# Provider Education and Communication

## October 2019 MTF Afternoon session

Executive Office of Health & Human Services

# Welcome to MassHealth!

We are excited to have you as part of our provider community.

The purpose of this presentation is to deliver a high level overview of important MassHealth provider initiatives and current updates. Throughout presentation we have also included where provider resources and information pertaining to these topics are available on either Mass.gov or the Provider Online Service Center (POSC). Our goal is to ensure clear educational material to assist with incorporating each requirement into your respective organizations operational processes.

# Agenda

- Payment and Care Delivery Innovation (PCDI) Year 3 Update
- Ordering, Referring and Prescribing (ORP) Provider Update
- Technical Refresh Initiative (TPT)
- Eligibility Verification Overview
- Remittance Advice (RA) via POSC
- Claims Denials (ORP edits) Review
- Billing Submission Timeframes

# Payment and Care Delivery Innovation (PCDI)
# Year 3 Update

# Agenda

- Payment and Care Delivery Innovation (PCDI) background
- Managed Care Health Plan Options
- MassHealth health plan options for 2020
- Primary Care Exclusivity
- Updates for 2020- new primary care practices joining ACO plans
- Impacted Member Notifications and Timeline
- Continuity of Care (CoC) for impacted members
- MassHealth Choices
- Provider Reminders
- Provider Resources

# Payment and Care Delivery Innovation (PCDI)

## Background

- The Executive Office of Health and Human Services (EOHHS) is committed to a sustainable, robust MassHealth program for its 1.8 million members

- On March 1, 2018, MassHealth's PCDI initiative offered new health plan options to MassHealth members eligible for managed care. These managed care options include Accountable Care Organizations (ACOs) plans in addition to re-procured managed care organizations (MCOs) plans and the Primary Care Clinician (PCC) Plan

# Managed Care Health Plan Options

- **Accountable Care Organizations (ACOs) :** An ACO is a provider-led health plan that holds participating providers financially accountable for both cost and quality of care for members. ACOs are composed of groups of primary care providers (PCPs) to whom members are attributed. In an ACO, the PCP and their team are responsible for working with the member and the ACO's network of providers to help coordinate care and connect the member with available services and supports
  - Accountable Care Partnership Plans
  - Primary Care ACOs

- **Managed Care Organizations** (**MCOs) :** health plans run by insurance companies that provide care through their own provider network that includes PCPs, specialists, behavioral health providers, and hospitals. Care coordinators are employed by the MCO

- **Primary Care Clinician (PCC) Plan :** The primary care providers are called primary care clinicians (PCCs). The MassHealth network of PCCs, specialists, and hospitals delivers services. The Massachusetts Behavioral Health Partnership (MBHP) provides behavioral health services

# MassHealth Health Plan Options Effective January 1, 2020

| Accountable Care Partnership Plans |
|---|
| Be Healthy Partnership - Baystate Health Care Alliance with Health New England |
| Berkshire Fallon Health Collaborative - Health Collaborative of the Berkshires with Fallon Health |
| BMC HealthNet Plan Signature Alliance - Signature Healthcare with BMC HealthNet Plan |
| BMC HealthNet Plan Community Alliance - Boston Accountable Care Organization with BMC HealthNet Plan |
| BMC HealthNet Plan Mercy Alliance - Mercy Medical Center with BMC HealthNet Plan |
| BMC HealthNet Plan Southcoast Alliance - Southcoast Health with BMC HealthNet Plan |
| Fallon 365 Care - Reliant Medical Group with Fallon Health |
| My Care Family - Merrimack Valley ACO with Allways Health Partners |
| Tufts Health Together with Atrius Health - Atrius Health with Tufts Health Plan (THP) |
| Tufts Health Together with BIDCO - Beth Israel Deaconess Care Organization (BIDCO) with Tufts Health Plan (THP) |
| Tufts Health Together with Boston Children's ACO – Boston Children's ACO with Tufts Health Plan (THP) |
| Tufts Health Together with CHA - Cambridge Health Alliance (CHA) with Tufts Health Plan (THP) |
| Wellforce Care Plan - Wellforce with Fallon Health |

| Managed Care Organizations |
|---|
| Boston Medical Center (BMC) HealthNet Plan |
| Tufts Health Together |

| Primary Care Clinician (PCC) Plan | Primary Care ACO Plans |
|---|---|
| Primary care Providers in the MassHealth Network | Community Care Cooperative (C3) |
| | Partners HealthCare Choice |
| | Steward Health Choice |

# Primary Care Exclusivity

- A primary care practice entity that contracts with an ACO may only empanel managed care members who are also enrolled in that same ACO
  - They may not empanel MassHealth managed care members enrolled in an MCO, the Primary Care Clinician (PCC) Plan, or any other ACO
  - They may only provide primary care services to managed care members who are also enrolled in that same ACO (outside of the exceptions listed on the next slides )
- Primary care exclusivity is applied at the site level because the member is assigned to the primary care practice entity site rather than to the individual PCPs performing the primary care functions and services at the site

# Primary Care Exclusivity - Exceptions

Primary Care Exclusivity does not apply in the following situations:

- PCPs serving members in the Special Kids Special Care Program

- PCPs that also provide medication assisted treatment (MAT) services may provide MAT services to members enrolled in any ACO, MCO, or the PCC Plan, without regard to limitations related to primary care exclusivity

- School-Based Health Centers (SBHCs) operated through CHCs can serve all MassHealth members and must submit claims for services delivered at SBHCs directly to MassHealth

- Other MassHealth programs*, such as:
  - MassHealth Fee-for-service (FFS) (including those over age 65 or with third-party coverage)
  - OneCare
  - Senior Care Options (SCO)
  - Program of All-inclusive Care for the Elderly (PACE)

**Providers who contract with an ACO may continue to provide services to members enrolled in the above programs regardless of their contracts with ACOs.*

# Primary Care Exclusivity – Exclusions

- Specialists, Hospitals, and Other Providers*

  - Primary care exclusivity requirements neither apply to nor impact specialists, hospitals, and other providers—including behavioral health providers. Specialists, hospitals, and other providers may continue to provide specialty services across MassHealth managed care options. Such providers may contract with multiple health plans at the same time and may provide services to members in any of the health plans with which the providers have contracts.

  - Primary Care ACOs and the PCC Plan use the MassHealth fee-for-service network of specialists and hospitals. Specialists, hospitals, and other providers may see MassHealth members enrolled in a Primary Care ACO or the PCC Plan if the provider is a MassHealth participating provider contracted to provide medical services.

**Please refer to All Provider Bulletin 279 for more information (https://www.mass.gov/files/documents/2018/11/05/all-provider-bulletin-279.pdf )*

# Updates for 2020 - new primary care practices joining ACO plans

## Opportunity for Existing ACOs to Add Participating PCPs

To support and further the goals of the ACO Program, MassHealth offered an opportunity for existing ACOs to request the addition of new participating PCPs effective January 1, 2020.

ACOs were required to submit such request for MassHealth review in May 2019. Each request was evaluated by MassHealth against criteria that included, but were not limited to;

- Impact on members;
- Impact on network adequacy;
- The ACO's proposed approach to ensuring Continuity of Care;
- The demonstrated commitment by the PCP to participate in the ACO

# Updates for 2020 - new primary care practices joining ACO plans

## Primary Care Provider Changes for January 1, 2020

MassHealth is excited to announce 56 primary care sites will be joining MassHealth ACOs effective January 1, 2020. These include several providers who are changing from one ACO to another ACO.

The total 56 new sites* are across the following ACOs:

29 providers to Partners HealthCare Choice
8 providers to Steward Health Choice
5 providers to Tufts Health Together with Boston Children's ACO
5 providers to BMC HealthNet Plan Community Alliance
4 providers to Wellforce Care Plan
3 providers to Tufts Health Together with BIDCO
2 providers to Community Care Cooperative

*A full list of new primary care providers joining ACO plans, can be found at: https://www.mass.gov/info-details/primary-care-providers-joining-new-masshealth-acos-starting-january-1-2020

# Updates for 2020

## Key reminders :

- New providers are joining ACOs effective January 1, 2020
- MassHealth intends to keep members with their existing Primary Care Provider (PCP) when possible. As a result, a number of members (~37,000) will be following their PCP into the same health plan their PCP has joined effective January 1, 2020
- Members will receive a letter letting them know of their new health plan
- Service area and region updates effective for January 1, 2020
- Changes to time and distance standards - Martha's Vineyard (Oak Bluffs service area) and Nantucket only

# Impacted Member Notifications

**Late October, 2019** , impacted members will begin to receive notices informing them of changes to their MassHealth health plan. Notices will inform the member that their PCP will be joining an ACO, or changing ACOs on January 1, 2020 and they will be moving with their PCP into this ACO.

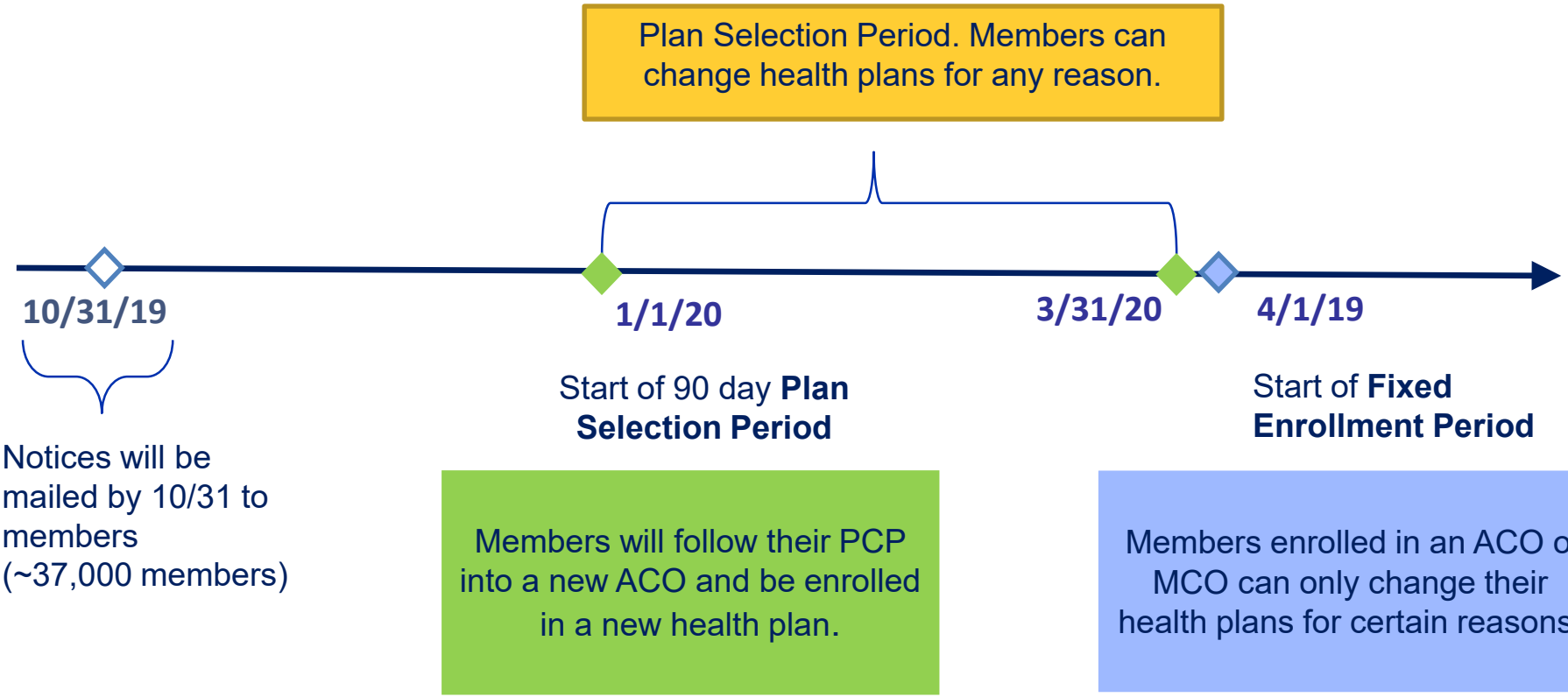
**Member actions following assignment:**

- members should confirm that other doctors, specialists, behavioral health providers, and hospitals that are most important to them are part of their new plan. Members can do so by:
  - Checking their new MassHealth health plan's website
  - Calling their new MassHealth health plan
  - Contact your doctors, specialist, behavioral health providers, or other providers and hospitals and ask them if they participate in the ACO
  - Checking www.MassHealthChoices.com

- If members are satisfied with their plan assignment, *they do not need to do anything*. On January 1, 2020 they will be enrolled in their new MassHealth health plan.

- **Members who want to switch MassHealth health plans from their plan assignment can do so by visiting www.MassHealthChoices.com and completing an Online Enrollment Form, or calling MassHealth Customer Service 1-800-841-2900 TTY: 1-800-497-4648.**

# Impacted Member Notifications Timeline



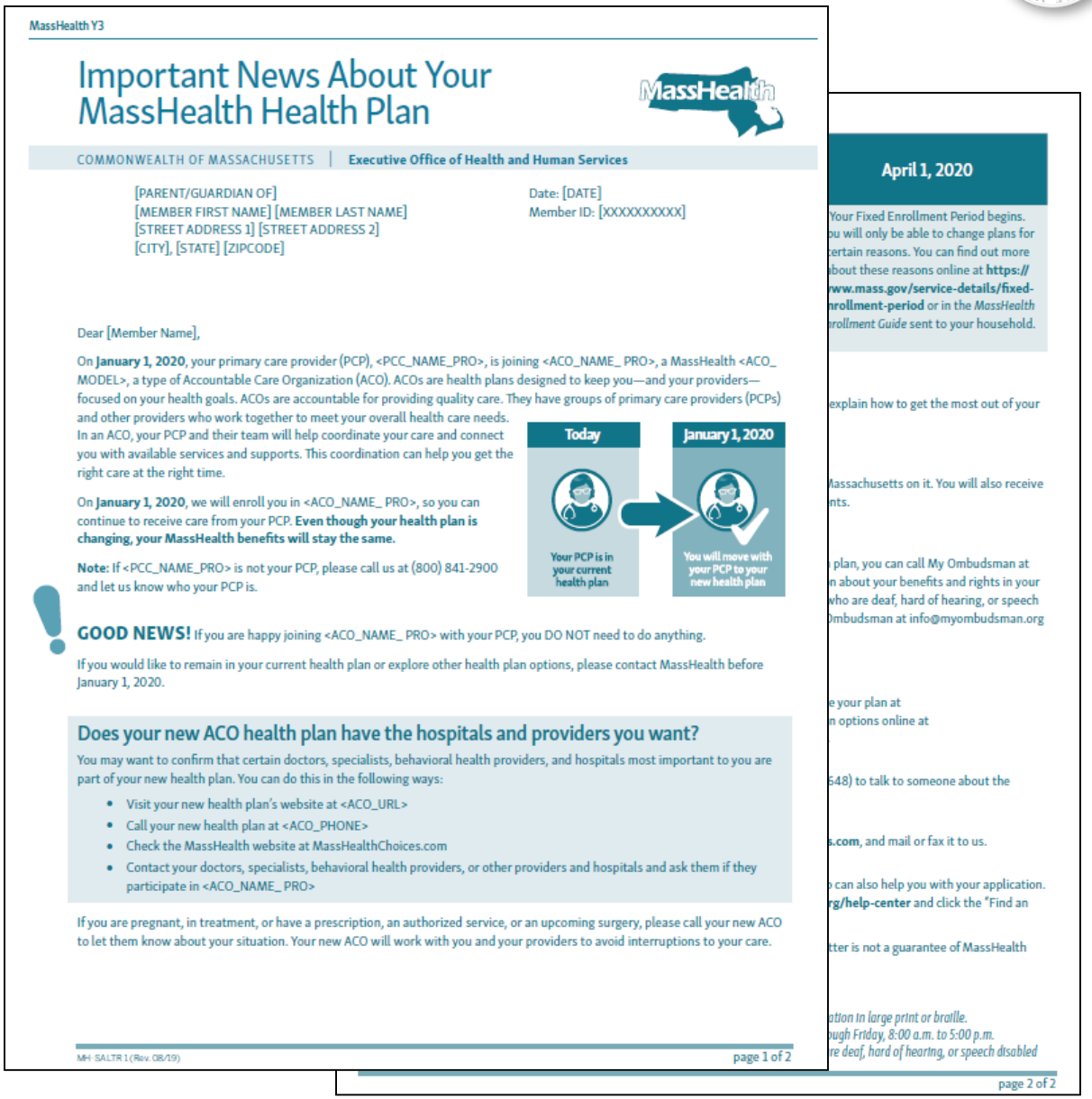

***Important:*** *The Plan Selection and Fixed Enrollment Period dates are member specific and depend on the date of their health plan enrollment. The dates above do not apply to all MassHealth members, only those that receive a MassHealth Health Plan notice in October.*

# Impacted Member Notice

Example:

The member's current PCP has joined an ACO.

The member will be enrolled in the ACO their PCP is affiliated with and continue receiving care from their PCP.



MassHealth Y3

## Important News About Your MassHealth Health Plan

COMMONWEALTH OF MASSACHUSETTS | **Executive Office of Health and Human Services**

[PARENT/GUARDIAN OF]
[MEMBER FIRST NAME] [MEMBER LAST NAME]
[STREET ADDRESS 1] [STREET ADDRESS 2]
[CITY], [STATE] [ZIPCODE]

Date: [DATE]
Member ID: [XXXXXXXXXX]

Dear [Member Name],

On **January 1, 2020**, your primary care provider (PCP), <PCC_NAME_PRO>, is joining <ACO_NAME_ PRO>, a MassHealth <ACO_ MODEL>, a type of Accountable Care Organization (ACO). ACOs are health plans designed to keep you—and your providers—focused on your health goals. ACOs are accountable for providing quality care. They have groups of primary care providers (PCPs) and other providers who work together to meet your overall health care needs. In an ACO, your PCP and their team will help coordinate your care and connect you with available services and supports. This coordination can help you get the right care at the right time.




On **January 1, 2020**, we will enroll you in <ACO_NAME_ PRO>, so you can continue to receive care from your PCP. **Even though your health plan is changing, your MassHealth benefits will stay the same.**

**Note:** If <PCC_NAME_PRO> is not your PCP, please call us at (800) 841-2900 and let us know who your PCP is.

**GOOD NEWS!** If you are happy joining <ACO_NAME_ PRO> with your PCP, you DO NOT need to do anything.

If you would like to remain in your current health plan or explore other health plan options, please contact MassHealth before January 1, 2020.

### Does your new ACO health plan have the hospitals and providers you want?

You may want to confirm that certain doctors, specialists, behavioral health providers, and hospitals most important to you are part of your new health plan. You can do this in the following ways:

- Visit your new health plan's website at <ACO_URL>
- Call your new health plan at <ACO_PHONE>
- Check the MassHealth website at MassHealthChoices.com
- Contact your doctors, specialists, behavioral health providers, or other providers and hospitals and ask them if they participate in <ACO_NAME_ PRO>

If you are pregnant, in treatment, or have a prescription, an authorized service, or an upcoming surgery, please call your new ACO to let them know about your situation. Your new ACO will work with you and your providers to avoid interruptions to your care.

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**April 1, 2020**

Your Fixed Enrollment Period begins.
ou will only be able to change plans for
ertain reasons. You can find out more
bout these reasons online at **https://**
**ww.mass.gov/service-details/fixed-**
**nrollment-period** or in the *MassHealth*
*rollment Guide* sent to your household.

explain how to get the most out of your

Massachusetts on it. You will also receive
nts.

plan, you can call My Ombudsman at
n about your benefits and rights in your
who are deaf, hard of hearing, or speech
Ombudsman at info@myombudsman.org

e your plan at
n options online at

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**s.com**, and mail or fax it to us.

can also help you with your application.
**rg/help-center** and click the "Find an

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*ough Friday, 8:00 a.m. to 5:00 p.m.*
*re deaf, hard of hearing, or speech disabled*

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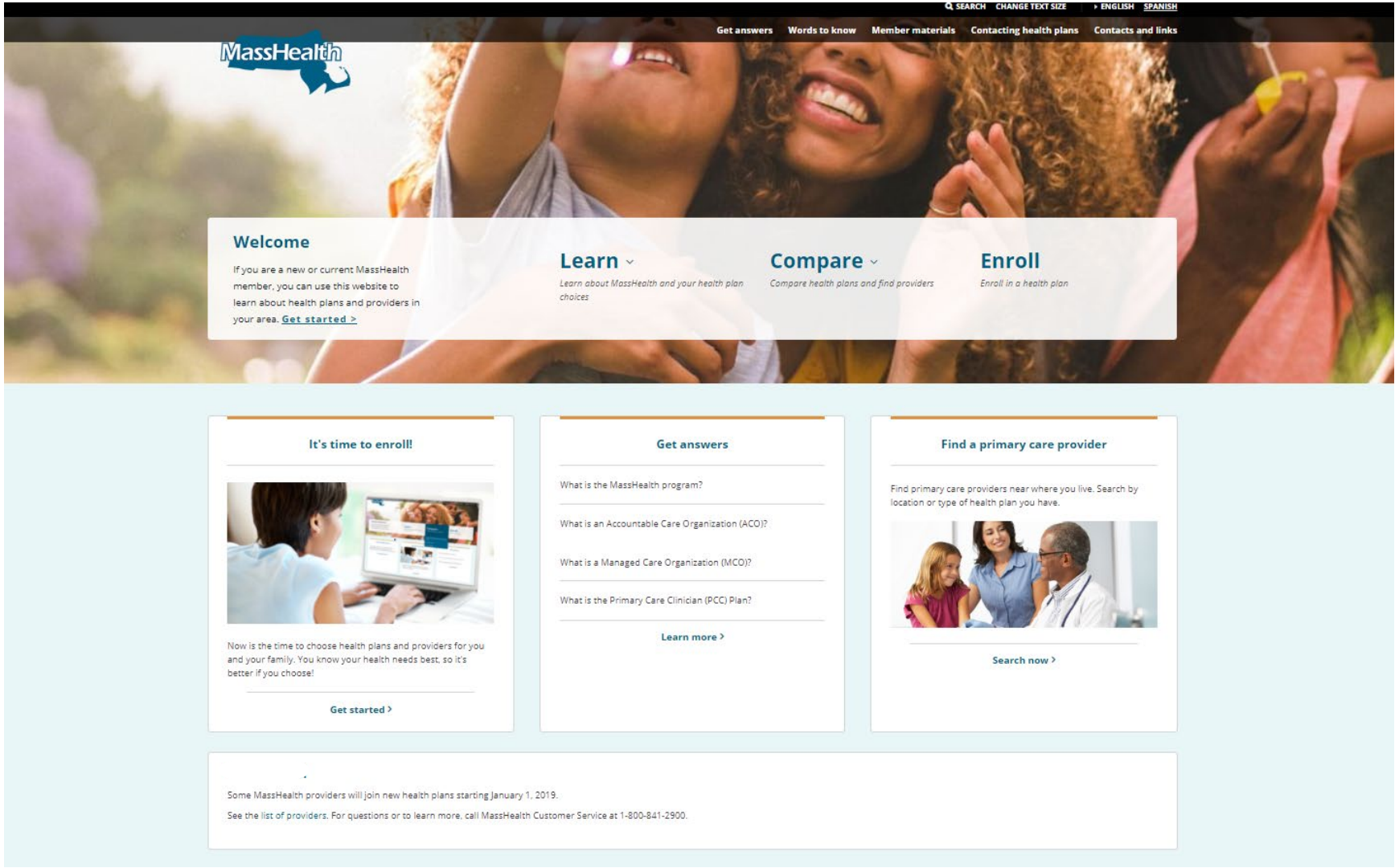
# Continuity of Care (CoC) for Impacted Members

**MassHealth is committed to working with all relevant parties to promote continuity of care for members who move into new plans. To support a successful transition, members have a 90 day continuity of care period to help prevent interruptions to care as members transition health plans.**

- In most cases, members can continue to see their existing providers for 90 days, even if those providers are not in their new plan's network
- Providers who are not in the new plan's network can contact the new plan to make appropriate payment arrangements
- In some cases, the continuity of care period may be extended. For example, members who are pregnant can continue seeing their existing OB/GYN providers throughout their pregnancy and up to six weeks postpartum
- Focused efforts will be made for members with needs requiring specialized care, including but not limited to members who are pregnant, have autism spectrum disorder and receiving ABA services, receiving ongoing services such as dialysis, home health, chemotherapy, and/or radiation, receiving treatment for behavioral health or substance use, including Medication for Addiction Treatment (MAT) services
- We are asking all plans, providers, and assisters to reinforce this message and to ensure that members continue to receive all needed health care services during this transition
- Members can contact their new plan now to let them know of any ongoing treatments or scheduled appointments
- Providers will be able to see new plan information in the MassHealth Eligibility Verification System (EVS) starting January 1, 2020. They can contact the new plan at that time for new authorization requests, or with any questions or concerns
- While ACOs are ultimately responsible for coordinating member's transition and service coordination into their new health plan, both MassHealth and ACOs will ensure protocols are in place for continuity of care issues that may arise

# MassHealthChoices.com

MassHealthChoices.com is an online provider directory used to help members learn, compare, and enroll in a new MassHealth health plan



# Provider Reminders

**Identify the Member**

- Use EVS to verify eligibility and current Plan*
- Determine if you participate in the Member's Plan and if applicable you have a referral from that Plan

*Member enrollment selection information available 1.1.20

**Contact the Plan**

- Contact the member's Plan if you need a referral or if you do not participate in that Plan
- Work with the Plan to understand claims submission
- Work with the Plan and the Primary Care Provider to coordinate the care plan

**Provider Care and Services**

- Impacted Members have an extended 90 day continuity of care
- Before refusing to see a Member or canceling appointments contact the MassHealth Customer Service Center at 1-800-841-2900

# Provider Reminders

## MassHealth eligibility verification system (EVS) and claims submission reminders

The MassHealth Eligibility Verification System (EVS) is designed to display the status of a member's health care coverage for the date(s) of service requested (please note EVS does not display eligibility for future dates). This includes the identification of the health plan and the type of plan that the member is enrolled if applicable. If you are using EVS via the Provider Online Service Center (POSC), or through third party software, please ensure that you review all of the EVS messages associated with the eligibility response.

For providers that are looking to identify where claims should be submitted based on the EVS messages, please use the information below to ensure the proper location to submit your claims. Claims submission to the incorrect health plan will result in delayed processing and payment.

- For Primary Care ACO and PCC Plan members, please submit electronic only claims directly to MassHealth except for behavioral health (BH). BH claims should be submitted directly to MBHP.
- For Accountable Care Partnership Plan members, please refer directly to the applicable Accountable Care Partnership Plan submission instructions for medical and behavioral health claims
- For MCO members, please refer to the MCO for medical and behavioral health claims submission.

If you have any questions, please contact the MassHealth Customer Service Center via email at **providersupport@mahealth.net** or call 1-800-841-2900.

# Provider Resources

Payment and Care Delivery (PCDI) for Providers:
*https://www.mass.gov/payment-care-delivery-innovation-pcdi-for-providers*

- Information for providers about the MassHealth PCDI initiative

Mass.Gov/MassHealth
*https://www.mass.gov/topics/masshealth*

- General information regarding the MassHealth program and other resources

MassHealthChoices.com
*http://www.masshealthchoices.com/*

- Online Provider directory where members can learn, compare, and enroll in health plans.

MassHealth Enrollment Guide:
*https://www.masshealthchoices.com/member-materials*

- Printed enrollment guide for members to view health plans, service areas, and extra benefits.

MassHealth Enrollment Centers:
*https://www.mass.gov/service-details/masshealth-enrollment-centers-mecs*

- A list of the MassHealth enrollment centers for in-person eligibility assistance.

MassHealth Customer Service:

- 1-800-841-2900 (Monday- Friday 8:00am-5:00pm)
- TTY: 1-800-497-4648

# Questions

# Ordering, Referring and Prescribing (ORP) Update

# Ordering, Referring & Prescribing (ORP) Requirements

- ACA Section 6401 (b)
- States must require:
  - All ordering or referring physicians and other professionals be enrolled under the State [Medicaid] Plan…as a participating provider; and
  - The NPI of any ordering or referring physician or other professional…be specified on any claim for payment that is based on an order or referral of the physician or other professional.
- State law requires that authorized ordering/referring/prescribing provider types must apply to enroll with MassHealth at least as a nonbilling provider in order to obtain and maintain state licensure, regardless of practice location (private practice, hospital, CHC, CMHC, etc.) The legislation applies to physician interns and residents but not other types of interns and residents.

# ORP Requirements

The services below must be ordered, referred or prescribed. MassHealth is applying ORP requirements to fee for service, crossover (where Medicare requires ORP), third party liability, and Health Safety Net and Children's Medical Security Plan claims but not to claims submitted to MassHealth contracted managed care entities.

- Any service that requires a PCC referral
- Adult Day Health
- Adult Foster Care
- Durable Medical Equipment
- Eyeglasses
- Group Adult Foster Care
- Home Health
- Independent Nurse
- Labs and Diagnostic Tests
- Medications
- Orthotics
- Oxygen/Respiratory Equipment
- Prosthetics
- Psychological Testing
- Therapy (PT, OT, ST)

# ORP Requirements

Provider Types (including interns and residents in those provider types) authorized to be included on a claim as the ordering, referring or prescribing provider and who must enroll as at least a nonbilling provider

- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist
- Dentist
- Licensed Independent Clinical Social Worker
- Certified Nurse Practitioner
- Optometrist
- Pharmacist (if authorized to prescribe)
- Physician
- Physician Assistant
- Podiatrist
- Psychiatric Clinical Nurse Specialist
- Psychologist

Fillable nonbilling provider applications and contracts are available on the MassHealth website: http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html

# Implementation of ORP Billing Requirements

- When ORP is fully implemented, impacted claims submitted for payment to MassHealth must meet the following requirements:
  - The Individual ORP provider's NPI must be included on the claim
  - The NPI of the provider on the claim must be one of the ORP provider types
  - The ORP provider must be enrolled with MassHealth, at least as a nonbilling provider
- To assist providers to better prepare for these changes, MassHealth has been providing detailed information and education to providers for the last several years.

**February/ March 2016**
**All Provider Bulletin 259** introduced Informational messaging on claims not meeting O&R Requirements

**May 2017**
**All Provider Bulletin 268** announced changes to the PCC Plan POSC referral process

**June 2017**
POSC updated to ensure individual provider NPI was identified on referral submissions
also
PCC Referral letter updated

**February 2018**
All Provider Bulletin 274
Provided additional information about billing processes

# ORP Provider Education and Outreach Activities

- MassHealth has been using a variety of communication strategies and methods to share information with providers since 2015, which includes:

**Resources and Information:**

- Webinars
- Provider bulletins
- MassHealth website
- MassHealth regulations
- Message text (POSC)

**Collaboration Strategies:**

- Work with stakeholders to provide consistent messaging
- Work closely with Provider Associations
- Proactive outbound calls from MassHealth
- Knowledgeable MassHealth Provider Services staff, available to answer providers' questions as needed
- Working with respective provider licensing boards

# Implementation of ORP Billing Requirements

**MassHealth is implementing denials for not meeting the ORP billing requirements in several phases.**

## Phase 1 Denials – for claims for services that require an order, referral or prescription

- The Individual ORP provider's NPI must be included on the claim
- The NPI of the provider on the claim must be one of the authorized ORP provider types

**September 2019**

**All Provider Bulletin 286 posted with additional information about billing processes and including the schedule to begin denying claims**

**For dates of service on or after December 15, 2019**

Impacted claims from Group 1 (individual non-LTSS) providers will deny if they do not include the NPI of an authorized ORP provider

**For dates of service on or after February 15, 2020**

Impacted claims from Group 2 (entity non-LTSS) providers will deny if they do not include the NPI of an authorized ORP provider

**For dates of service on or after April 15, 2020**

Impacted claims from Group 3 (LTSS) providers will deny if they do not include the NPI of an authorized ORP provider

# Implementation of ORP Billing Requirements

## Phase 1 Denials

**Group 1** (individual non-LTSS) provider types denials go into effect **12/15/19**

- Audiologist
- Chiropractor
- Clinical Nurse Specialist
- Group practices of the types in this group
- Hearing Instrument Specialist
- Nurse Practitioner
- Ocularist
- Optician
- Optometrist
- Physician
- Podiatrist
- Psychologist
- QMB Only Providers

# Implementation of ORP Billing Requirements

## Phase 1 Denials

**Group 2** (entity non-LTSS) provider types denials go into effect **2/15/20**

- Abortion/Sterilization Clinic
- Acute Inpatient Hospital
- Acute Outpatient Hospital
- Certified Independent Laboratory
- Community Health Center
- Early Intervention
- Family Planning Agency
- Hospital-licensed Health Center
- Independent Diagnostic Testing Facility
- Mental Health Center
- Pharmacy (for claims processed through MMIS
- Psychiatric Outpatient Hospital
- Renal Dialysis Center
- Substance Use Disorder Outpatient Hospital
- Volume Purchaser

# Implementation of ORP Billing Requirements

## Phase 1 Denials

**Group 3** (LTSS) provider types denials go into effect **4/15/20**

- Adult Day Health
- Adult Foster Care
- Chronic Outpatient Hospital
- Competitive Bid Only (DMEPOS)
- Durable Medical Equipment
- Group Adult Foster Care
- Group Practice (Therapist)
- Independent Nurse
- Orthotics
- Oxygen and Respiratory Therapy
- Prosthetics
- Rehabilitation Center
- Speech and Hearing Center
- Therapist

For dates of service on or after 4/15/20, any/all impacted claims will be denied for failure to comply with the requirements of Phase 1

# ORP Billing - Denial Edits on Remittance Advices (RAs)

MassHealth has been providing informational edits for impacted ORP claims to inform billing providers of claims that do not meet ordering, referring, and prescribing requirements.

Once the ORP requirements are fully implemented, *impacted claims will be denied* for these reasons if provider billing processes are not corrected:

## The NPI of the ORP provider must be included on the claim:

- **835 Electronic Remittance Advice** (log into the POSC to see the applicable detailed edit from the list below)

| HIPAA Claim Adjust Reason Code (CARC) | HIPAA Remark Adjust Reason Code (RARC) |
|---|---|
| 206 – National Provider Identifier – missing | N265 – Missing/incomplete/invalid ordering provider primary identifier<br>N286 – Missing/incomplete/invalid referring provider primary identifier |

- **POSC version of the remittance advice**

1080 – Ordering Provider Required

1081 – NPI required for Ordering Provider

1200 – Referring Provider Required

1201 – NPI Required for Referring Provider – HDR

1202 – NPI Required for Referring Provider 2 – HDR*

1203 – NPI Required for Referring Provider – DTL *

1204 – NPI Required for Referring Provider 2 – DTL*

*According to federal guidance, Ordering and Referring rules do not require a secondary referring provider identifier on claims. However, there may be circumstances where the HIPAA V5010 Implementation Guide situationally requires a second referring provider identifier. In those circumstances, if the second referring provider's NPI is included on the claim, but that provider is not enrolled with MassHealth or is not an authorized ORP provider, relevant informational edits will be included on the remittance advice.

# ORP Billing - Denial Edits on Remittance Advices (RAs)

- **Billing provider types currently receiving large (500+) numbers of "NPI Missing" edits:**

Group 1
- Chiropractor
- Group Practice – Physician
- Physician

Group 2
- Acute Outpatient Hospital
- Community Health Center
- Early Intervention
- Family Planning Agency
- Hospital Licensed Health Center
- Pharmacy (MMIS claims)
- Renal Dialysis Clinic
- Volume Purchaser

Group 3
- Adult Day Health
- Adult Foster Care
- Group Adult Foster Care
- Group Practice – Therapist

# ORP Billing - Denial Edits on Remittance Advices (RAs)

## The ORP provider must be in one of the eligible ORP provider types:

- **835 Electronic Remittance Advice** (log into the POSC to see the applicable detailed edit from the list below)

| HIPAA Claim Adjust Reason Code (CARC) | HIPAA Remark Adjust Reason Code (RARC) |
|---|---|
| 183 – The referring provider is not eligible to refer the service billed | N574 – Our records indicate the ordering/referring provider is of a is of a type/specialty that cannot order refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider. |
| 184 – The prescribing/ordering provider is not eligible to prescribe/order the service billed | N574 – Our records indicate the ordering/referring provider is of a type/specialty that cannot order refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider. |

- **POSC version of the remittance advice**

  1085—Ordering Provider Not Authorized to Order Services

  1217—Referring Provider Not Authorized to Refer - HDR

  1218—Referring Provider 2 Not Authorized to Refer – HDR*

  1219—Referring Provider Not Authorized to Refer - DTL

  1220—Referring Provider 2 Not Authorized to Refer – DTL*

# ORP Billing - Denial Edits on Remittance Advices (RAs)

- **Billing provider types currently receiving large (500+) numbers of "NPI Not Authorized" edits:**

Group 1
- Group Practice – Physician

Group 2
- Acute Outpatient Hospital
- Certified Independent Lab
- Community Health Center
- Early Intervention

Group 3
- Adult Day Health

Note that MassHealth has discovered many **incorrect claim submissions** where **the NPI of the referring practice is being listed on the claim instead of NPI of the individual ORP provider**, resulting in "NPI not authorized" edits.

# Implementation of ORP Billing Requirements

**MassHealth is implementing denials for not meeting the ORP billing requirements in several phases.**

**Phase 2 – for claims for services that require an order, referral or prescription**

- The NPI of the ORP provider is included on the claim but the ORP provider is not actively enrolled with MassHealth, at least as a nonbilling provider

**August 15, 2020**

Impacted claims from :

- Group 1 (individual non-LTSS) providers
- Group 2 (entity non-LTSS) providers
- Claims processed by the Pharmacy Online Processing System (POPS)

will deny if the ORP provider is not actively enrolled with MassHealth

**November 15, 2020**

Impacted claims from:

Group 3 (LTSS) providers

will deny if the ORP provider is not actively enrolled with MassHealth

For dates of service on or after November 15, 2020, any/all impacted claims will be denied if the claim does not meet all three ORP requirements

# ORP Billing - Future Claim Denial Edits on Remittance Advices (RAs)

## The ORP provider must be actively enrolled with MassHealth at least as a nonbilling provider:

- **835 Electronic Remittance Advice** (log into the POSC to see the applicable detailed edit from the list below)

| HIPAA Claim Adjust Reason Code (CARC) | HIPAA Remark Adjust Reason Code (RARC) |
|---|---|
| 183 – The referring provider is not eligible to refer the service billed<br>208 – National Provider Identified – Not matched. | N265 – Missing/incomplete/invalid ordering provider primary identifier<br>N286 – Missing/incomplete/invalid referring provider primary identified |

- **POSC version of the remittance advice**

| | |
|---|---|
| 1082—Ordering Provider NPI not on file | |
| 1084—Ordering Provider not actively enrolled | |
| 1205—Referring Provider NPI not on file – HDR | 1213—Referring Provider not actively enrolled – HDR |
| 1206—Referring Provider 2 NPI not on file – HDR* | 1214—Referring Provider 2 not actively enrolled – HDR* |
| 1207—Referring Provider NPI not on file – DTL | 1215—Referring Provider not actively enrolled – DTL |
| 1208—Referring Provider 2 NPI not on file – DTL* | 1216—Referring Provider 2 not actively enrolled – DTL* |

Billing providers that are receiving these edits should contact the ORP provider and/or the MassHealth CSC to request that the ORP provider enroll in MassHealth to avoid future claims denials.

# ORP Provider Types and Enrollment Status as of October 9, 2019

***With detail regarding MassHealth Service Area Enrollment Saturation**

| Authorized ORP Provider Types | *MA Licensed & Business Addresses in MA, ME, NH,VT,CT,RI,NY | Total # of ORP Provider Types "Known" to MassHealth | Total % Enrolled or in Progress |
|---|---|---|---|
| **Physician** | 31,284 | 35,414 | 114% |
| **Optometrist** | 1,404 | 1,125 | 80% |
| **Psychologist** | 5,608 | 4,851 | 87% |
| **Podiatrist** | 462 | 405 | 88% |
| **Nurse Midwife** | 489 | 408 | 83% |
| **Dentist** | 6,518 | 4,379 | 67% |
| **Nurse Practitioner (NP)** | 9,977 | 7,978 | 80% |
| **Physician Assistant (PA)** | 3,723 | 3,605 | 97% |
| **Certified Registered Nurse Anesthetists (CRNA)** | 1,114 | 1,169 | 105% |
| **Clinical Nurse Specialist (CNS)** | 68 | 13 | 19% |
| **Psychiatric Nurse Mental Health Specialist (PCNS)** | 622 | 291 | 47% |
| **Pharmacist** | 62 | 76 | 123% |
| **Licensed Independent Clinical Social Worker (LICSW)** | 14,051 | 11,659 | 83% |
| **Total** | **75,382** | **71,373** | **95%** |

- Claims for the services that are ordered, referred, or prescribed by a clinician who is not one of the authorized ORP provider types listed above must include the NPI of the clinician's supervising physician (or other authorized ORP provider) on the claim.
- Note that pharmacy claims must include the individual NPI of the actual prescribing provider.

# ORP Billing – Additional Notes

- On 837I claims that require orders/referrals, the ordering/referring provider is only required if different than Attending.
- Refer to MassHealth All Provider Bulletin 286 for more details and billing instructions related to ORP requirements.

- **POSC Provider Search Function**
  - In order to use the Provider Search Function you must be logged into the POSC. The Provider Search Option is in the left navigation list.
  - Results will return PROVIDER NAME, ADDRESS, NPI and “ACTIVE Y” or “No active MassHealth providers found.”
  - Please note that a response of ACTIVE Y does not definitively confirm that the provider is eligible to be an Ordering, Referring or Prescribing provider. For example, facilities and entities (e.g., hospitals, health centers, group practices) are not authorized ORP providers. Also, individual providers could be in a provider type that is not authorized to Order, Refer or Prescribe.

# ORP Claims Denials Edits Review

# ORP Denial Edits

The billing provider will receive denial edits once MassHealth and the HSN begin denying claims for the reasons indicated below and ORP edits may result in denial of claims in whole or in part for:

1. **The NPI of the ORP provider is not included on the claim**
2. **The ORP provider's NPI is on the claim but is not an authorized ORP provider type**
3. **The ORP provider on the claims is not actively enrolled with MassHealth**

**Note:** *If a billing provider includes an ORP provider's NPI on a claim that does not require one, the claims processing system may still look to see if the ORP provider is known to MassHealth and is authorized to order, refer or prescribe and may deny the claim if such conditions are not met*

# ORP Denial Edits

## Denial Edits:

The following edits will appear as denial edits once MassHealth and the HSN begin denying claims.

| Phase 1 | Edit Types | DOS on/after |
|---|---|---|
| Group 1 | ORP Provider not included on claim or not an authorized ORP | 12/15/19 |
| Group 2 | ORP Provider not included on claim or not an authorized ORP | 2/15/20 |
| Group 3 | ORP Provider not included on claim or not an authorized ORP | *4/15/20 |
| **Phase 2** | **Edit Types** | **DOS on/after** |
| Group 1 & 2 | The ORP provider NPI is included on claim but is not actively enrolled with MassHealth | 8/15/20 |
| Group 3 | The ORP provider NPI is included on claim but is not actively enrolled with MassHealth | **11/15/20 |

*For dates of Service on or after 4/15/20, any/all impacted claims will be denied for failure to comply with the ORP requirements of Phase 1

**For dates of Service on or after 11/15/20, any/all impacted claims will be denied if the claim does not meet all three ORP requirements (ORP provider NPI on the claim, ORP provider is an authorized ORP provider type, ORP provider is enrolled with MassHealth)

# ORP Denial Edits

1. **The NPI of the ORP provider is not included on the claim:**

POSC and 835 Electronic Remittance Advice messaging (if you receive an 835 RA you can log into the POSC to see the applicable detailed edit from the left hand column in the list below)

| POSC Version of the RA | HIPAA Claim Adjust Reason Code (CARC) | HIPAA Remark Adjust Reason Code (RARC) |
|---|---|---|
| 1080 Ordering Provider Required | 206-National Provider Identifier – missing | N265-Missing/Incomplete/invalid ordering provider primary identifier |
| 1081 NPI REQUIRED FOR ORDERING PROVIDER | 206-National Provider Identifier – missing | N265-Missing/Incomplete/invalid ordering provider primary identifier |
| 1200 REFERRING PROVIDER REQUIRED | 206-National Provider Identifier – missing | N286-Missing/incomplete/invalid ordering provider primary identifier |
| 1201 NPI REQUIRED FOR REFERRING PROVIDER – HDR | 206-National Provider Identifier – missing | N286-Missing/incomplete/invalid referring provider primary identifier |
| 1202 NPI REQUIRED FOR REFERRING PROVIDER 2 - DTL | 206-National Provider Identifier – missing | N286-Missing/incomplete/invalid referring provider primary identifier |
| 1203 NPI REQUIRED FOR REFERRING PROVIDER – DTL | 206-National Provider Identifier – missing | N286-Missing/incomplete/invalid referring provider primary identifier |
| 1204 NPI REQUIRED FOR REFERRING PROVIDER 2 – DTL | 206-National Provider Identifier – missing | N286-Missing/incomplete/invalid referring provider primary identifier |

# ORP Denial Edits

## 2. The ORP provider's NPI is on the claim but is not an authorized ORP provider type:

| POSC Version of the Remittance Advice | HIPAA Claim Adjust Reason Code (CARC) | HIPAA Remark Adjust Reason Code (RARC) |
|---|---|---|
| 1085 ORDERING PROVIDER NOT AUTHORIZED TO ORDER SERVICES | 184-The prescribing/ordering provider is not eligible to prescribe/order the service billed. | N574-Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please Verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider |
| 1217 REFERRING PROVIDER NOT AUTHORIZED TO REFER - HDR | 183-The referring provider is not eligible to refer the service billed | N574-Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please Verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider |
| 1218 REFERRING PROVIDER 2 NOT AUTHORIZED TO REFER - HDR | 183-The referring provider is not eligible to refer the service billed | N574-Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please Verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider |
| 1219 REFERRING PROVIDER NOT AUTHORIZED TO REFER - DTL | 183-The referring provider is not eligible to refer the service billed | N574-Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please Verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider |
| 1220 REFERRING PROVIDER 2 NOT AUTHORIZED TO REFER - DTL | 183-The referring provider is not eligible to refer the service billed | N574-Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please Verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider |

# ORP Denial Edits

## 3. The ORP provider on the claim is not actively enrolled with MassHealth:

| POSC Version of the Remittance Advice | HIPAA Claim Adjust Reason Code (CARC) | HIPAA Remark Adjust Reason Code (RARC) |
|---|---|---|
| 1082 ORDERING PROVIDER NPI NOT ON FILE | 208-National Provider Identifier – Not matched | N265-Missing/incomplete/invalid ordering provider primary identifier |
| 1084 ORDERING PROVIDER NOT ACTIVELY ENROLLED | 184-The prescribing/ordering provider is not eligible to prescribe/order the service billed | N265-Missing/incomplete/invalid ordering provider primary identifier |
| 1205 REFERRING PROVIDER NPI NOT ON FILE – HDR | 208-National Provider Identifier – Not matched | N286 – Missing/incomplete/invalid referring provider primary identifier |
| 1206-REFERRING PROVIDER NPI NOT ON FILE – HDR | 208-National Provider Identifier – Not matched | N286 – Missing/incomplete/invalid referring provider primary identifier |
| 1207 REFERRING PROVIDER NPI NOT ON FILE – DTL | 208-National Provider Identifier – Not matched | N286 – Missing/incomplete/invalid referring provider primary identifier |
| 1208 REFERRING PROVIDER 2 NPI NOT ON FILE – DTL | 208-National Provider Identifier – Not matched | N286 – Missing/incomplete/invalid referring provider primary identifier |
| 1213 REFERRING PROVIDER NPI NOT ACTIVE ENROLLED HDR | 183-The referring provider is not eligible to refer the service billed | N286 – Missing/incomplete/invalid referring provider primary identifier |

# ORP Denial Edits

## 3. The ORP provider on the claim is not actively enrolled with MassHealth continued:

POSC and 835 Electronic Remittance Advice messaging (if you receive an 835 RA you can log into the POSC to see the applicable detailed edit from the left hand column in the list below)

| POSC Version of the Remittance Advice | HIPAA Claim Adjust Reason Code (CARC) | HIPAA Remark Adjust Reason Code (RARC) |
|---|---|---|
| 1214 REFERRING PROVIDER 2 NOT ACTIVELY ENROLLED – HDR | 183-The referring provider is not eligible to refer the service billed | N286 – Missing/incomplete/invalid referring provider primary identifier |
| 1215 REFERRING PROVIDER NOT ACTIVELY ENROLLED – DTL | 183-The referring provider is not eligible to refer the service billed | N286 – Missing/incomplete/invalid referring provider primary identifier |
| 1216 REFERRING PROVIDER 2 NOT ACTIVELY ENROLLED – DTL | 183-The referring provider is not eligible to refer the service billed | N286 – Missing/incomplete/invalid referring provider primary identifier |

# ORP Resources

- To learn more about **Ordering, Referring and Prescribing (ORP) (and to download Nonbilling Application),** visit the Provider ORP page at : www.mass.gov/the-aca-ordering-referring-and-prescribing-orp-requirements-for-masshealth-providers

- To register for a webinar for non-LTSS providers, please visit the **MassHealth Learning Management System** at : www.masshealthtraining.com

- An Ordering and Referring Guide for LTSS Providers is on the LTSS Provider Portal at: www.masshealthltss.com

- **Provider Updates Email Sign Up**

  To receive e-mail notification of updates to MassHealth provider manuals, including regulations, and new provider bulletins send an email to join-masshealth-provider-pubs@listserv.state.ma.us

- **Note:** Just send the blank e-mail as it's addressed. No text in the body or subject line is needed.

# Questions?

# Technical Refresh Initiative (TPT) Update

# Technical Refresh

## What Is Technical Refresh?

MassHealth will implement the Technical Refresh in the following phased approach and the Trading Partner Testing (TPT) timeline. Trading partners may upload test transactions to the TPT testing environment at any time during the corresponding TPT phase to **validate compliance**:

| Phase | HIPAA Transactions | TPT Timeframe | Duration | GO LIVE |
|---|---|---|---|---|
| 1 | 270/271 | 7/29/2019 – 9/20/2019 | 8 weeks | 10/27/2019 |
| 2 | 837P, 837I, 276/277, 835 | 1/27/2020 – 3/27/2020 | 9 weeks | 3/30/2020 |

## Companion Guides – Future Updates

MassHealth may update the HIPAA Companion Guides once it completes internal testing per the following timeframes:

- Phase 1: *updated Companion Guides published June 2019*
- Phase 2: November 2019

# Member Eligibility – Phase 1: 270/271 Batch Transaction Update

## REMINDER & UPDATE

Effective **December 16, 2019** MassHealth no longer returns the member social security number (SSN) in the Health Care Benefit Response (271) unless the correct SSN was submitted on the Health Care Benefit Inquiry (270) request.

## Next Steps

Please share this information with your constituents. If they need assistance, please ask them to contact Provider Support at providersupport@mahealth.net.

# Technical Refresh – Phase 1

## Known Changes / Provider Impacts

Here is a **high-level summary** of changes. Please ask your constituents to view the 999/TA1 Comparison (otherwise known as Flyer: **The Grid),** published here for additional details: https://www.mass.gov/files/documents/2019/07/25/999-ta1-comparison-technical-refresh-current-state-future-state.pdf.

| ID | Known Change | Provider Impact |
|---|---|---|
| 1. | ISA13 Control Numbers will be returned as "000000001" only on 999/TA1. | The 999 will report Control Numbers for Functional Group Header (GS) in the **AK1** and the Transaction Set Header (ST) in the **AK2**. |
| 2. | Transaction Set Control Numbers (ST02) will not be returned. | Providers should submit a Subscriber Trace Number (TRN) instead to correlate their 270 or 276. |
| 3. | Transaction Set Control Number (ST02) is sequential beginning with 0001. | Ensure your systems can receive this change. |
| 4. | Control Numbers (ISA13/IEA2, GS06/GE02, ST02/SE02) must match and must be unique within the file | File will fail pre-compliance and will not generate a 999. |
| 9. | The 999 will return only one ISA/IEA and only one GS/GE regardless of how many reported in the request. | For each Functional Group Header/Trailer (GS/GE) submitted, match up with the corresponding AK1 in the 999 and AK2 for each Transaction Set Header/Trailer (ST/SE). |

# Technical Refresh – Phase 1

## TPT Results & Statistics

### ***Expected Number of Testers***

| Category | Expected | Actually Tested *(as of 10/11/19)* |
|---|---|---|
| Total PIDSLs Currently Submitting Eligibility* | 21,000 | 86 |
| Total Vendors Currently Approved to Submit Eligibility on Behalf of Providers | 100 | 28 |
| Direct Submitters (Top 50) | 50 | 58 |

### ***Test File Results***

| Category | Total Number of Submitter IDs | Total Number of Vendors | Total Number of Direct Submitters |
|---|---|---|---|
| Passed without Errors | 53 | 15 | 38 |
| Failed Pre-compliance (no 999 Received) | 20 | 9 | 11 |
| Passed Compliance with Errors | 10 | 3 | 7 |
| Test File Analysis In-Progress | 3 | 1 | 2 |

** MassHealth anticipated that the Vendors will submit on behalf of 75% of the total providers that are not direct submitters.*

# Technical Refresh – Phase 1

## Testing Impact

MassHealth **strongly encourages** all trading partners that submit electronic eligibility (270) files, to participate in testing before the Implementation date to avoid any disruption in their workflow for checking member eligibility, providing the member's care and possible financial impact downstream with claims submissions.

If they do not successfully pass testing, their files may not get processed in PRODUCTION on or after the Implementation date. In that case, trading partners must use Direct Data Entry (DDE) in the Provider Online Service Center (POSC) and manually check eligibility – instead of submitting electronic eligibility files.

## Next Steps

Please share this information with your constituents. If they need assistance, please ask them to **immediately** contact EDI at edi@mahealth.net.

# Technical Refresh – Phase 1

## Testing Issues

Here is a list of common EDI file-related issues providers encountered during testing. The files failed pre-compliance and a 999 was not generated for the submitter.

**Submission Errors specific to Technical Refresh**

- **ISA13 / IEA02 – Interchange Control Header / Trailer Control Number** must match and must be unique within the transaction set; file failed pre-compliance
- **ISA13 / IEA02 – Interchange Control Header / Trailer Control Number** must not be a duplicate within the entire file; file failed pre-compliance
- **BHT03 – Submitter Transaction Identifier** must not contain “EVSPC” or “REPW” (EVSpc/EVScall); file failed pre-compliance

# Technical Refresh – Phase 1

## Vendor List Updates

The Approved Vendor List was updated with the status of those vendors who were authorized to submit eligibility transactions. The updates included if the vendor attended the MassHealth training sessions and their testing status. It was published periodically on mass.gov.

If your constituents have their vendor check their eligibility, ask them to check their vendor's testing status.

Here is the link to the latest update to the **MassHealth Approved Vendor List** on 10/4/2019: https://www.mass.gov/files/documents/2019/09/24/masshealth-approved-vendor-list.pdf.

# Technical Refresh – Phase 1

## We Need Your Help

Ensure that your constituents can perform the basic following eligibility workflow tasks as a direct submitter or that their vendors are able to on their behalf:

- Successfully submit eligibility (270) HIPAA files to MassHealth
- Receive a 999 file for all 270s submitted
- Review in the 999 file **all IK5 and all AK9 segments**. If there are any errors, they will need to submit a corrected file in order to receive the eligibility responses correctly
- Receive an eligibility request response (271) HIPAA file AND process it within their system without any issues
- Review the 271 response. If there are any errors reported in the **AAA – Reject Reason Code** segment for **Loop 2100C – Information Receiver Name**, they will need to correct that member eligibility request and send it in a new 270 file.
- **If any issues,** please have them contact the EDI Department for immediate assistance.

# Technical Refresh – Phase 1

## GO LIVE Support

The MassHealth Customer Service Center (CSC) enhanced the level of post implementation support to trading partners.

- **Overall Goal:** Quickly and easily assist providers with any EDI eligibility file-related issues
- Updated **IVR** messaging when calling the MassHealth CSC at (800) 841-2900
- Posted updated **Banner Messaging** on PDF Remittance Advices (RAs)
- Sent **email blasts** to targeted provider types such as vendors, etc.
- **Quick Reference Guide** published on Technical Refresh webpage to remediate EDI eligibility file-related errors
- **Enhanced Call Center Support:** Customer Service Representatives will be directed providers to the Quick Reference Guide and followed customized scripts to help with front line support of EDI file-related issues; will be escalated to EDI for follow-up.
- **Enhanced EDI Support:** 270 related inquires will be triaged and resolved as a high priority.

# Technical Refresh – Phase 2

## Examples of What's Changing

- Pre-compliance editing *(see slide #12)*
- Claims and Claim Status transactions will be affected. Submitters must modify their systems to ensure compliance:
  - **Interchange Control Header/Trailer (ISA/IEA)** values across all envelopes in the file must be unique *(with the exception of the date/time and control # data elements).* They cannot contain the same values or the file will be rejected.
  - **Interchange Control Header (ISA)** and **Functional Group Header (GS)** values across all envelopes in the file must be unique *(with the exception of the date/time and control # data elements).* They cannot contain the same values or the file will be rejected.
  - All **Transaction Set Control Numbers (ST02)** must be unique.
- Claims transactions must not contain more than **5,000** claims per **Transaction Set (ST/SE)** segment or the ST/SE will be rejected.
- Files greater than 16MB will be rejected.

Remind your constituents to view the updated Companion Guides for full details – available on mass.gov now.

# Technical Refresh – Phase 2

## Known Changes / Provider Impacts

Here is a **high-level summary** of changes. Please ask your constituents to view the 999/TA1 Comparison (otherwise known as Flyer: **The Grid),** published here for additional details: https://www.mass.gov/files/documents/2019/07/25/999-ta1-comparison-technical-refresh-current-state-future-state.pdf.

| ID | Known Change | Provider Impact |
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| 1. | ISA13 Control Numbers will be returned as "000000001" only on 999/TA1. | The 999 will report Control Numbers for Functional Group Header (GS) in the **AK1** and the Transaction Set Header (ST) in the **AK2**. |
| 2. | Transaction Set Control Numbers (ST02) will not be returned. | Providers should submit a Subscriber Trace Number (TRN) instead to correlate their 270 or 276. |
| 3. | Transaction Set Control Number (ST02) is sequential beginning with 0001. | Ensure your systems can receive this change. |
| 4. | Control Numbers (ISA13/IEA2, GS06/GE02, ST02/SE02) must match and must be unique within the file | File will fail pre-compliance and will not generate a 999. |
| 9. | The 999 will return only one ISA/IEA and only one GS/GE regardless of how many reported in the request. | For each Functional Group Header/Trailer(GS/GE) submitted, match up with the corresponding AK1 in the 999 and AK2 for each Transaction Set Header/Trailer (ST/SE). |

# Technical Refresh – Phase 2

## TPT Information Sessions *(837I, 837P, 276/277, 835)*

MassHealth will began to conduct a series of one hour information sessions to educate Billing Intermediaries / Clearinghouses (BIs/CHs) and software vendors (SWVs) about the technical refresh and trading partner testing. There will be a series of separate sessions scheduled for providers that submit transactions directly to MassHealth. MassHealth will began to provide additional updates and information about testing, the timeline, and answered any questions received during the sessions.

## TPT Information Sessions Schedule

Providers and vendors may sign up for any of the following Information sessions by clicking on this link: www.masshealthtraining.com. There will be separate sessions for vendors and providers. The sessions will be held on Thursdays from 2:00 pm – 3:00 pm, tentatively scheduled to start on 11/12/2019:

**BI/CH/SWV**

- 11/12/2019
- 11/19/2019

**Providers**

- 11/14/2019
- 11/21/2019

# Technical Refresh

## EDI Resources

- **MassHealth Customer Service Center – EDI Department**
  Email: edi@mahealth.net
  Phone: 1-800-841-2900

  Please have your constituents contact us if they have questions or need assistance.

- Webpage: **Technical Refresh**
  https://www.mass.gov/masshealth-technical-refresh

- **Companion Guides**
  https://www.mass.gov/lists/technical-refresh-companion-guides

- **Job Aid: Upload Eligibility Batches Master & Download 271 Responses:**
  https://www.mass.gov/files/documents/2019/02/27/jobaids-uploadeligibilitybatchesmaster.pdf

- Job Aid: **Download Responses (999)**
  https://www.mass.gov/files/documents/2017/11/13/batch-claims-download.pdf

- **Training Partner Education**
  https://www.mass.gov/service-details/trading-partner-education

# Technical Refresh

## EDI Resources *(continued)*

- Flyer: **999 Example**
  https://www.mass.gov/files/documents/2019/07/24/999-transaction-examples.pdf

- Flyer: **x12 Processing Example**
  https://www.mass.gov/files/documents/2019/07/18/x12-transaction-processing-pre-compliance-errors.pdf

- Flyer: **The Grid**
  https://www.mass.gov/files/documents/2019/07/25/999-ta1-comparison-technical-refresh-current-state-future-state.pdf

- **TPT Frequently Asked Questions (FAQ)**
  https://www.mass.gov/info-details/additional-technical-refresh-transition-information#frequently-asked-questions-

- Flyer: **EVSpc/EVScall Transition Options**
  MassHealth will publish on the Technical Refresh webpage once available.

- NEW: **Quick Reference Guide**
  MassHealth will publish on the Technical Refresh webpage once available.

# Technical Refresh – Phase 2

## Next Steps

Please advise your constituents to begin to prepare for Phase 2 by following this check-list.

- ☐ Download Companion Guides for Phase 2
- ☐ Review the three **Flyers** under the EDI Resources *(slide #15)*
- ☐ Assess impacts to their systems and begin to accommodate the changes
- ☐ Sign up the Information Sessions and participate
- ☐ If utilizing a vendor to submit claims (837I, 837P), claims status (276/277) or receive electronic remittance advice files (835s), coordinate testing

# Important Reminders – EVSpc Users

MassHealth would like to remind you that the EVSpc and EVScall software tools were terminated on September 1, 2015. You should have discontinued sending eligibility (270) and claim status (276) batch HIPAA files generated from EVSpc/EVScall at that time.

The EVSpc and EVScall software tools, that have been obsolete for the past 4 years, will not be compatible when the agency implements Phase I of its Technical Refresh project this fall. Your transactions will fail compliance. Providers must stop using the tool and transition to one of the following options immediately:

- Use DDE (Direct Data Entry) in the Provider Online Service Center (POSC)
- Hire a vendor to generate and send your 270 and receive 271 batch files
- Submit and receive 270/271 or 276/277 batch files in accordance with the MassHealth specifications
- Submit and receive a 270/271 or 276/277 batch files through the POSC or through a system-to-system connection

MassHealth will publish the following flyer on the Technical Refresh webpage once available: EVSpc/EVScall Transition Options.

For questions or assistance, please contact the MassHealth Customer Service Center at 1-800-841-2900 or edi@mahealth.net.

# Important Reminders – EVSpc Users

## EDI Resources

- Webpage Updates: **Eligibility Verification System (EVS) Overview**
  https://www.mass.gov/service-details/eligibility-verification-system-overview

- Updated **Job Aid: Upload Eligibility Batches Master & Download 271 Responses:**
  https://www.mass.gov/files/documents/2019/02/27/jobaids-uploadeligibilitybatchesmaster.pdf

- **270/271 MassHealth Companion Guide**
  https://www.mass.gov/masshealth-technical-refresh

- **MassHealth Customer Service Center – EDI Department**
  If you have questions or would like to switch from DDE to electronic batch file submissions, please send an email to edi@mahealth.net or call 1-800-841-2900.

## Next Steps

Please share this information with your colleagues and business partners.

# Important Reminders – Duplicate Claims Submissions

MassHealth wants to remind all claims submitters (providers and billing intermediaries that submit claims on their behalf) to curtail excessive and duplicative claims transactions

- MassHealth provider regulations 130 CMR 450.307(B)(1) state that duplicate billing is an unacceptable billing practice and providers should not engage in submission of duplicate claims
- Providers are encouraged to check claim status (276/277) via POSC *first* prior to submission of a second claim. MMIS adjudicates claims real time and claims status is available within at least two business days
- Medicare crossover claims for dually eligible members are automatically transmitted by the Medicare contractor – Benefits Coordination and Recovery Center (BCRC) to MassHealth when at least one claim line is Medicare approved. MassHealth receives and adjudicates Medicare crossover files in MMIS, the status of these claims can also be checked via POSC

To learn more about how to check claim status in POSC, please refer to https://www.mass.gov/how-to/check-claim-status for more information.

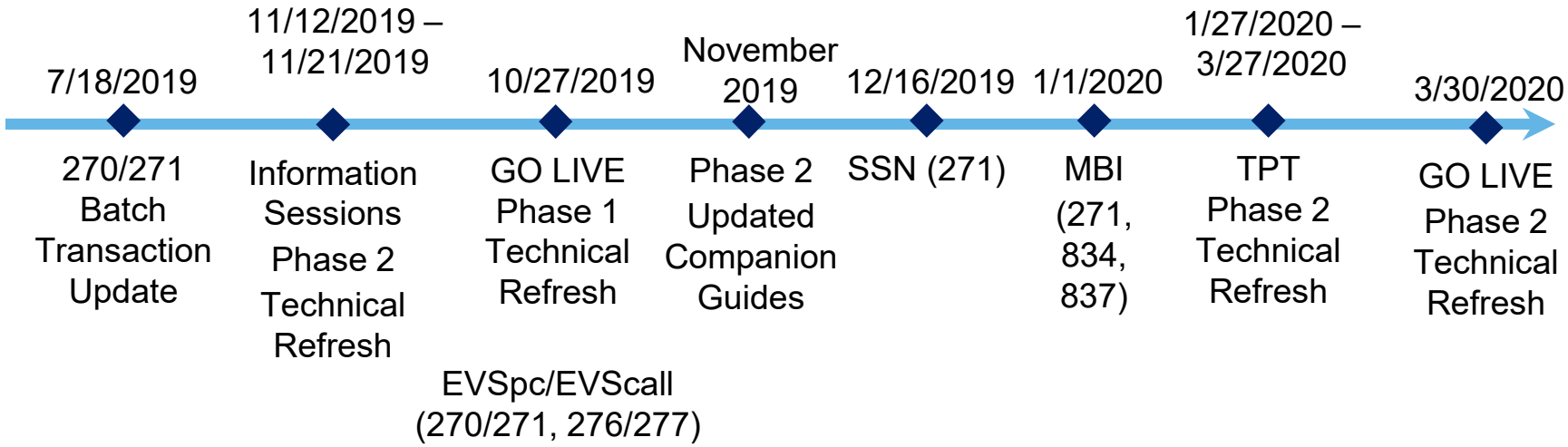
## Next Steps

Please share this information with your colleagues and business partners.

# Important Reminders

MassHealth requests that you remind your constituents of the following important changes that may potentially impact their business workflows. Below is a high-level timeline and summary of the changes.

## Timeline



# Important Reminders

## Timeline *(continued)*

| Timeframe | Milestone | Provider Impact |
|---|---|---|
| 7/18/2019 | 270/271 Batch Transaction Update. | Eligibility requests that contain invalid Member IDs (MIDs) will be rejected. Correct the eligibility request with a valid MID or only the member's first name, last name, date of birth and gender. |
| 11/12/2019 – 11/21/2019 | Technical Refresh Phase 2 – Information Sessions | Providers should attend in order to prepare for testing. |
| 10/27/2019 | Technical Refresh Phase 1 GO LIVE | Eligibility HIPAA files will reject if they do not meet the requirements. This includes files submitted from the sunsetted EVSpc/EVScall software tool. |
| 12/16/2019 | Social Security Number Change (270/271) | SSNs will no longer be returned unless a valid SSN was submitted on the 270 eligibility request |
| 1/1/2020 | Member Beneficiary Identifier (MBI) (271, 834, 837) | For both electronic HIPAA files and Direct Data Entry (DDE), MassHealth will no longer accept the Health Insurance Claim Number (HICN). When the MBI is known, MassHealth will return instead. |
| 1/27/2020 – 3/27/2020 | Trading Partner Testing – Phase 2 | Providers should test in order to prepare for implementation. |
| 3/30/2020 | Trading Partner Testing – Phase 2 GO LIVE | Provider's files will fail if they do not fully test prior to the Implementation date. |

# Questions?

# Eligibility Verification Overview

# Eligibility Verification System (EVS)

**The Eligibility Verification System is:**

- A web based application that enables a MassHealth provider to verify a member's eligibility
- Is accessible through the Provider Online Service Center (POSC)
- Available 24 hours a day, 7 days a week
- Provides easy access to the most current and complete member eligibility information

- Providers reduce the risk of denied claims by using EVS to verify member enrollment and eligibility prior to providing services to MassHealth members.
- It is highly recommended that you check eligibility on each date of service.

If you have questions about how to check a member's eligibility, please refer to the Verify Member Eligibility Job Aid to learn how to access and check member eligibility using EVS on the POSC

(URL: https://www.mass.gov/how-to/check-member-eligibility)

# Eligibility Verification System (EVS)

- 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

- There are two types of Restrictive Messages that appear on EVS:
  - Eligibility Restrictive Messages
  - Managed Care Data Restrictive Messages
- The Managed Care Data Restrictive Messages identify which type of health plan a member is enrolled in, and their contact information for inquiries regarding:
  - Billing (medical and behavioral health claims)
  - Service authorizations (medical and behavioral health services)
  - Behavioral Health vendors

If you have questions about how to check a member's eligibility, please refer to the Verify Member Eligibility Job Aid to learn how to access and check member eligibility using EVS on the POSC

(URL: https://www.mass.gov/how-to/check-member-eligibility)

# Eligibility Verification – Member ID Card

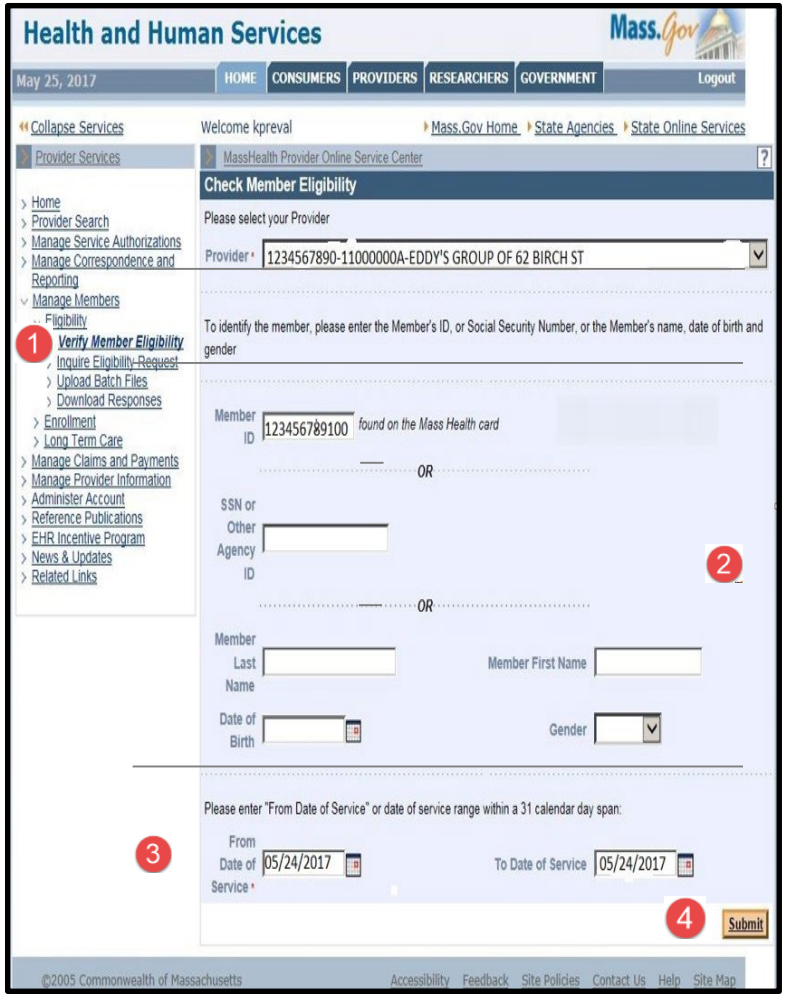
## Member Identification Card:

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

Note: The member may also have a card issued by the plan the member has chosen if they are managed care eligible

# Eligibility Verification System (EVS)

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**

Job Aid for checking eligibility for a single member on the POSC:
https://www.mass.gov/files/documents/2017/11/13/eligibility-verification-submit-inquiry.pdf

# Eligibility Verification System (EVS)

## Member Information Tab

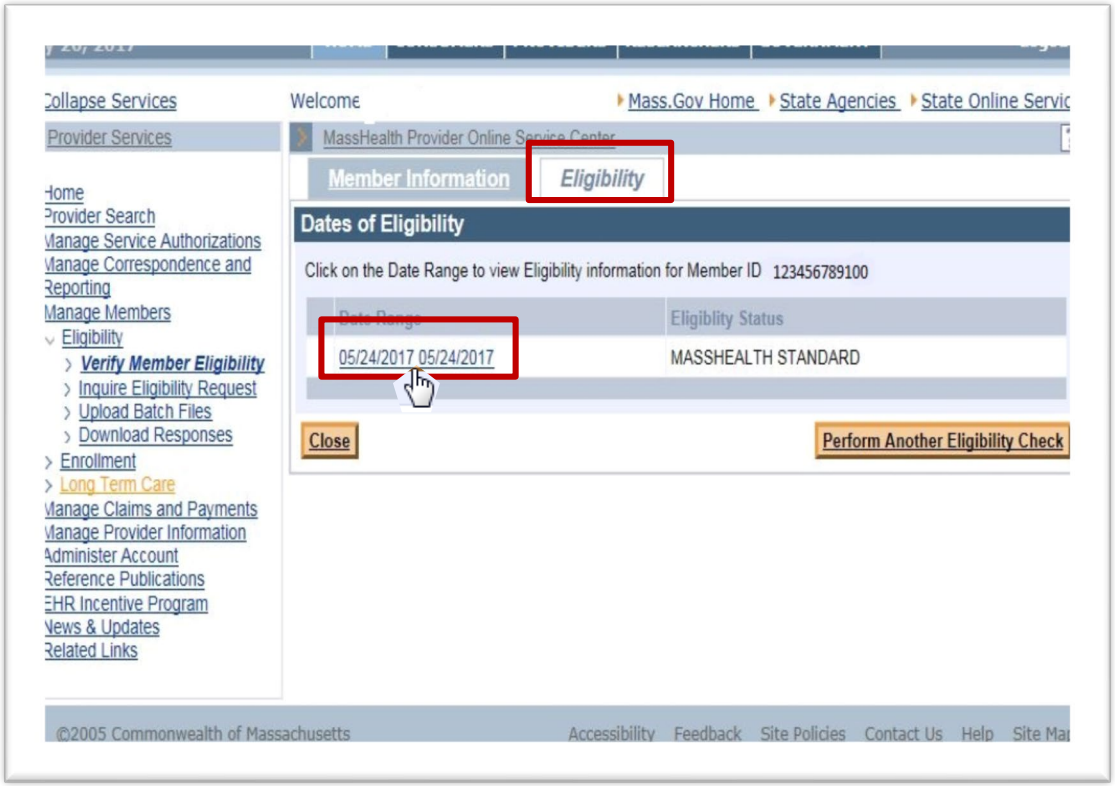
From the *Member Information* Tab ensure that you have the correct member by verifying all of his or her Information as indicated in the example below (which includes the member's name, social or Agency ID and address) are correct.

Note: Member eligibility information is specific to the date of service entered and also as a reminder, no future dates are allowed

# Eligibility Verification System (EVS)

## Eligibility Tab

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




This is a live link, please use mouse to hover ( ) or click 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. http://www.mass.gov/eohhs/consumer/insurance/masshealth-coverage-types/masshealth-coverage-types.html

# Eligibility Verification Provider Resources

- Mass.gov Resource Page https://www.mass.gov/how-to/check-member-eligibility
  - Link to access EVS through the Provider Online Service Center
  - Link to job aids for Eligibility Verification process
- MassHealth Customer Service
  - providersupport@mahealth.net
  - Main Tel: 800-841-2900
  - TTY: 800-497-4648

# Remittance Advice

# Remittance Advice (RA)

## What is a Remittance Advice (RA)?

An RA is a report that provides claims processing status to providers indicating if the claim is paid, denied, or suspended.

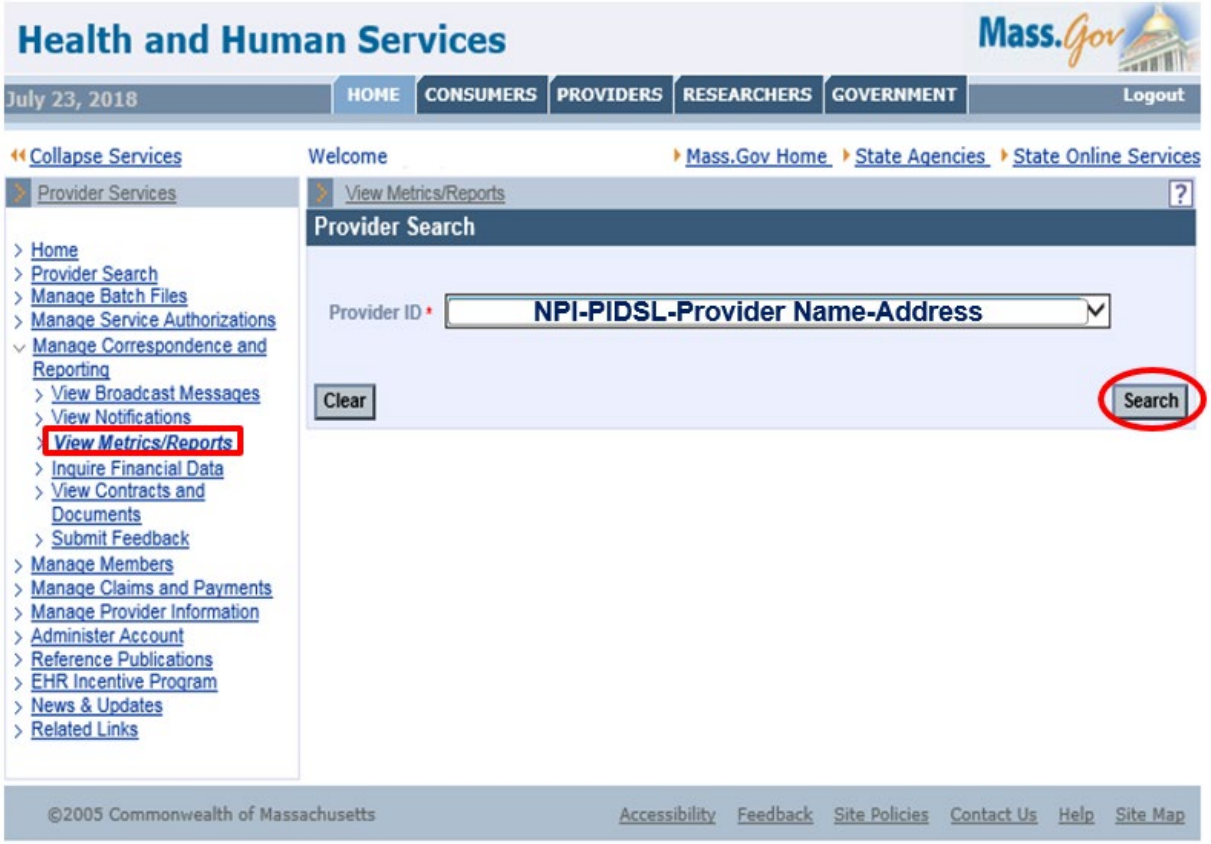
- The RA is utilized by providers in order to reconcile your account with MassHealth.
- The RA is available on the Provider Online Service Center for viewing, downloading, and printing for up to 6 months
- Providers can access their electronic, PDF, remittance advice on the POSC to view download and print
- The RA also provides message text and financial information.
- Reference the Remittance Advice Message Text for updates and information pertaining to claims processing, rate changes, and policy
- Message text can also be accessed through the MassHealth Provider Remittance Advice Message Text page https://www.mass.gov/masshealth-provider-remittance-advice-message-text

# How To access Remittance Advice (RA) on POSC

**Once logged in to the Provider Online Service Center (POSC), click on:**

- Manage Correspondence and Reporting
  - View Metrics/Reports

Then:
- Select Provider ID
- Click Search



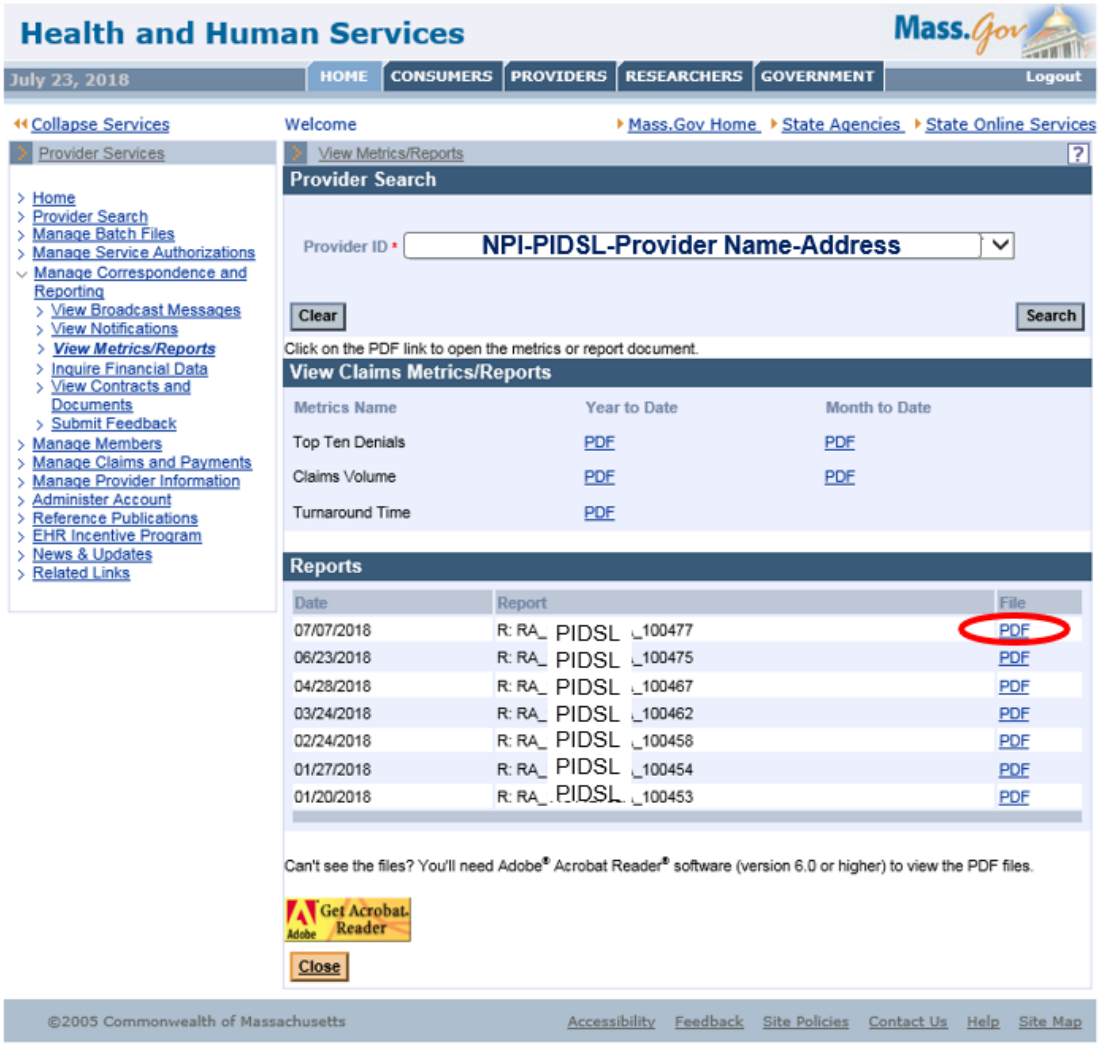
# How To access Remittance Advice (RA) on POSC

**View Claims Metrics/Reports**

- Top Ten Denials
- Claims Volume
- Turnaround Time

**Reports**

- The RA files are broken out by Date, Run Number, and the clickable RA PDF file
- Click on the PDF file to open the RA

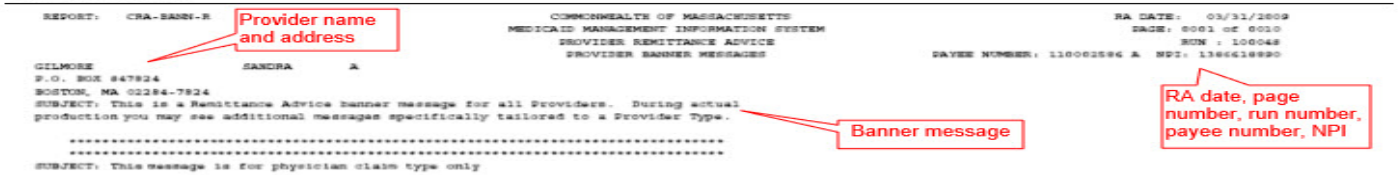


# How To access Remittance Advice (RA) on POSC

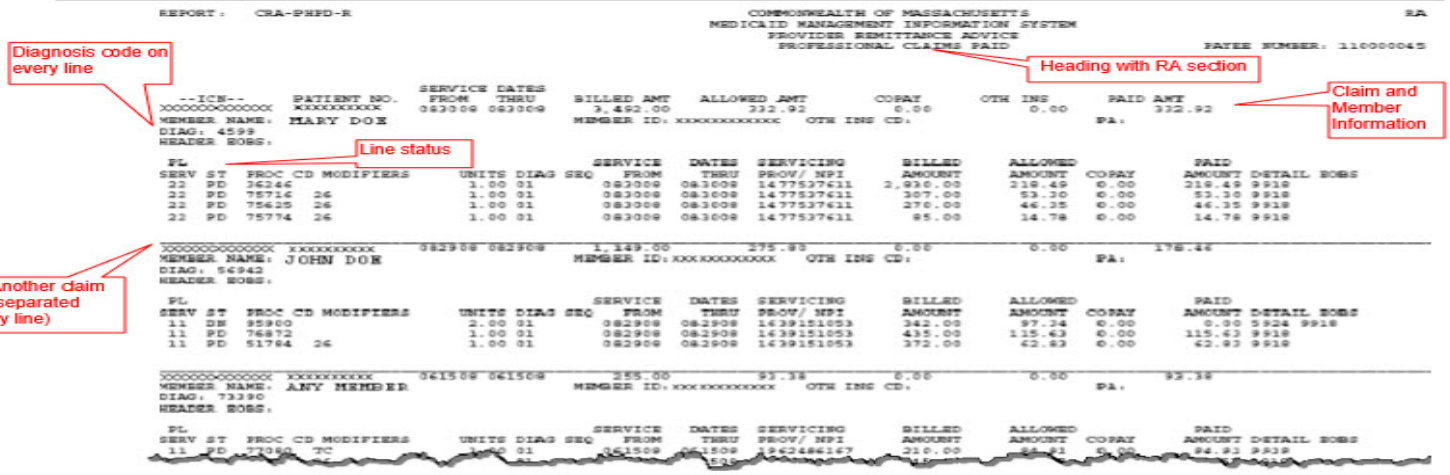
## Read Remittance Advice (RA) on the Provider Online Service Center

*Note: Some pictures are narrowed.*

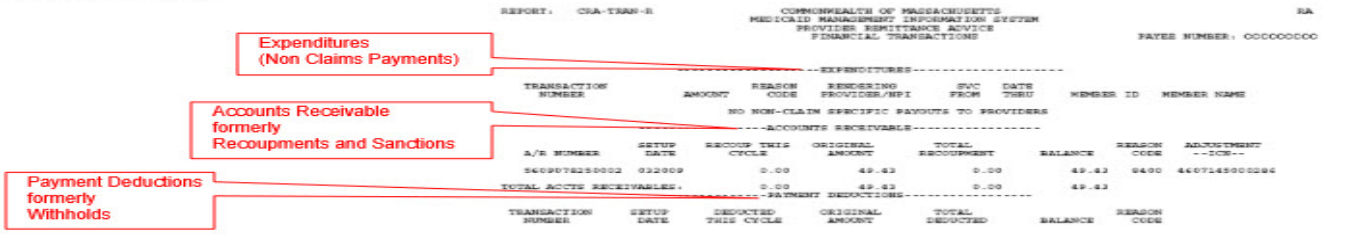
### Address/Banner




### Claims Activity and Status




### Financial Transactions




continued ▸

List of Explanation of Benefit Codes Appearing on the Remittance Advice

# How To access Remittance Advice (RA) on POSC

## Read Remittance Advice (RA) on the Provider Online Service Center

### TPL Information

- List of any claims affected by TPL
- TPL letter no longer sent

REPORT: CRA-TPLP-R

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
TPL INFORMATION

RA DATE: MM/DD/CCYY
PAGE: 9999 of 9999
RUN: 9999
PAYEE NUMBER XXXXXXXX X NPI: XXXXXXXXX

| MEMBER NAME / POLICY HOLDER NAME | MEMBER NUMBER / POLICY NUMBER / COVERAGE DATES | --ICN-- / GROUP NUMBER / COVERAGE TYPE | CARRIER/EMP ID / BILLING ADDRESS | CARRIER/EMPLOYER NAME |
|---|---|---|---|---|
| JANE DOE | XXXXXXXXXXX RRYYJJJBBBSS<br>XXXXXXXXXXXXXXX/XXXXXXXXXXXXXXXX<br>XX/XX/XX - XX/XX/XX / XXXXX | XXXXXX<br>XXXXXXXXXXXXXXXXXXXXXXXXXXXX | BLUE CROSS BLUE SHEILD MEDEX GOLD<br>XXXXXXXXXXXXXX, XX XXXXX-XXXX |
| JANE DOE | XXXXXXXXXXX RRYYJJJBBBSS<br>XXXXXXXXXXXXXXX/XXXXXXXXXXXXXXXX<br>XX/XX/XX - XX/XX/XX / XXXXX | XXXXXX<br>XXXXXXXXXXXXXXXXXXXXXXXXXXXX | TUFTS MEDICARE PREFERRED<br>XXXXXXXXXXXXXX, XX XXXXX-XXXX |

### Summary Report

- Summary of all claim and financial activity for each weekly cycle
- Year-to-date totals of all claim and financial activity

REPORT: CRA-SUMM-R

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
SUMMARY

RA
PAYEE NUMBER: OOOOOOOOO

CLAIMS DATA

| | CURRENT NUMBER | CURRENT AMOUNT | YEAR-TO-DATE NUMBER | YEAR-TO-DATE AMOUNT |
|---|---|---|---|---|
| CLAIMS PAID | 0 | 0.00 | 4 | 121.65 |
| CLAIM ADJUSTMENTS | 0 | 0.00 | 0 | 0.00 |
| TOTAL CLAIMS PAYMENTS | 0 | 0.00 | 4 | 121.65 |
| CLAIMS DENIED | 0 | | 0 | |
| CLAIMS SUSPENDED | 1 | | | |
| CLAIMS PENDED | 0 | | | |

PAYMENT DATA

| | | |
|---|---|---|
| PAYMENTS: | | |
| CLAIMS PAYMENTS | 0.00 | 121.65 |
| CAPITATION PAYMENT | 0.00 | 0.00 |
| EXPENDITURES | 0.00 | 0.00 |
| ACCOUNT RECEIVABLE RECOUPMENTS | (-0.00) | (-0.00) |
| PAYMENT DEDUCTIONS | (-0.00) | (-0.00) |
| NET PAYMENT | 0.00 | 121.65 |

VOUCHER NUMBER: 0

### EOB Descriptions

REPORT: CRA-EOBM-R

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
EOB CODE DESCRIPTIONS

RA
PAYEE NUMBER: GGGGGGGG

List of the EOB codes used in the RA

| EOB CODE | EOB CODE DESCRIPTION |
|---|---|
| 0256 | MISSING MEDICARE PAID DATEDETAIL |
| 4014 | NO PRICING SEGMENT ON FILE |
| 4170 | UNITS BILLED GREATER THAN ALLOWED |

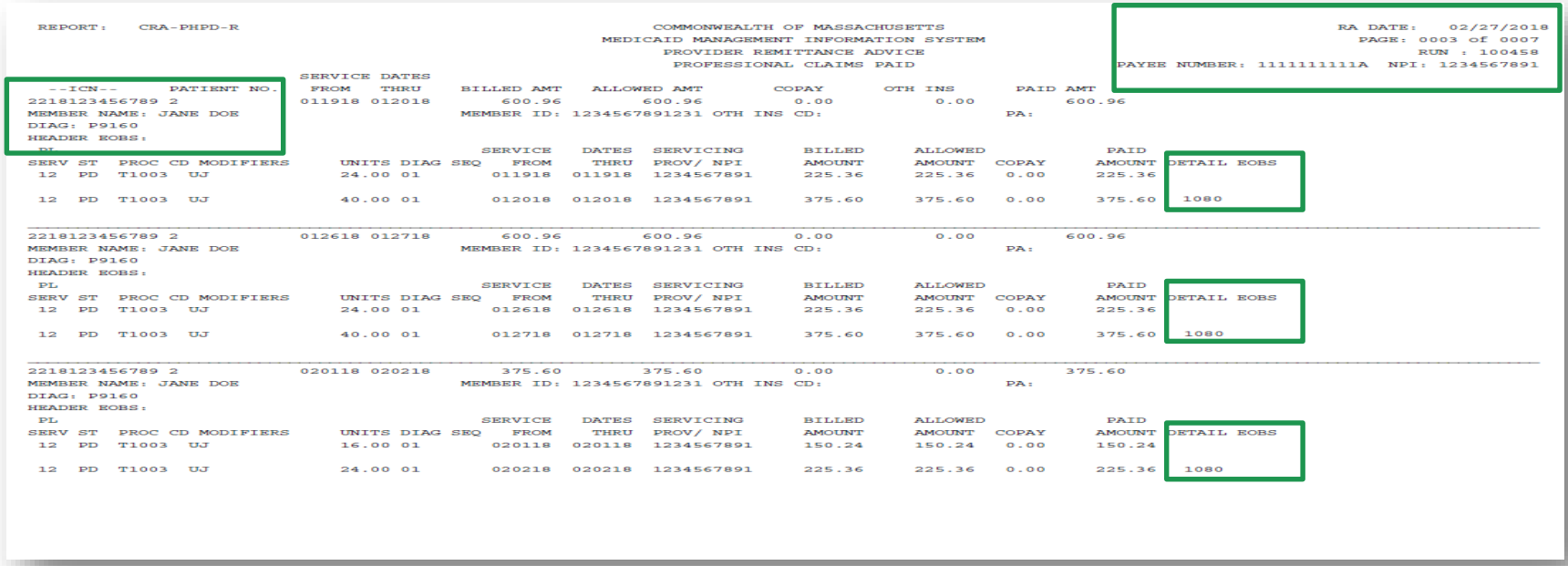
Description of EOB codes

List of Explanation of Benefit Codes Appearing on the Remittance Advice

# Remittance Advice (RA)

## RA number (Run number) on provider's remit

- When claims process, they report on the RA (Remittance Advice), posted on POSC weekly, and are dated on the Tuesday of that week.
- RA's are also referred to as 'runs' as they used to be printed in big batches each week – a printing run.
- Each week's RA is given a 6-digit number, e.g., 100458 one week and 100459 the next week. Both the Tuesday's date and the 'run' number are on the Remittance Advice when it's posted on POSC for providers



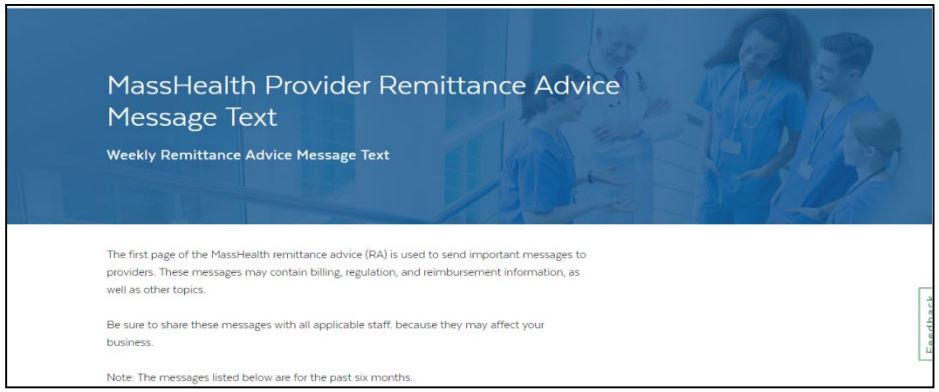
```
 REPORT:    CRA-PHPD-R                                          COMMONWEALTH OF MASSACHUSETTS                                                  RA DATE:    02/27/2018
                                                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                              PAGE: 0003 of 0007
                                                                PROVIDER REMITTANCE ADVICE                                                          RUN : 100458
                                                                PROFESSIONAL CLAIMS PAID                                                  PAYEE NUMBER: 1111111111A  NPI: 1234567891
                                 SERVICE DATES
  --ICN--       PATIENT NO.      FROM    THRU     BILLED AMT    ALLOWED AMT        COPAY       OTH INS       PAID AMT
2218123456789 2                 011918 012018        600.96         600.96          0.00          0.00          600.96
MEMBER NAME: JANE DOE                          MEMBER ID: 1234567891231 OTH INS CD:                      PA:
DIAG: P9160
HEADER EOBS:
 PL                                                SERVICE    DATES   SERVICING       BILLED      ALLOWED              PAID
SERV ST   PROC CD MODIFIERS       UNITS DIAG SEQ    FROM     THRU   PROV/ NPI       AMOUNT      AMOUNT   COPAY      AMOUNT DETAIL EOBS
 12  PD   T1003   UJ               24.00 01        011918   011918   1234567891      225.36      225.36    0.00      225.36

 12  PD   T1003   UJ               40.00 01        012018   012018   1234567891      375.60      375.60    0.00      375.60   1080
-------------------------------------------------------------------------------------------------------------------------------------
2218123456789 2                 012618 012718        600.96         600.96          0.00          0.00          600.96
MEMBER NAME: JANE DOE                          MEMBER ID: 1234567891231 OTH INS CD:                      PA:
DIAG: P9160
HEADER EOBS:
 PL                                                SERVICE    DATES   SERVICING       BILLED      ALLOWED              PAID
SERV ST   PROC CD MODIFIERS       UNITS DIAG SEQ    FROM     THRU   PROV/ NPI       AMOUNT      AMOUNT   COPAY      AMOUNT DETAIL EOBS
 12  PD   T1003   UJ               24.00 01        012618   012618   1234567891      225.36      225.36    0.00      225.36

 12  PD   T1003   UJ               40.00 01        012718   012718   1234567891      375.60      375.60    0.00      375.60   1080
-------------------------------------------------------------------------------------------------------------------------------------
2218123456789 2                 020118 020218        375.60         375.60          0.00          0.00          375.60
MEMBER NAME: JANE DOE                          MEMBER ID: 1234567891231 OTH INS CD:                      PA:
DIAG: P9160
HEADER EOBS:
 PL                                                SERVICE    DATES   SERVICING       BILLED      ALLOWED              PAID
SERV ST   PROC CD MODIFIERS       UNITS DIAG SEQ    FROM     THRU   PROV/ NPI       AMOUNT      AMOUNT   COPAY      AMOUNT DETAIL EOBS
 12  PD   T1003   UJ               16.00 01        020118   020118   1234567891      150.24      150.24    0.00      150.24

 12  PD   T1003   UJ               24.00 01        020218   020218   1234567891      225.36      225.36    0.00      225.36   1080
```

# Remittance Advice Messages

## MassHealth Provider Remittance Advice Message Texts – September & August 2019

- 09/17/19 – MassHealth reminder – excessive batch eligibility submissions
- 09/03/19 – Update for quarterly drug code rates effective July 1, 2019
- 08/27/19 – Claims denied for edit 4244
- 08/06/19 – Technical refresh phase 1 testing now through 09/20/19

Provider Message texts are also located on Mass.gov:
https://www.mass.gov/masshealth-provider-remittance-advice-message-text



# Claims Submission Timeline

**30 Days:** Average time for both electronic and paper claims to process on a remittance advice.

**60 Days:** The usual turnaround time for Medicare/MassHealth crossover claims forwarded to MassHealth by Massachusetts Medicare Fiscal agent to be processed.

**90 Days:** Initial claims must be received by MassHealth within 90 days of the service date. If another insurance was billed before MassHealth, claims must be received within 90 days from the date of the explanation of benefits (EOB) of the primary insurer.

**12 Months:** Final submission deadline to resolve claims that were initially submitted within 90 days of the date of service (DOS). Claims that exceed this deadline will be denied.

**18 Months:** Final submission deadline to resolve claims submitted to another insurance carrier prior to MassHealth. Claims must be initially submitted within 90 days from the date of the explanation of benefits (EOB) of the primary insurer. Claims that exceed this deadline will be denied.

**36 Months:** Final submission deadline for all claims

For more information, please see https://www.mass.gov/service-details/billing-timelines-and-appeal-procedures; *also in All Provider Regulations 130 CMR 450.309, 450.319 and 450.314*

# Questions?