MassHealth Training Forum – Provider Services

July 2022

Executive Office of Health & Human Services

Agenda

- **Welcome and Agenda Review**
- **Transportation Updates**
- **Robotics Processing Automation (RPA)**
- **Telehealth Policy**
- **Top Denial Edits**
- **Medicaid and CHIP Managed Care Final Rule**
- **Gender Affirming Care Provider Self- Identification**
- **Provider Training and LMS Updates**
- **Checking Member Eligibility**
- **Additional MassHealth Updates**
  - POSC Accommodation/Language Updates
  - COVID-19 Flexibilities
  - Revalidation
  - ORP
  - Bulletins (April 2022 – July 2022)

MassHealth Transportation Updates

Presented by – Karla Burgos Sr. Provider Relations Specialist, MassHealth Business Support Services

Transportation Program Changes

As of June 1, 2022, wheelchair van services are covered solely through the two regional transit authority (RTA) brokers contracted by the Human Services Transportation unit. Fee for service billing will no longer be accessible to providers through the MassHealth Provider Online Service Center (POSC). Providers are reminded to disregard HCPCS codes related to wheelchair van services within the subchapter 6 of covered services as of June 1, 2022.

MassHealth will not directly enroll or pay providers for nonemergency medical transportation provided by wheelchair van. If providers wish to continue providing wheelchair van transportation to MassHealth members, they will need to contract with MART or GATRA or both brokers.

Impacts for non-Transportation providers:

- As of April 1, 2022, a PT-1 needs to be submitted via the CWP, in place of the current Medical Necessity Form, for MassHealth members to receive wheelchair van transportation as part of safe discharge planning
- Accommodations have been enhanced to account for the needs of an individual to be safely transported, such as: Door-to-door transportation services and adding a Facility Discharge PT-1 process

Transportation Program Changes Effective 4/1 (Continued)

Effective Date	Service Type	Transportation Reimbursement	Authorization Form Needed
Pre-April 1	Wheelchair Van	Fee-for-service & Brokered	Medical Necessity Form (FFS), PT-1 (Brokered)
April 1	Wheelchair Van	Brokered*	PT-1
Current (Not Changing)	Non-emergency Ambulance	Fee-for-service	Medical Necessity Form
Current (Not Changing)	Sedan (Ambulatory Members)	Brokered	PT-1

*Existing relationships with transportation vendors will be honored for needs that require enhanced support, such as door to door transportation

Who should be aware of these changes?

All provider staff involved with coordinating transportation for MassHealth members should be aware of the changes that took effect on April 1, including:

- Staff responsible for coordinating transportation for Emergency Department discharges
- Staff responsible for coordinating transportation for outpatient discharges
- Staff who currently complete Medical Necessity Forms for wheelchair van services

Robotics Processing Automation (RPA) Updates

Presented by – Karla Burgos, Sr. Provider Relations Specialist, MassHealth Business Support Services

MassHealth Robotics Processing Automation (RPA) Policy

Effective July 1, 2022, MassHealth requires MassHealth providers, relationship entities, and business partners (hereafter referred to as “organizations”) that use RPA tools/bots on the POSC or intend to use RPA tools/bots in the future to register any/all bots with MassHealth by submitting a request for approval. This will enable MassHealth to identify, document, and manage RPA utilization on the POSC.

Organizations that use Robotics Processing Automation (RPA) tools must adhere to the following RPA Policy requirements:

- Submit a registration request (two stages and two forms) to MassHealth to use RPA tools/bots on the POSC. Upon approval, MassHealth will issue an RPA User ID for each transaction the bot will perform.

- Organizations that are actively using an RPA tool/bot within the POSC on or before July 1, 2022, can be grandfathered into the RPA Policy. These organizations will only be required to complete the RPA Stage II Registration Form – Grandfathered Entities

MassHealth will monitor any/all approved organizations to ensure compliance and monitor sign-on activity to identify unauthorized bot utilization. Any organization that violates the RPA policy may have their access to submit bot-based transactions on the POSC terminated

RPA Stage I & II Registration Request

Organizations may request RPA approval by completing the following steps.

Two Stage Registration Process

1. Organizations must submit an initial request using the RPA Stage I Registration Form to identify the types of transactions the bot will perform, RPA tool and implementation timelines

2. If approved, a Stage II Registration Form must be submitted along with the following documentation:

    A. A signed RPA Agreement
    B. Systems Design Documentationn (SDD) that includes process flows, full end-to-end activity of each bot transaction
    C. Test Scenarios that cover the full end-to-end activity of the bot
    D. Ensure compliance with Section 2 of the MassHealth RPA policy. This compliance may also be demonstrated via documented statements where applicable.

MassHealth will evaluate requests at each stage and either approve the request, solicit missing/clarifying information, or reject the request.

Grandfathered Entities

Organizations that were using a bot on the POSC before July 1, 2022, can be grandfathered into the RPA Policy. Those organizations must complete the Stage II Registration Form – Grandfathered Entities. Grandfathered entities must:

- Complete the RPA stage II Grandfathered Entities Registration form (includes documenting the existing bot information and related user IDs) for MassHealth approval along with the following documentation:

  A. A signed RPA Agreement
  B. Systems Design Documentation (SDD) that includes process flows, full end-to-end activity of each bot transaction
  C. Relevant test Scenarios that cover the full end-to-end activity of the bot
  D. Ensure compliance with Section 2 of the MassHealth RPA policy. This compliance may also be demonstrated via documented statements where applicable.

The organization must submit the MassHealth RPA Stage II Registration Form or the Stage II Registration Form – Grandfathered Entities along with all the supporting documentation to MassHealth at functional.coordination@mass.gov no later than September 1, 2022.

MassHealth will evaluate requests at each stage and either approve the request, solicit missing/clarifying information, or reject the request.

RPA User ID

- When MassHealth approves the Stage II Registration Form and RPA Agreement, an official RPA User ID will be assigned to each approved bot.

- Before using any approved bot on the POSC, the organization must generate and assign the MassHealth-issued RPA User ID to the bot that will perform the approved function for that specific PID/SL. Organizations must follow specific instructions to generate the assigned RPA User ID. Please review the RPA Job aid found at https://www.mass.gov/rpapolicy

- Grandfathered entities will not receive an RPA User ID. These organizations will keep the User ID currently assigned to the bot that will be grandfathered into the RPA policy.

- Neither the RPA User ID assigned by MassHealth, nor the approved grandfathered User ID previously assigned by the organization may be used for any other purpose than the RPA activity outlined in the approved registration request.

Technical Guidelines, Requirements & Maintenance

- Organizations that request approval to use RPA tools on the POSC must ensure that they, at a minimum, comply with the guidelines and requirements that are outlined in the RPA Agreement that each organization must sign, and in the MassHealth RPA Policy.

- Each bot must perform tasks on the POSC in the same manner as a human would perform them. This means performing the activities in a sequential manner; Organizations must adhere to the Specific human characteristics outlined in the policy

- Organizations may not share its assigned User ID or password with anyone. These credentials must not be used for any purpose other than the approved RPA tool activity outlined in the approved RPA Stage I, Stage II, and Stage II - Grandfathered Entities Registration Forms.

- Organizations that have been approved to use RPA tools on the POSC must notify MassHealth of any changes to the bot that are outside the scope of the approved Stage II Registration Form or Stage II Registration Form for Grandfathered Entities. Organizations must submit a Modification Request Form to MassHealth at functional.coordination@mass.gov for approval before making the modifications, where applicable.

Monitoring, Enforcement, and Compliance

MassHealth will monitor the status of all RPA registration requests and each organization's adherence to the RPA policy. MassHealth will continue to monitor its MMIS to identify any bot used on the POSC that has not been approved by MassHealth. Any organization that uses a bot that has not been approved by MassHealth will be subject to the following:

- Outreach and validation.
- Remediation of the violation (opportunity to cure)
- If compliance is not achieved within mutually agreed upon timeframes, the organization will be subject to:
  - Suspension or termination of the bot User ID.
  - Prohibition from performing functions on the POSC.
  - Organization-wide ban on ability to use RPA tools on the POSC.
  - Other penalties or remedial actions as determined by MassHealth after outreach to the organization.

Using a bot on the POSC is a convenience to organizations. Any organization that violates the MassHealth RPA Policy may have its access to submit transactions via the POSC using RPA technology revoked.

Please review RPA Policy to view the full scope of the monitoring, enforcement, and compliance requirements.

RPA Policy Website

RPA Policy Website

The RPA Policy and all relevant forms can be found at the MassHealth Robotics Processing Automation (RPA) Policy page. The following registration forms and related documents can be downloaded and submitted to MassHealth for review:

- RPA Stage I Registration Form
- RPA Stage II Registration Form
- RPA Stage II Registration Form – Grandfathered Entities
- RPA Modification Form
- RPA User ID Job Aid
- RPA Agreement
- RPA Policy

Please visit MassHealth Robotics Processing Automation (RPA) Policy webpage to review MassHealth's RPA policy and learn how to submit an RPA registration request for MassHealth approval.

If you have questions regarding the RPA Policy please contact MassHealth at functional.coordination@mass.gov

Telehealth Policy

Presented by – Karla Burgos Sr. Provider Relations Specialist, MassHealth Business Support Services

Current Emergency Policy and New Healthcare Legislation

- Steps to broaden MassHealth's existing telehealth policy were in motion prior to the COVID-19 pandemic to enhance member access to high quality care delivered via telehealth, but these efforts were expedited in response to the public health emergency (PHE)

- In response to the PHE, MassHealth rapidly developed and implemented an expansive telehealth policy, permitting providers to deliver all clinically appropriate, medically necessary MassHealth-covered services via all telehealth modalities (All Provider Bulletin 289). All Provider Bulletin 324 further explained that MassHealth would issue additional guidance on telehealth that would describe MassHealth's successor telehealth policy

Telehealth Policy: APB 327 Effective October 16, 2021

All Provider Bulletin 327 : Access to Health Services through Telehealth Options

Certain categories of service are deemed inappropriate for delivery via any telehealth modality.

1. Ambulance Services
2. Ambulatory Surgery Services
3. Anesthesia Services
4. Certified Registered Nurse
5. Anesthetist Services
6. Chiropractic Services
7. Hearing Aid Services
8. Inpatient Hospital Services
9. Laboratory Services
9. Nursing Facility Services
10. Orthotic Services
11. Personal Care Services
12. Prosthetic Services
13. Renal Dialysis Clinic Services
14. Surgery Services
15. Transportation Services
16. X-Ray/Radiology Services

Except for those services, and notwithstanding any regulation to the contrary, any MassHealth-enrolled provider may deliver any medically necessary MassHealth-covered service via any telehealth modality, if the provider satisfies all requirements set forth in All Provider Bulletin 327, including Appendix A to the bulletin, and any applicable program-specific bulletin.

Telehealth Policy Cont'd

Reimbursement:

Through December 31, 2022:

1. MassHealth will reimburse providers delivering any telehealth-eligible covered service via any telehealth modality at parity with its in-person counterpart; and
2. An eligible distant site provider delivering covered services via telehealth in accordance with this updated policy may bill MassHealth a facility fee if such a fee is permitted under such provider's governing regulations or contracts

Billing

1. Providers must include the place of service (POS) code 02 when submitting a professional claim for telehealth provided in a setting other than in the patient's home; POS code 10 when submitting a professional claim for telehealth provided in the patient's home. Additionally, for any such professional claim providers must include:
   - Modifier 95 to indicate counseling and therapy services rendered via audio-video telecommunications;
   - Modifier 93 to indicate services rendered via audio-only telehealth; and/or
   - Modifier GT to indicate services rendered via interactive audio and video telecommunication systems
   - Modifier GQ to indicate services rendered via asynchronous telehealth
   - Modifier FQ to indicate counseling and therapy services providing using audio-only telecommunications
   - Modifier FR to indicate a supervising practitioner was present through a real-time two-way, audio and video communication technology

IMPORTANT NOTE: MassHealth intends to publish a bulletin with further details. Within six months of publication of the upcoming bulletin, MassHealth will discontinue this informational edit, and will deny claims containing POS code 02 or POS code 10 that are missing one of these modifiers. Exact timeline for discontinuing of the informational edit will be released with the upcoming bulletin.

Telehealth Policy Institutional Claims

Billing cont'd

2. For any institutional claim, providers must include the following modifiers:
   - Modifier 95 to indicate counseling and therapy services rendered via audio-video telecommunications;
   - Modifier 93 to indicate services rendered via audio-only telehealth; and/or
   - Modifier GT to indicate services rendered via interactive audio and video telecommunication systems
   - Modifier GQ to indicate services rendered via asynchronous telehealth
   - Modifier FQ to indicate counseling and therapy services providing using audio-only telecommunications
   - Modifier FR to indicate a supervising practitioner was present through a real-time two-way, audio and video communication technology

   Professional and institutional claims with the aforementioned modifiers must also meet the following requirements:
   - Modifier 93 is only allowed for codes listed in appendix T of the CPT coding book
     - Modifier 95 is allowed only with codes listed in appendix P of the CPT coding book

IMPORTANT NOTE: MassHealth intends to publish a bulletin with further details. Within six months of publication of the upcoming bulletin, MassHealth will discontinue this informational edit, and will deny claims containing POS code 02 or POS code 10 that are missing one of these modifiers. Exact timeline for discontinuing of the informational edit will be released with the upcoming bulletin.

Top Denial Edits

Presented by – Karla Burgos Sr. Provider Relations Specialist, MassHealth Business Support Services

Top Denial Edits

- 90 Day Billing Deadline
- Member Has Other Insurance/Medicare
- Duplicate

Billing Timelines

- **30 Days:** This is the average time for both electronic (EDI) and paper claims to process on a remittance advice
- **60 Days:** This is the usual turnaround time for Medicare/MassHealth crossover claims forwarded to MassHealth by the Massachusetts Medicare fiscal agent to be processed
- **90 Days:** Initial claims must be received by MassHealth within 90 days of the service date. If the provider ad to bill another insurance carrier before billing MassHealth, the provider has 90 days from the date of the explanation of benefits (EOB) of the primary insurer to submit the claim
- **12 Months:** This is the final submission deadline. Providers have 12 months from the date of service to resolve a claim and must of originally met the 90 day billing deadline, or have been approved for a 90 day waiver. If this deadline is exceeded, the claim will be denied for error code 853 or 855 (Final Deadline Exceeded) on a remittance advice (RA)
- **18 Months**: This is the final submission deadline if another insurance carrier was billed before billing MassHealth, providers have 18 months from the service date to resolve the claim, as long as the claim was received by MassHealth within 90 days of the EOB date. If this deadline is exceeded, the claim will be denied for error code 853 or 855 (Final Deadline Exceeded) on an RA
- **36 Months**: If the date of service is more than 36 months when it is received by MassHealth, the claim will be denied for error 856 or 857 (Date of Service Exceeds 36 Months) on an RA. A claim with this error cannot be appealed
- https://www.mass.gov/doc/billing-timelines-appeal-procedures/download

After 90 Days

- If original claim was submitted after 90 days, it will deny for untimely submission
- Providers can submit a 90 Day Waiver Request for review
- For timely submissions, whether the claim paid or denied, providers have up to one year from the date of service or 18 months with other insurance to adjust a paid claim or time to correct a denied claim in order to receive payment
- Providers should not adjust a claim over 1 year when seeking additional payment, the claim will deny for 853/855 and the payment will be taken back
- If a claim has both paid and denied lines, providers should only submit the denied lines for a final deadline exceeded denial and not submit an adjustment

90 Day Overview

All documentation relevant to each particular claim must accompany the Direct Data Entry (DDE) claim. Each DDE claim must be submitted with a 90-Day Waiver Request Form or the Universal Provider Request for Claim Review Form and the respective documentation to support the 90 day waiver submission. These documents must be scanned and included with each DDE claim submission. The provider will use the attachments tab of the Provider Online Service Center (POSC) to upload all applicable documents related to each 90-day waiver request. For professional claims, providers must select the appropriate delay reason code from the drop-down box on the Extended Services tab of the POSC. For institutional claims, providers must select the appropriate delay reason code from the drop-down box on the Billing and Service tab. Only providers with an approved electronic claim waiver can submit their 90-day waiver request on paper.

Only the following delay reason codes may be used when submitting 90-day waiver request.
1 – Proof of Eligibility Unknown or Unavailable
4 – Delay in Certifying Provider
8 – Delay in Eligibility Determination

Claims submitted with 90-day waiver requests will initially appear in a Waiver Requests suspended status on the provider's remittance advice for Edit 818-Special Handling 90-day waiver. Ninety-day waiver decisions will be reflected when the claims appear processed on a subsequent remittance advice.

Acceptable Supporting Documents

- If documentation being submitted contains multiple claim information, providers must circle/highlight the specific claim the 90 day waiver is corresponding to.
  - An example of this would be an RA, which may contain information about other claims.
- The following are the most commonly used (this does not constitute the only acceptable documentation):
  - Bill [billed to the member]
  - MassHealth Remittance Advice to support originally timely filed
  - Member Retroactive Eligibility letter
  - Provider Enrollment Letter
  - Registration Forms/Printouts
  - EVS Printouts [Eligibility Verification System]

EVS– The prior print outs showing ineligibility will be required, in addition to the eligible printout when no registration or bill is present.

- Third Party Liability – Explanation of Benefits dated within 90 days of waiver request. If the EOB date is entered with the TPL information when submitting the claim and is within 90 days, a 90 day waiver request is not required

For failed electronic submissions these are the most commonly used:

- 999 Report
- 835 Remittance Advice
- Emails from CST / EDI/MassHealth staff showing ongoing issue was just resolved

Common 90-Day Waiver Denials

- If the claim and documentation do not meet the review criteria, the request for the waiver is denied with Error 2626 and the corresponding EOB Code that will appear on the Remittance Advice

- Common denials are:
  - Name and or Date of Service does not match documentation or is missing
  - No supporting documentation
  - Does not meet the criteria
  - A copy of the bill sent to the member is not attached
  - Prior remittance advice is not attached

  - These are not all the reasons, just the most common

Other Insurance/Medicare

- Providers should always check eligibility on the day of service to ensure eligibility and any third-party coverage

- Per MassHealth and Third-Party Liability (TPL) regulations, providers must make "diligent efforts" to identify and obtain payment from all other liable parties

- When the member has other insurance, providers must submit the claim to the other payer, following the other payer's billing and authorization guidelines.
  - If the claim is denied for reasons other than a correctable error, or if there is a remaining patient responsibility, providers may submit the claim to MassHealth including the COB adjudication information as it appears on the other payer's EOB
  - Providers may not submit the claim to MassHealth if the claim is denied for noncompliance with any one of the payer's billing and authorization requirements

Medicare Crossovers

- A crossover is defined as a claim for a member who has Medicare in addition to MassHealth, where Medicare has made a payment or has approved an amount that was applied to the member's deductible

- After Medicare has made a payment or applied the charge to the deductible, the Benefits Coordination and Recovery Center (BCRC) will automatically transmit claims for dual-eligible members (Medicare and MassHealth) to MassHealth for adjudication. A claim must contain at least one Medicare-approved service line in order for the entire claim to be crossed over automatically to MassHealth

Duplicate Billing

Unacceptable Billing Practices

(A) No provider may claim payment in a way that may result in payment that exceeds the maximum allowable amount payable for such service under the applicable payment method

(B) Without limiting the generality of 130 CMR 450.307(A), the following billing practices are forbidden:
(1) duplicate billing, which includes the submission of multiple claims for the same service, for the same member, by the same provider or multiple providers; (2) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more comprehensive service for which a single rate of payment is established; and (3) submitting claims under an individual practitioner's provider ID/service location number for services for which the practitioner is otherwise entitled to compensation

Status of Claim Inquiry

- To avoid submitting duplicate claims and unsure if a claim has paid, you can check using the following tools:
- For an EDI Batch Response, you can download a batch response
  - https://www.mass.gov/doc/new-mmis-job-aid-download-batch-responses/download
  - After a claim is submitted, regardless of the method of submission, a 999 is generated and used by providers to determine the status of their submitted claims. This job aide will assist them to download a 999 functional response
- Use your remittance advice.
  - Visit mass.gov for assistance in downloading remittance advices
  - https://www.mass.gov/doc/new-mmis-job-aid-view-remittance-advice-reports/download
- Check claim status via the POSC, you can use a job aid on Mass.gov
  - https://www.mass.gov/how-to/check-claim-status

Medicaid and CHIP Managed Care Final Rule Updates

Presented by – Marilyn Thurston, Manager, Provider Relations, MassHealth Business Support Services

Managed Care Final Rule Requirements

Final Managed Care Rule, 42 CFR § 428.602(b) and 608(b)

1. States must screen, enroll, and periodically revalidate all Managed Care Entity (MCE) network providers
   a. MassHealth has delegated the screening, enrollment and revalidation of the MCE provider networks to the MCEs
   b. Screening includes all federally required disclosures, verifications of federal exclusions, NPI, Social Security Administration (SSA) Death Master File (DMF) and license information as applicable

2. States must enroll providers that are not already actively enrolled with MassHealth (Fee-for-Service (FFS) and Ordering, Referring & Prescribing (ORP))
   a. Where the MCE has a different NPI, address, TIN or Provider Type (PT) from MassHealth a contract/enrollment are required

3. An MCE-only provider must have a signed MassHealth Nonbilling Managed Care Entity (MCE) Network-only Provider Contract
   a. For entities one contract is needed for each NPI/TIN/ PT combination
   b. If the provider has an existing MassHealth relationship that is different than the MCE, a contract is needed for the MCE relationships
   c. The MCE will identify providers who require a contract/enrollment

Managed Care Final Rule Process

- An MCE only (not enrolled with MassHealth but enrolled with one or more MCEs) provider is not required to render fee-for-service (FFS) care
- Validating MCE networks against the MassHealth network
  - Validation is based on NPI/TIN/PT/Address
- Plans are outreaching to providers who must complete a MassHealth Nonbilling Managed Care Entity (MCE) Network-only Provider contract
- MCEs are submitting enrollment files for MCE only providers. Providers are only required to submit a contract
- If a provider is disputing the requirement to sign a contract and the information the MCE is maintaining they must contact the MCE
- If a provider is disputing the information MassHealth is maintaining, they must contact their respective MassHealth customer service vendor

Gender Affirming Care Provider Self-Identification

Presented by – Marilyn Thurston, Manager, Provider Relations, MassHealth Business Support Services

Gender Affirming Care Background

In September 2021, MassHealth launched its Gender-Affirming Care for MassHealth Members web page, providing information and resources about MassHealth coverage for gender-affirming care and other resources about health care for transgender and gender-diverse members.

To further this initiative, MassHealth is collecting information from MassHealth providers who want to self-identify as providers of gender-affirming care.

This form is intended to capture self-reported provider information for the purpose of informing MassHealth members of self-identified gender-affirming care providers participating in the MassHealth program, and the services they provide.

Using the information collected, MassHealth may create a publicly available MassHealth gender-affirming care provider directory on our gender-affirming-care web page, at https://www.mass.gov/gender-affirming-care-for-masshealth-members.

Gender Affirming Care Provider Self Identification Form

If you are an active MassHealth provider who provides gender-affirming care and would like to self-identify as a provider of gender-affirming care, please fill out the form at https://www.mass.gov/forms/gender-affirming-care-provider-self-identifcation.

Please note that this information is self-reported only. MassHealth reserves the right to verify any information submitted, but assumes no obligation to do so. Any providers completing this form must report to MassHealth any changes to their status as self-reported providers of specified gender-affirming care (e.g., change of address, new services offered, etc.).

For More Information

Resources

- For more information about gender-affirming surgeries and hair removal as a treatment for gender dysphoria, see MassHealth's Guidelines for Medical Necessity Determination for Gender-Affirming Surgery and Guidelines for Medical Necessity Determination for Hair Removal, found at MassHealth Guidelines for Medical Necessity Determination | Mass.gov
- If possible, it would be helpful to receive a response **by September 20, 2022**, although providers may complete the form at any time
- If you have questions about this form, email physicianservices@mass.gov with the subject line, "gender-affirming care provider form"

Provider Education and The Provider Learning Management System (LMS)

Presented by – Marilyn Thurston, Manager, Provider Relations, MassHealth Business Support Services

Provider Education LMS

The MassHealth Provider Learning Management System(LMS) for Non-OLTSS providers is a system providers can use 24/7 as an educational resource.

The Provider LMS delivers:

- Previous live training presentations
- New on demand training courses
- Resources
- Course surveys

Users that were enrolled in the previous version of the LMS were sent an e-mail notification in October and November of 2021 announcing the change and providing important login information. If you have forgotten your user-name or password you can retrieve it from the sign-in screen

New Users can create a profile and begin using the system immediately

Visit: https://masshealth.inquisiqlms.com/Default.aspx

OLTSS and Dental providers should visit their respective vendor site for training opportunities

Training Courses

Recently released trainings:

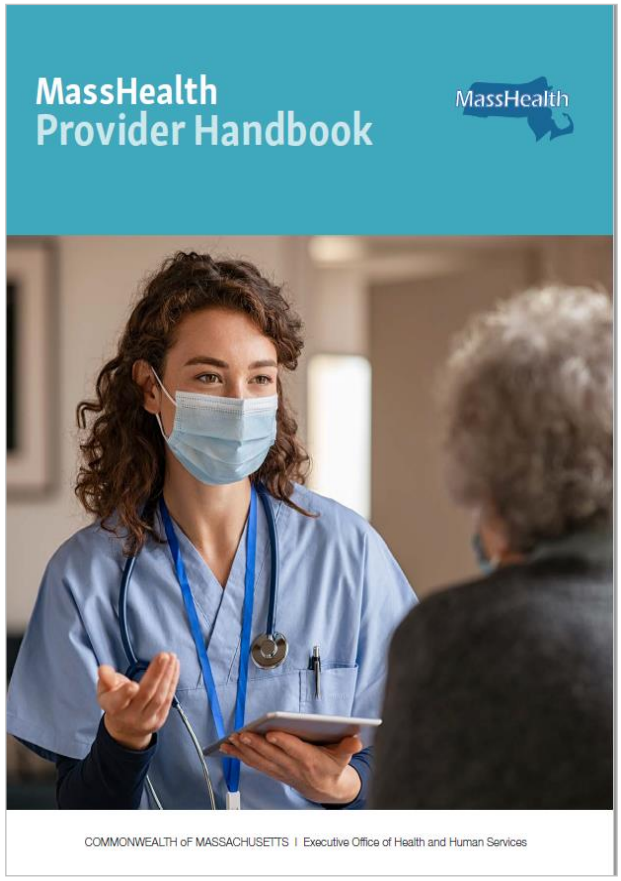
- Revalidation
- Hearing Aid Member Search in the POSC
- Updated Customer Web Portal PT-1 Request

Introducing Provider Online Service Center (POSC) webinar training sessions:

- June trainings included:
  - Coordination Of Benefits Professional Claims Submission
  - Professional Claim Correction on the POSC
- The next training is expected in August
  - Checking Eligibility on POSC and Coverage Types
  - Common Claim Edits and POSC Remittance Advice Review
  - Announcement and registration link will be released by email

MassHealth Provider Handbook

We're excited to announce that the *MassHealth Provider Handbook* is now available on the Mass.gov website.



Intended as a resource for Fee-for-Service (FFS) providers, the *Provider Handbook* includes general information that new and existing providers will find helpful. Topics covered in the *Handbook* include the following:

- Member eligibility
- MassHealth Plans
- Billing claims
- Provider regulations
- Integrity expectations
- And much more

We hope you'll take advantage of this new, valuable resource! And we would love to hear your feedback, since MassHealth is always looking for ways to improve the services we offer to providers.

**the handbook is not meant to be an all-encompassing resource for provider information*

Checking Member Eligibility

Presented by – Nestor Rivera, Sr. Provider Relations Specialist, MassHealth Business Support Services

Eligibility Verification

The Eligibility Verification System (EVS) is:

- A web-based application that enables a MassHealth provider to verify a member's eligibility
- Accessible through the POSC
- Available 24 hours a day, 7 days a week
- Easy access to the most current and complete member eligibility information

Eligibility Verification 2

Where you go to check eligibility?

- **Eligibility Verification System (EVS):** The EVS is accessed through the Provider Online Service Center (POSC) at www.mass.gov/masshealth/providerservicecenter
- For additional information, see the Submit Eligibility Inquiry job aid:

  https://www.mass.gov/files/documents/2016/07/rg/eligibility-verification-submit-inquiry.pdf

What you need when checking eligibility?

- POSC User ID & Password
- MMIS Provider ID/Service Location
- Dates of Service
- Member ID Number or Member Name and DOB

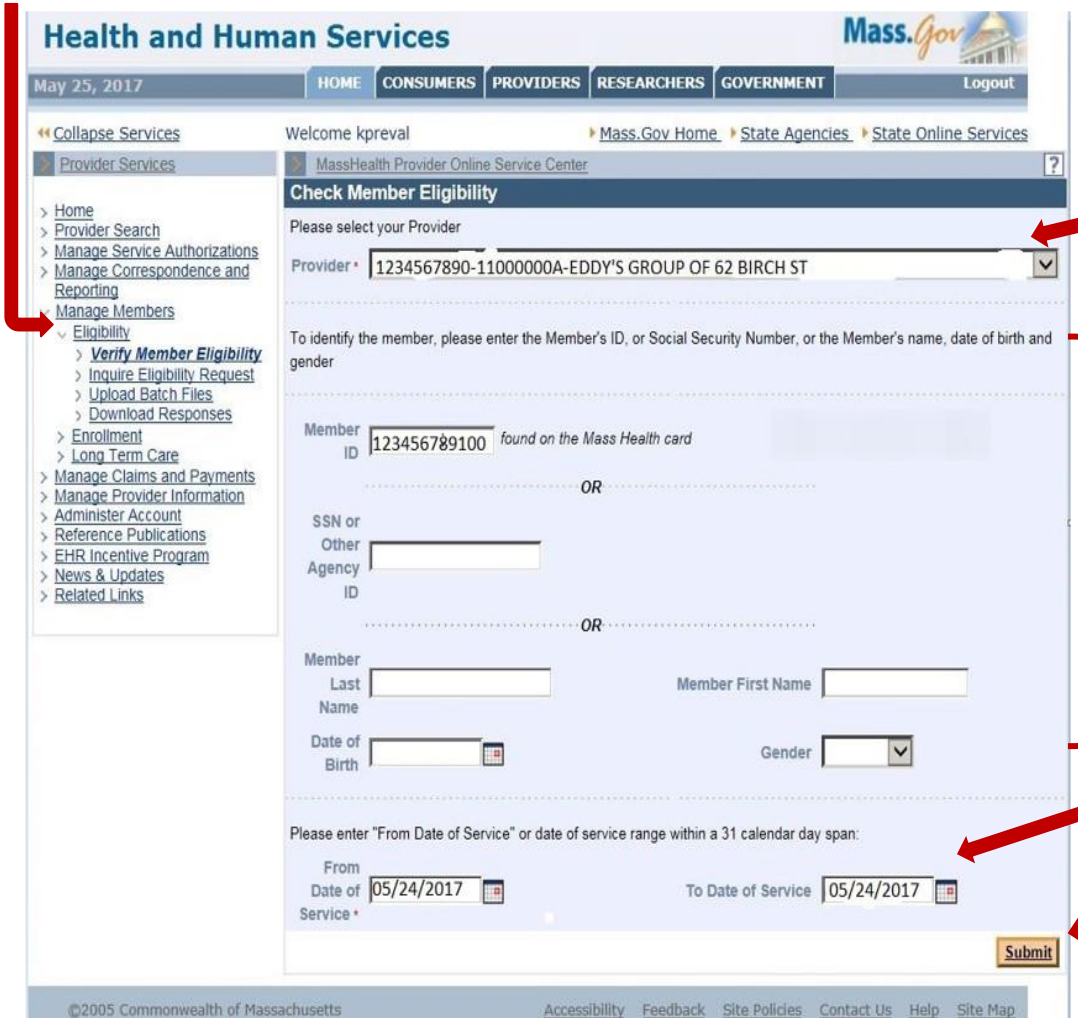
Member Identification Card

Member Identification Card

Each member is issued a MassHealth ID card, which includes the individual and their system-generated 12-digit ID number.

Eligibility Verification 3

The Check Member Eligibility page can be accessed by clicking *Manage Members* from the menu then click *Verify Member Eligibility*.



1. Select the provider from the drop-down menu

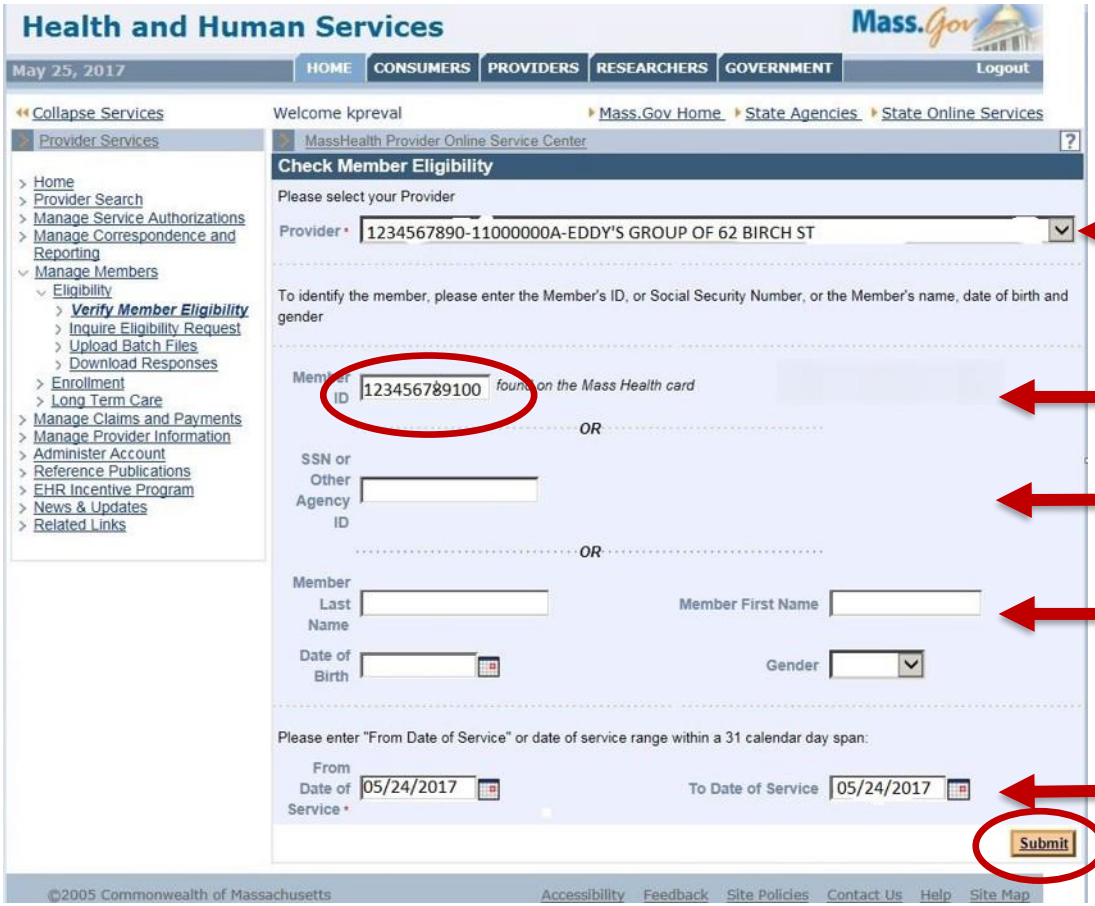
2. Search for the member either by the *MassHealth ID*, *Social Security Number*, or *Agency ID* or *Member's last name, First name, DOB & Gender*

3. Enter the *From Date of Service to Date of Service* fields (*date range needs to be equal to or before the current date*)

4. Click **Submit**

Eligibility Verification 4

The Check Member Eligibility page can be accessed by clicking *Manage Members* from the menu then click *Verify Member Eligibility*.



1. Select the provider from the drop-down menu

2. Search for the member either by MassHealth ID

Or Social Security Number, or Agency ID

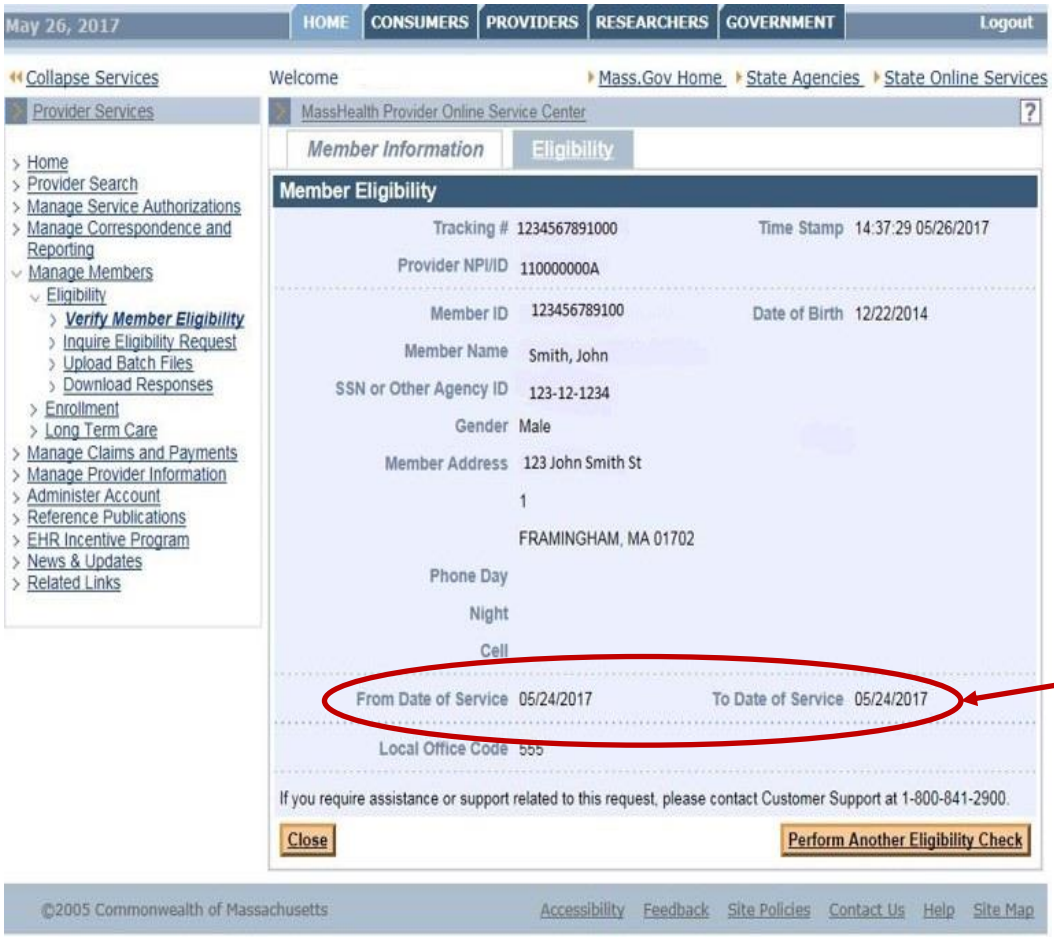
Or Member's Last Name, First name, DOB & Gender

3. Enter the date of service (future dates are not allowed)

4. And finally Click **Submit**

Eligibility Verification 5

From the *Member Information* Tab ensure that you have the correct member by verifying all Information is correct.



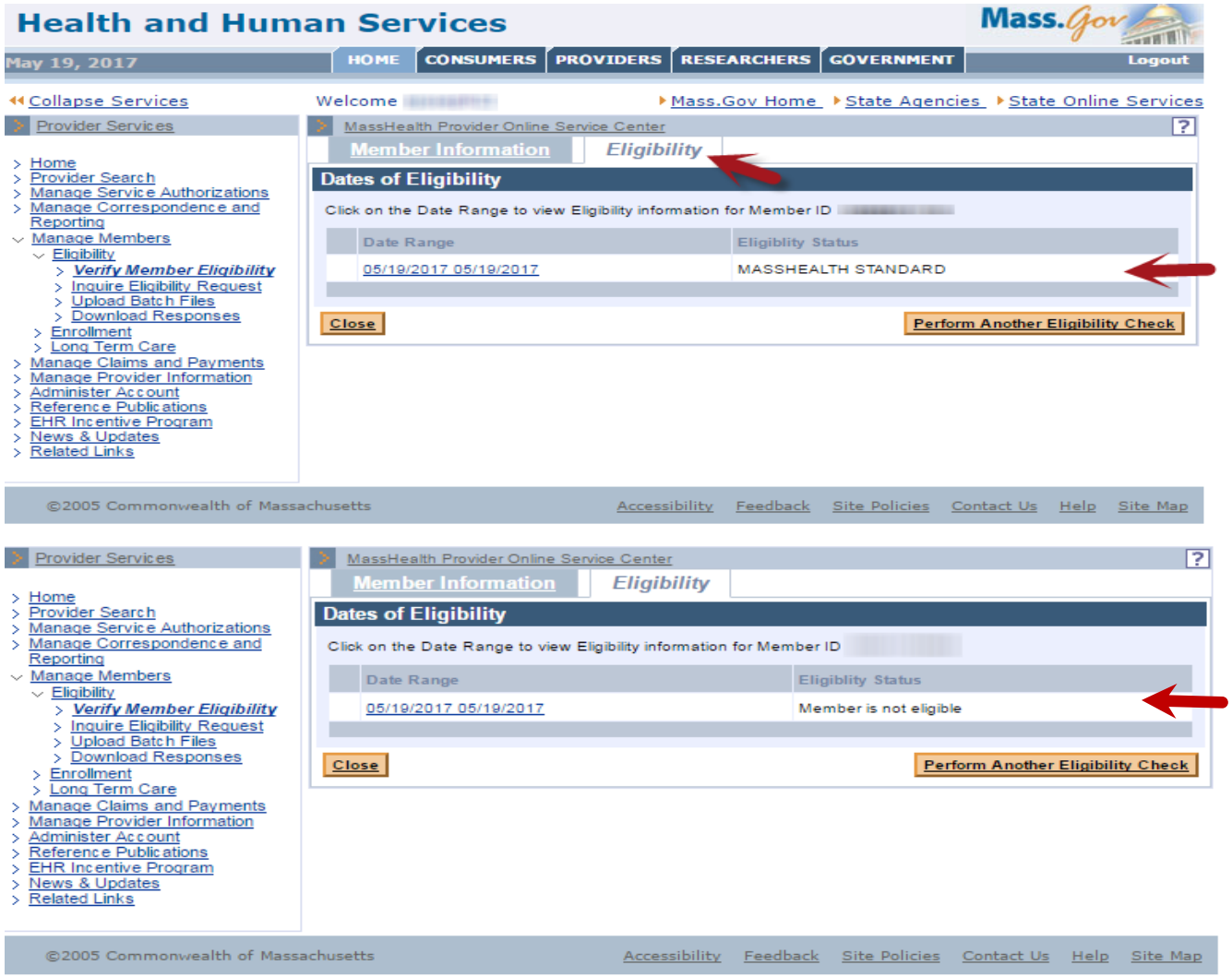
Verify the member's:

- Member ID
- Name
- Date of Birth
- Gender
- Address
- Social Security or Agency ID

Note: Member eligibility information is specific to the date of service entered. MassHealth does not allow eligibility verification for future dates of service.

Eligibility Verification 6

Eligibility Tab

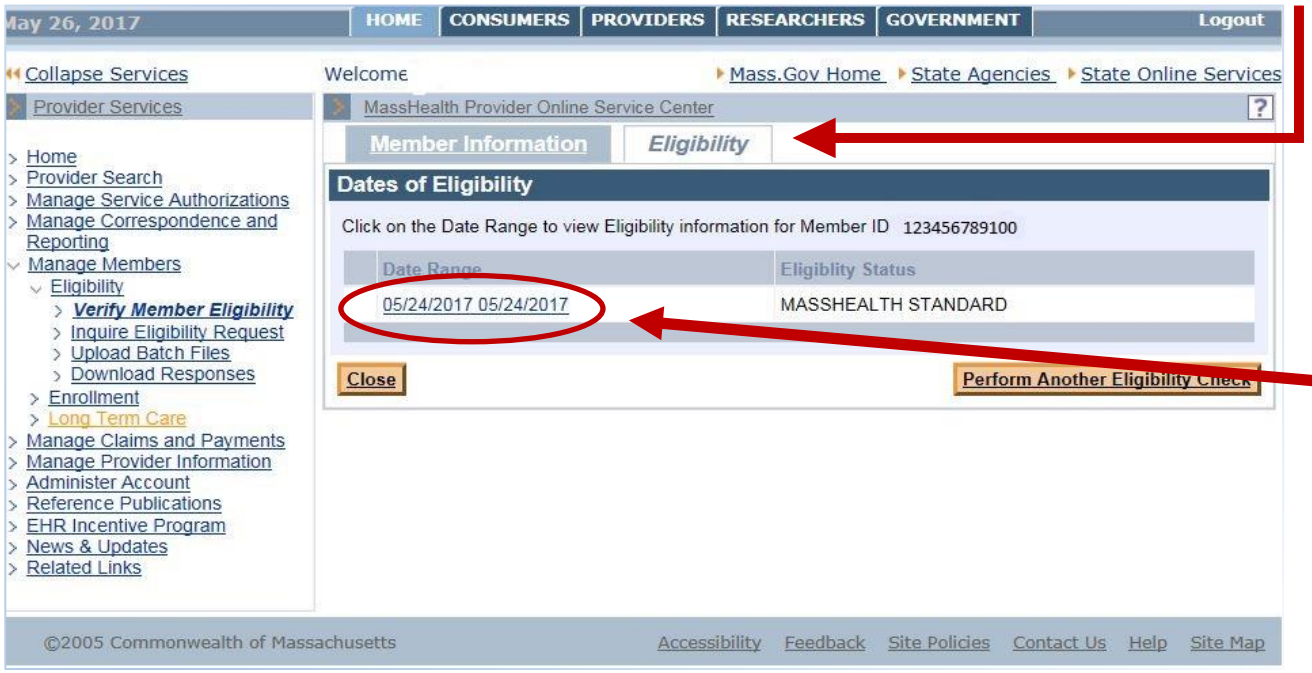


From the *Eligibility* Tab you will see which plan(s) the member is enrolled with

If the member is not eligible you will find that information from this tab

Eligibility Verification 7

From the *Eligibility* Tab you will see which coverage type the member is enrolled in.

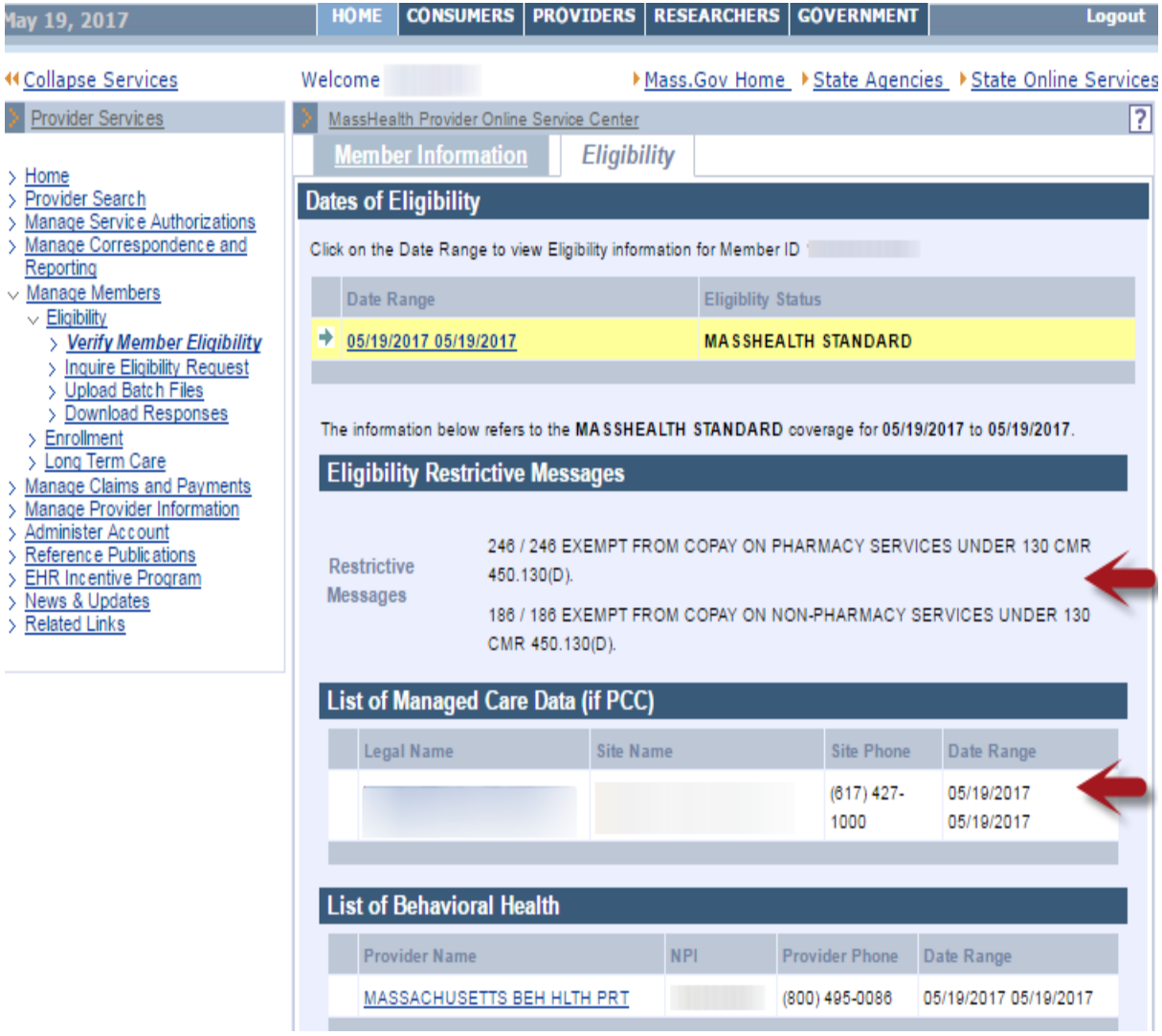


Click on the Date Range for more descriptive information regarding the Plan type (if any)

The example above indicate the member's coverage as ***MassHealth Standard*** (which is one of the coverage types), but for a more comprehensive listing of all the various coverage types please see the link below.
https://www.mass.gov/service-details/masshealth-coverage-types-for-individuals-and-families-including-people-with

Eligibility Verification 8

Eligibility tab expanded view

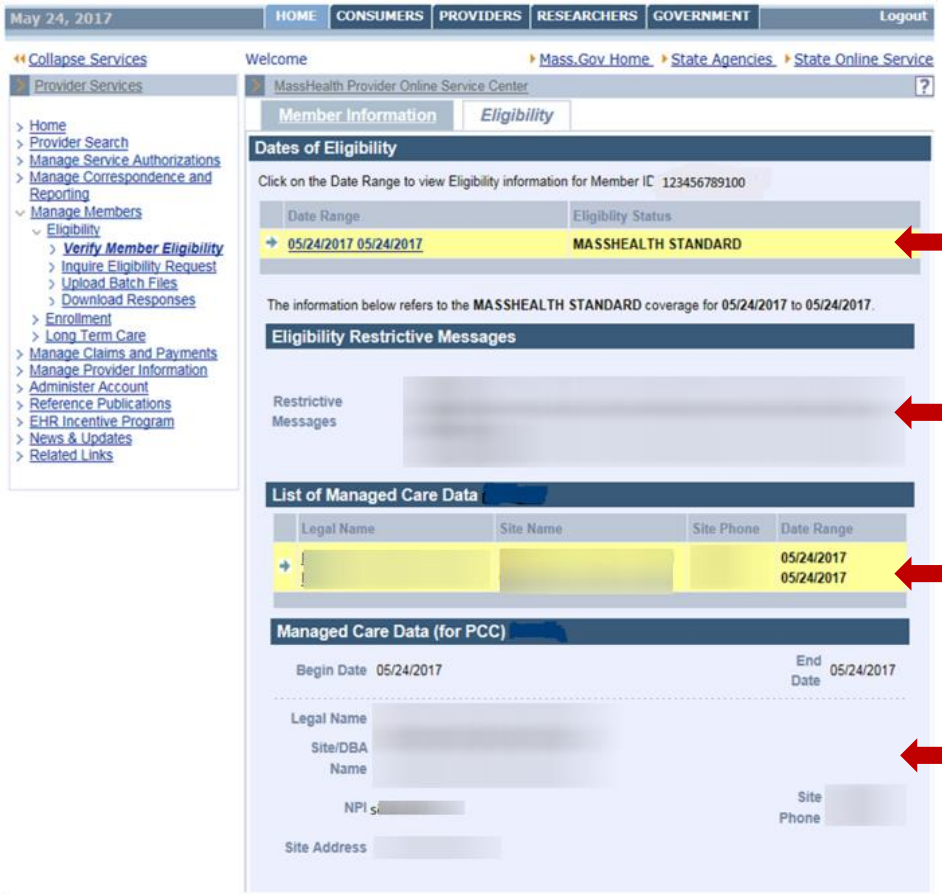


The *Restrictive Information* section will identify specific restrictions or eligibilities for this member

The *Managed Care Data* section shows the members PCC's Name and Site. This could be an individual or an entity

Eligibility Verification 9

Eligibility tab for member



1. Click on the Date Range for additional information such as the *Eligibility Restrictive Messages* pertaining to the coverage type

2. *Eligibility Restrictive messages* show any and all information pertaining to the member's **coverage type**

3. *List of Managed Care Data* Indicates if the member is enrolled in PCC, MCO or ACO plan

4. *Managed Care Data details* provides the contact information, DBA address, telephone number for the site (if PCC) or the Health Plan's (if MCO or ACO)

The example above indicate the member's coverage as ***MassHealth Standard*** (which is one of the coverage types), but for a more comprehensive listing of all the various coverage types please see the link below.
http://www.mass.gov/eohhs/consumer/insurance/masshealth-coverage-types/masshealth-coverage-types.html

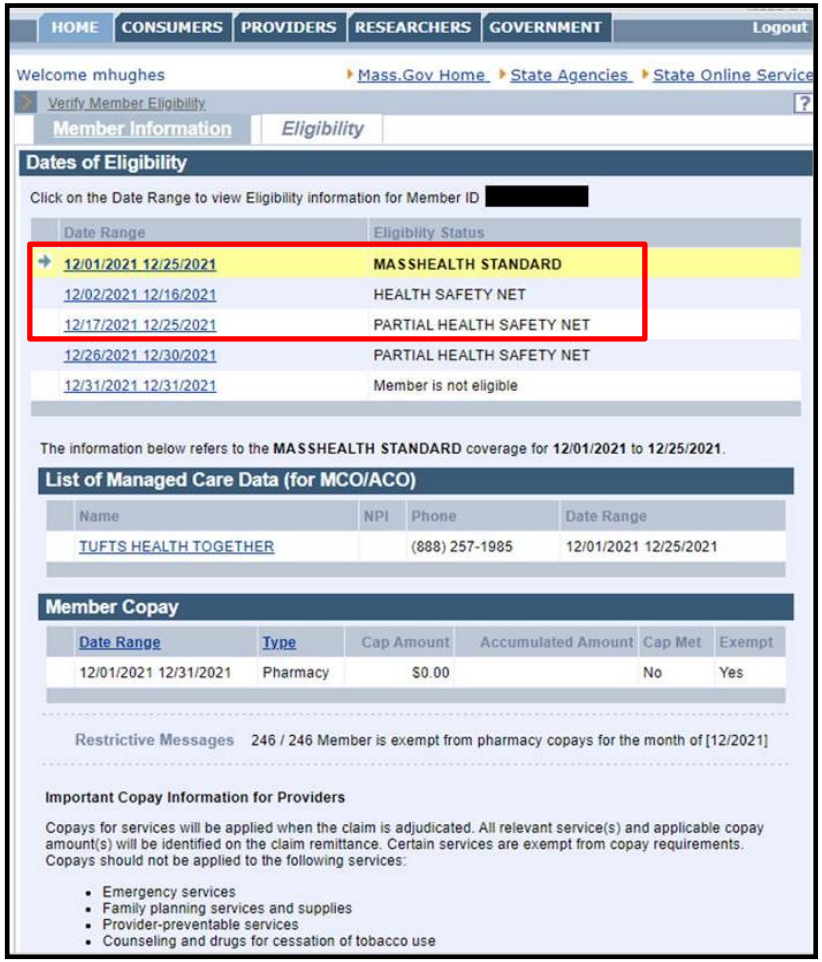
Multi Benefit Plan

On March 21, 2022, MassHealth updated its Eligibility Verification System (EVS) available on the Provider Online Service Center (POSC) and the HIPAA Health Care Eligibility Benefit Inquiry and Response (270/271) transaction to include the additional benefit plans:

- CMSP
- Limited
- HSN

Trading partners should visit the MassHealth HIPAA Companion Guides webpage listed below to evaluate the changes outlined in the MassHealth HIPAA Health Care Eligibility Benefit Inquiry and Response (270/271) Companion Guide, and ensure that their systems can accept the additional benefit plan information: https://www.mass.gov/lists/masshealth-hipaa-companion-guides

Multi Benefit Plan Example 1 Eligibility Verification System (EVS)



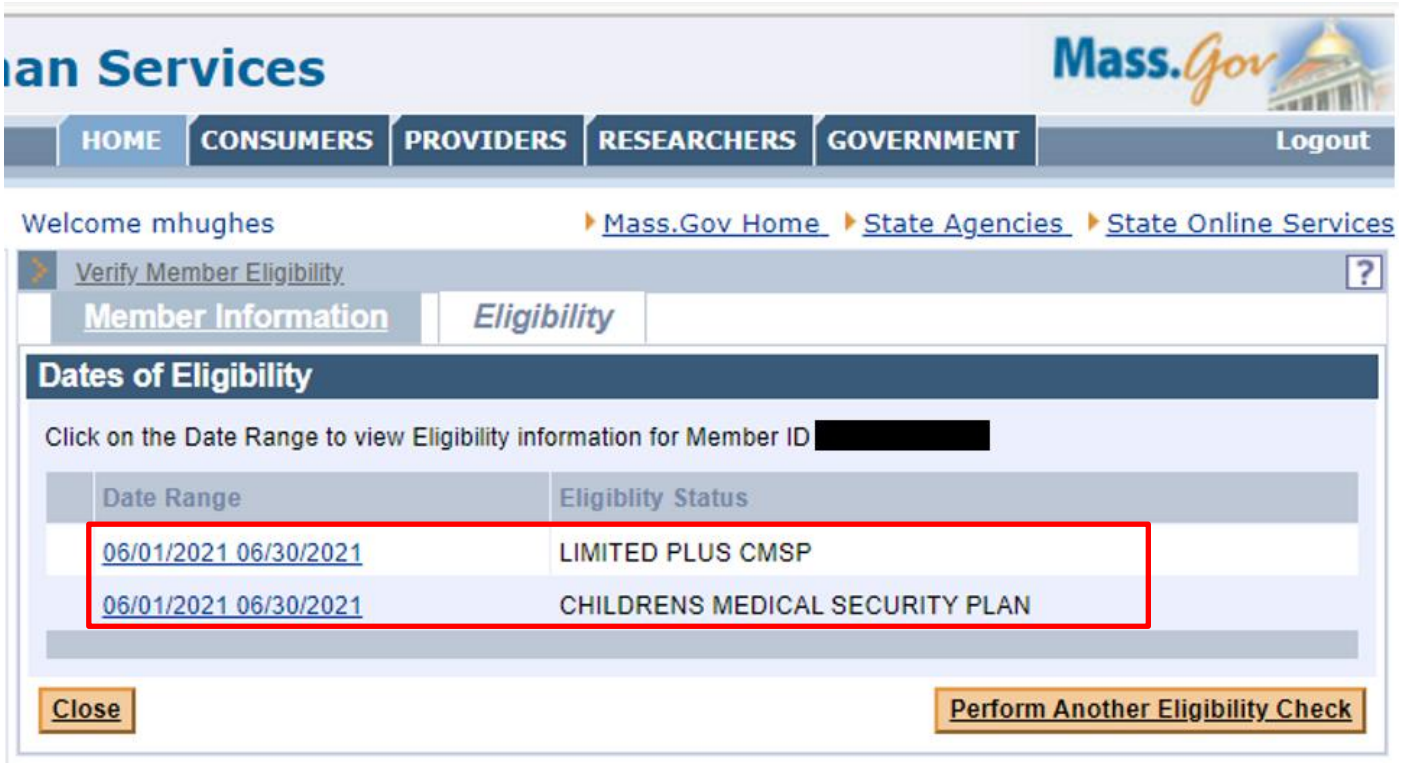
The member may have multiple overlapping benefit plans over a selected date range.

- Select the date or date range you want to check and click “Submit”
- Coverage types will first be displayed in hierarchical order regarding plan coverage (richest plan listed first) then by date
- Providers are reminded to pay attention to date range for each coverage type listed

For list of MassHealth coverages types and covered services please refer to 130 CMR 450.105: Coverage Types

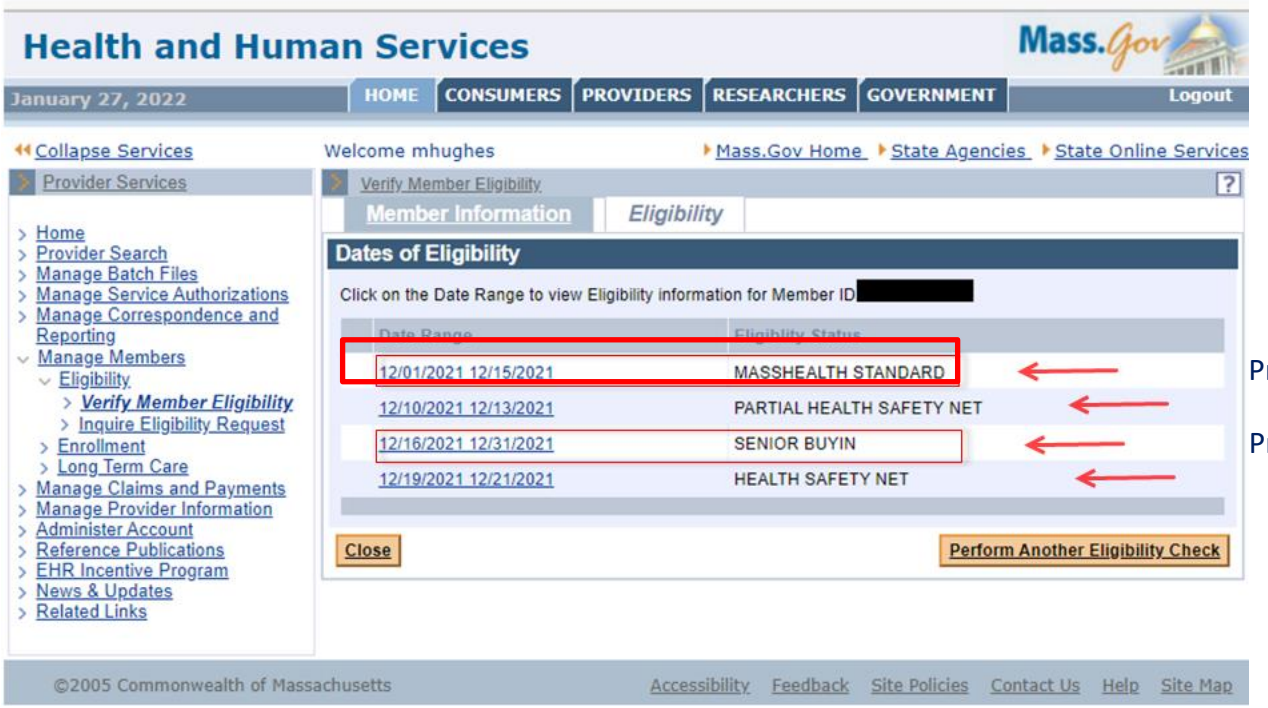
Multi Benefit Plan EVS Example 2

All the applicable benefit plans will display when the member has an aid category that contains multiple benefit plans from LIMITED, CMSP, and/or HSN and the displaying order for the benefit plans is based on the MMIS benefit plan hierarchy.



Multi Benefit Plan EVS Example 3

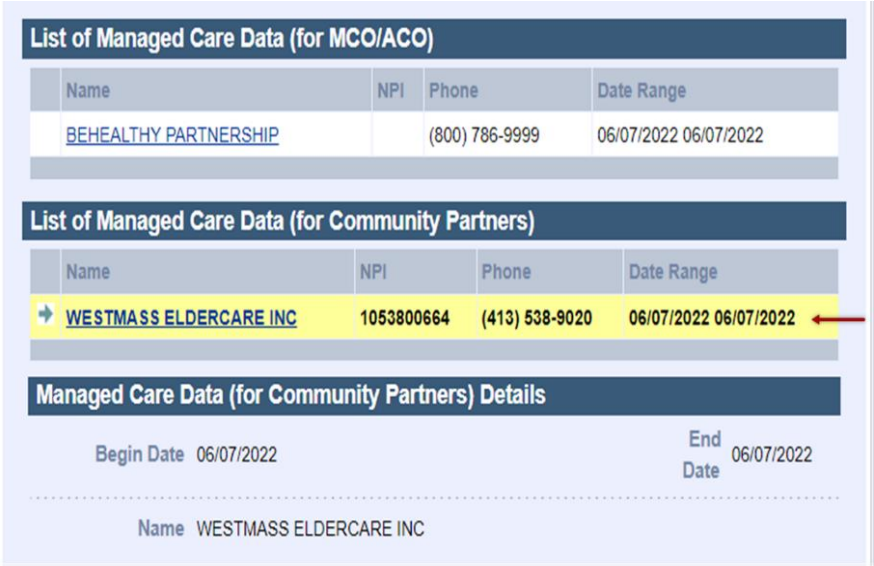
Each of the primary plans will display along with any supplemental plans in accordance with the date range for the primary date range. In this example none of the supplemental plans overlap with each other, therefore each primary plan will show a single member benefit plan overlap.



Primary
Secondary
Primary
Secondary

Member enrolled in Community Partners Program

The MassHealth Community Partners Program coordinates person-centered, community-based supports that promote continuity of care and independence for MassHealth members with behavioral health (BH) or long-term services and supports (LTSS) needs. Enrollment in the community partners program can be seen in the Eligibility Verficiation system under the heading List of **Managed Care Data(for Community Partners)** as see below.



List of Managed Care Data (for MCO/ACO)

Name	NPI	Phone	Date Range
BEHEALTHY PARTNERSHIP		(800) 786-9999	06/07/2022 06/07/2022

List of Managed Care Data (for Community Partners)

Name	NPI	Phone	Date Range
WESTMASS ELDERCARE INC	1053800664	(413) 538-9020	06/07/2022 06/07/2022

Managed Care Data (for Community Partners) Details

Begin Date 06/07/2022 End Date 06/07/2022

Name WESTMASS ELDERCARE INC

List of Managed Care Data (For MCO/ ACO) lists the members Managed Care Plan. For billing questions call the plan

List of Managed Care Data(For Community Partners) lists the community partner that works with the member and their PCC to manage their care

Resources

- For more information regarding EVS Codes and Restrictive Messages for Managed Care Health Plans:
  - https://massdocs-digital-mass-gov.s3.amazonaws.com/s3fs-public/2018/EVS%2520Quick%2520Reference%2520Guide%25202018-2018.02.23.pdf?KwuTs6oW.KlULD7KIKo5B35KCh_rbmJd
- Eligibility Verification Job Aids can be found at:
  - https://www.mass.gov/service-details/job-aids-for-the-provider-online-service-center-posc

MassHealth Updates

Presented by – Nestor Rivera, Sr. Provider Relations Specialist, MassHealth Business Support Services

POSC Accommodation and Language Updates

A new function has been added to the Provider Online Service Center (POSC). This function allows provider ID service locations (PIDSLs) to display specific accessibility accommodations and languages that are available at their service location. These updates will be displayed on the MassHealth Choices Provider Directory. Updates to the mass.gov Provider Directory are targeted for availability in late summer 2022.

The new function is already live in the POSC.

More information will be provided in the future, including instructions on how to complete these updates.

COVID-19 Updates

Presented by – Nestor Rivera, Sr. Provider Relations Specialist, MassHealth Business Support Services

COVID-19 Testing and Treatment for Uninsured Individuals and MassHealth Limited Members

Effective for dates of service on or after March 23, 2022, Health Safety Net (HSN) providers rendering COVID-19 testing and treatment services to HSN patients should submit claims for such services to the HSN.

Effective for dates of service on or after April 6, 2022, HSN providers rendering COVID-19 vaccine services to HSN patients should submit claims for such services to the HSN.

During the federal PHE, and for a period no less than 15 months after the end of the federal PHE, COVID-19 testing and treatment services are considered emergency services as defined in 130 CMR 450.105(F) for purposes of MassHealth Limited, and are payable by MassHealth to any participating provider qualified to provide such services.

- Further, during the federal PHE, and for a period of time not less than 15 months after the end of the federal PHE, COVID-19 vaccine services are a covered service under MassHealth Limited.

Refer to **All Provider Bulletin 342** for more information

Coverage of and Payment for the Administration of Remdesivir in an Outpatient Setting

Effective for dates of service on or after April 1, 2022, providers should bill using code HCPCS code J0248, Injection, remdesivir, 1 mg.

- Providers administering Remdesivir should bill MassHealth using existing HCPCS code J3490 for dates of service before April 1, 2022

This applies to members enrolled in MassHealth fee-for-service, the Primary Care Clinician (PCC) plan, and Primary Care ACOs (PCACOs).

- This also applies for MassHealth Limited members

Refer to **All Provider Bulletin 344** for more information

COVID-19 Resources

Additional Information

- Providers should visit the COVID-19 Provider Page dedicated for the latest COVID-19 related information
- For the latest Massachusetts-specific information, visit the following link: www.mass.gov/resource/information-on-the-outbreak-of-coronavirus-disease-2019-covid-19
- The latest Centers for Disease Control and Prevention (CDC) guidance for healthcare professionals is available at the following link: www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

Questions:

Long-Term Services and Supports

Phone: (844) 368-5184 (toll free)
Email: support@masshealthltss.com
Portal: MassHealthLTSS.com
Mail: MassHealth LTSS, PO Box 159108
Boston, MA 02215
Fax: (888) 832-3006

All Other Provider Types

Phone: (800) 841-2900; TTY: (800) 497-4648
Email: providersupport@mahealth.net
Fax: (617) 988-8974

Revalidation : ORP Providers

Revalidation: ORP Providers

Section 6401 of the Affordable Care Act established a requirement for Medicare and Medicaid to revalidate enrollment information for all enrolled providers, regardless of provider type, under new enrollment screening criteria at least every 5 years. MassHealth began implementation of this requirement in March 2014.

MassHealth will begin revalidation for ORP providers this fall.

- MassHealth will select providers each month for revalidation by date of enrollment or last revalidation date
- Providers will be required to submit the **Revalidation Attestation and Disclosures Form** to complete their revalidation
- Failure to complete revalidation in a timely fashion can result in sanctions. Sanctions may include, but are not limited to, administrative fines and suspension or termination from participation in MassHealth

Revalidation – ORP Providers (Continued)

A revalidation launch letter will be sent to provider's DBA and/or address of their confirmed credentialing contact to let them know it is time to revalidate and provide additional instructions on the date of launch

- Providers will have 45 days from the date of the revalidation letter to complete the revalidation process
  - If no documents have been sent, the provider will receive an initial Sanction Notice notifying them of impending termination should no documents be submitted
  - A second sanction notice will also be mailed to the provider if no documents are submitted 15 days later from the initial sanction notice
- For more information, visit the MassHealth Provider Revalidation Page on Mass.gov, or contact MassHealth Provider Enrollment & Credentialing at revalidation@mahealth.net

Ordering Referring and Prescribing

Ordering Referring and Prescribing (ORP)

ORP denials continue to be paused or postponed due to COVID-19

- Phase 1 denials for Group 1 (individual non-LTSS), Group 2 (entity non-LTSS) were paused beginning with DOS on or after 3/30/20 due to the COVID-19 emergency
- Phase 1 denials for Group 3 (LTSS) provider types were scheduled to go into effect with DOS on or after 4/15/20 but have been postponed due to the COVID-19 emergency
- An announcement will be made prior to the resumption of denials along with adjusted implementation dates for Phase 1 Group 3 and Phase 2 denials
- MassHealth continues to provide informational edits for impacted ORP claims to inform billing providers of claims that do not meet ordering, referring, and prescribing requirements

ORP Provider Recommendations

MassHealth recommends that providers:

- Continue to take notice of ORP edits on remittance advice
- Make any process adjustments to reduce future ORP denials
- Monitor the Provider ORP page on Mass.Gov for the most updated information
- Watch for notifications from MassHealth
- Continue to enroll ORP providers as non-billing or fully enrolled providers

Learn more about **Ordering, Referring and Prescribing (ORP)** requirements, please visit the Provider ORP page

MassHealth Bulletins
(May 2022 – June 2022)

All Provider Bulletins

- **All Provider Bulletin 342** Billing policies for Coronavirus Disease 2019 (COVID-19) Testing and Treatment Services for Uninsured Individuals and MassHealth Limited Members

- **All Provider Bulletin 343** MassHealth and Health Safety Net Coverage of Formula, including Temporary Modification of Prior Authorization Requirements

- **All Provider Bulletin 344** Update Concerning Coverage of and Payment for the Administration of (1) Remdesivir in an Outpatient Setting (2) COVID-19 Vaccines; and (3) Rapid Antigen Testing for COVID-19 for MassHealth Limited Members

- **All Provider Bulletin 345** Robotics Processing Automation (RPA) Policy