- **procedure not covered for benefit plans**
- **manual pricing required**
- **NDC submitted on invalid procedure code**
- **4038 services not covered for limited BP**

Providers with specific claim suspension/denial issues should contact CST at 1-800-841-2900 directly for assistance.

Can provider bill for MassHealth limited with codes 99211, or 00201 with contraceptive methods?
Providers need to refer to their Provider Manual under subchapter 1-3 for coverage types.

How do I handle suspended claims? I have a few that states "suspended" for 2513 Managed Care Services – 6000 manual pricing required. Most of these are for IUD's Mirenas Pepo. I just started attaching an invoice but not sure if this helps
Providers with specific claim suspension/denial issues should contact CST at 1-800-841-2900 directly for assistance.

Permedion claims - all are time consuming. Do you have an alternative way of submitting claims besides keying each one?
Providers need to follow All Provider Bulletin 225 when submitting a claim reviewed by Permedion Health Management after Permedion Systems (HMS); the claim must be submitted electronically via DDE HMS Review using Delay Reason Code 11 (Other).

3rd one way transportation, 4th round trip paid on same ICN#, then 4th denied for duplicate. 5th paid until next one way. How do you correct that?
Providers should adjust/replace paid claims that need correcting in the MMIS.

Modifier 25 is only being recognized sometimes. Why?
All providers that bill for services under the various circumstances in which these modifiers apply, according to the CPT code book, will be able to use the modifiers for claims submission when medically appropriate. Please refer to All Provider Bulletin 227 for additional information.

Could service providers in the personal care attendant program submit claims over 90 days? If so, how is that done?
If the claim is over 90 days, then Providers need to follow 90 Day Waiver procedures outlined in All Provider Bulletin 220. Job aids are also available on the website:
www.mass.gov/masshealth/newmmis

If a person has private insurance as primary and MassHealth as secondary, would PCA program be covered?
Providers should check eligibility for member's MassHealth coverage.

Why are Medicaid appeals taking 2 years?
Providers who have specific claim concerns need to contact CST directly.

Questions from the MTF October 2012 Meeting Evaluations

I'm having trouble with secondary claims that electronically pass into MMIS and then reject. I was advised to contact the EDI Department. I still don't understand how to resolve the $10,000 past due claim.
Provider should contact EDI department at CST in order to assist with batch file rejection issues. Please call 1-800-841-2900, and then select options 1, 8 and 3.

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HEALTH SAFETY NET

Questions from the MTF October 2012 Roundtable Forms:

I am having an issue getting on and testing the dental on sends due to not having permission to send file. What can I do to have this fixed?
Please contact the HSN Help Desk at (800) 609-7232 or **hsnhelpdesk@state.ma.us**.

What can be done regarding my Dept. of Health Finance (DHF) ID failure?
Please contact the HSN Help Desk at (800) 609-7232 or **hsnhelpdesk@state.ma.us**.

Can patient apply for Health Safety Net for sole purpose of treatment while visiting from another country? (Not yet planning to stay in MA) The treatment mentioned is Oncology or follow up.
No. To be eligible for the Health Safety Net a patient must be a resident of Massachusetts. "In order to be determined a Low Income Patient; an individual must be a Resident of the Commonwealth and document Family Income equal to or less than 400% of the FPL…." 114.6 CMR 13.04(1). "Resident" is defined by 114.6 CMR 13.02 as "A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in a Massachusetts institution of higher learning or confinement in a Massachusetts medical institution, other than a nursing facility, is not sufficient to establish residency.

If MassHealth denies the Health Safety Net claim for eligibility, how do we submit? Is it the same as before on a specialist?
Please refer to August 24, 2012 claim update regarding submission of claim denial reviews. Claim updates are located at http://www.mass.gov/chia/provider/client-eligibility/health-safety-net/providers/hospitals/billing-updates.html#mha_claims.

Can you explain the deductible periods for an HSN patient? Calendar year/Anniversary year?
For HSN Partial patients with Family Income between 201% and 400% of the FPL, there is an annual Deductible equal to 40% of the difference between the applicant's Family Income and 201% of the FPL. The patient is responsible for payment for all services provided up to this Deductible amount. Once the patient has incurred the Deductible, a Provider may submit claims for Eligible Services in excess of the Deductible. According to 114.6 CMR 13.04(6) (c) (2), "The annual

Deductible is applied to all Eligible Services provided to a Low Income Patient or Family member during the Eligibility Period." The eligibility period begins on the patient's benefit effective date, not the first of the calendar year. If the patient receives retroactive HSN eligibility prior to the benefit effective date, bills for eligible services provided during this time period may be applied to the first annual deductible.

Could you explain Health Safety Nets different coverage types? There is HSN prime coverage and regular HSN. What types of services are covered under each?
I might also copy and paste the explanation from the Annual Report because it's short and clear:

If a patient has no other insurance, whether MassHealth or private, they may be eligible for HSN primary. This means the HSN is the patient's only payer. If the patient has MassHealth or private insurance, they may be eligible for HSN secondary. This means the primary insurance provider must be billed first and HSN can only be billed after the primary insurer has processed the claim.

- Massachusetts residents who are uninsured or underinsured and have income up to 200% of the Federal Poverty Level (FPL) are eligible for full HSN primary or HSN secondary coverage.
- If residents have income between 201% and 400% of the FPL, they are eligible for partial HSN or partial HSN secondary coverage, which includes a sliding scale deductible.
- Residents who are enrolled in private health insurance, MassHealth, or Commonwealth Care may be eligible for HSN secondary coverage for certain services not covered by their primary insurance.

The HSN pays for the same set of services as MassHealth Standard, as long as they are provided by an acute hospital or a community health center. In general, HSN primary and HSN secondary cover the same set of services, with the following exceptions:

- For patients enrolled on Commonwealth Care, the HSN only pays for dental services not covered by the member's Commonwealth Care Plan
- For adults enrolled in MassHealth Standard, CommonHealth, Basic, Essential, or Family Assistance/Direct Coverage, the HSN only pays for outlier days (the portion of an inpatient stay exceeding 20 days), and for certain dental services not covered by MassHealth.

If a patient is not active and their application is in process, how far back will MassHealth Standard and Health Safety Net retroactive cover?

After a member is determined eligible for MassHealth Standard, they will receive 10 days of retroactive MassHealth Standard coverage before their date of application. The member will show up with an eligibility status of "MassHealth Standard" in the Provider Online Service Center (POSC). A member determined eligible for Health Safety Net Full or Partial will receive 180 days retroactive HSN coverage before their date of application. The member will show up with an eligibility status of "Member Not Eligible" in the POSC, with a restrictive message indicating that retroactive HSN is available. These messages will not be visible in the POSC until the patient's determination has been made. The "date of application" refers to the day that MassHealth receives the patient's application.

If a patient is active and chooses a plan with Commonwealth Care, Patient will be active on the 1st of the next month. How far retroactive will Health Safety Net (Commonwealth Care) pay? And for what will they pay?

When a patient is determined eligible for Commonwealth Care, the HSN provides 10 days of retroactive eligibility and up to 90 days of eligibility going forward starting on the patient's date of

application, in order to allow the patient time to enroll in a Commonwealth Care plan. If the patient does not enroll within this time period, they will no longer be eligible for HSN.
After 90 days, patients who are eligible for Commonwealth Care may still call to enroll in a Commonwealth Care plan, even though they are no longer eligible for the Health Safety Net. They will not need to re-apply for health benefits. Once the patient enrolls in a Commonwealth Care plan, the patient will have HSN eligibility between the time they enroll and their plan coverage start date. The HSN will pay for any HSN eligible services during the time period. Depending on the patient's income, they may be responsible for paying a deductible.

If the messaging for this coverage which appears in the Virtual Gateway is unclear, please contact the HSN Help Desk at (800) 609-7232 or **hsnhelpdesk@state.ma.us**.

Health Safety Net will or will not pay for a family planning visits seen by a "Non-Provider" i.e. Health Educator/Family Planning Counselor?

- DPH is the payer of last resort for family planning services when a client is also HSN-eligible.
- The HSN may be billed for contraceptive and HIV counseling with non-clinicians using codes 99211 (Established Patient Minimal Visit) or 99402 (Preventive Medicine, Individual Counseling). 99211 cannot be billed as an add-on to a medical visit. If code 99211 is used, the provider cannot bill another medical visit code to the HSN for the same person on the same day. However, 99402 can be billed as an add-on. Here are some examples of how these codes should be used:
    - If an HSN patient just sees family planning counselor, this visit should be billed using 99211 only.
    - If a patient sees a clinician AND a family planning counselor, the visit should be billed using the appropriate E&M code. 99211 shouldn't also be billed.
    - If a patient receives HIV counseling only from a non-clinician, the visit should be billed using 99402 only.
    - If a patient sees a clinician and receives HIV counseling (either form the clinician or from a counselor), the appropriate E&M code and 99402 may be billed.

Can a participant apply for grievance under HSN if MassHealth's determination is not acceptable? What is the process?

Patients may request that the Health Safety Net conduct a review of an HSN eligibility determination, or of provider compliance with the Health Safety Net regulation. To file a grievance with the HSN, send a letter to:

Health Safety Net
Attn: HSN Grievance
Two Boylston Street, 5th floor
Boston, MA 02116

At a minimum, the letter should include your name and address. If possible, it should also include information about the situation, the reason for the grievance, the provider's name (if a provider is involved), and any other relevant information. The more information you give the better. It is very important to include the provider's name if a provider is involved.

More information is available in the Health Safety Net Eligible Services regulation (114.6 CMR 13.00) in section 13.04(3). Questions about filing a grievance should be directed to the HSN Help Line at 877-910-2100 (toll-free) or email dhcfphelpdesk@state.ma.us.

How can I prove that I have reached my deductible if I have HSN partial?
HSN providers are responsible for tracking HSN deductibles when a 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.

Who is the payer of last resort for family planning services? MassHealth is saying they are, as is Dept. of Public Health and Health Safety Net? Which policy is correct? Which one do I follow to bill correctly? Where do I find these policies?
How family planning should practices bill for visits with lay counselors/non-clinicians?

- The HSN may be billed for contraceptive and HIV counseling with non-clinicians using codes 99211 (Established Patient Minimal Visit) or 99402 (Preventive Medicine, Individual Counseling). 99211 cannot be billed as an add-on to a medical visit. If 99211 is used, the provider cannot bill another medical visit code to the HSN for the same person on the same day. However, 99402 can be billed as an add-on. Here are some examples of how these codes should be used:
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    - If a patient sees a clinician and receives HIV counseling (either form the clinician or from a counselor), the appropriate E&M code and 99402 may be billed.

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