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Electronic or Paper: All You Need to Know About Voids, Adjustments, and Resubmittals

If you have a previously paid claim that you need to void, you can save time and paper by taking advantage of the electronic void transaction. You can even use the void-and-replace transaction to resubmit the voided claim to MassHealth, avoiding the entire paper process. These options are available to all providers who are approved to submit electronic claims to MassHealth.

Void transactions can be used by approved electronic submitters to correct and/or report the following circumstances:

- duplicate claim;
- payment to the wrong provider number;
- payment for services performed for the wrong MassHealth member identification number (RID);
- payment for overstated or understated services; and
- payment for services for which payment has been received from a third-party payer.

Electronic Void

You can submit a void electronically by using the electronic void transaction. To assist MassHealth in processing these requests, submit void transactions for only one service line at a time. Each transaction must include the transaction control number (TCN) for the service listed as the claim in the "Former TCN" field.

To submit a void electronically, follow the procedures below for the applicable 837I or 837P transaction.

- Enter the frequency code "8" in Loop 2300 Segment CLM05-03.
- Enter the 10-character TCN of the

original claim in Loop 2300 in an REF segment and use F8 as the qualifier.

For more information about this transaction, please see Section 3.4 in the applicable MassHealth 837 Companion Guide.

Electronic Adjustment

If you want to void and adjust a previously paid claim, you can do so using the void-and-replace transaction. This procedure can be used for alterations to any fields on the claim form except changes to the member RID, pay-to-provider number, or invoice type. If any of these items are changing, you must resubmit the claim on paper, following the procedures outlined below in the paper section.

To submit an electronic adjustment, follow the two-step procedure below.

Step 1: Void the Claim

- Enter the frequency code "8" in Loop 2300 Segment CLM05-03.
- Enter the 10-character TCN of the original claim in Loop 2300 in an REF segment and use F8 as the qualifier.

Step 2: Replace the Claim

- Enter the frequency code "7" in Loop 2300 Segment CLM05-03.
- Enter the 10-character TCN of the original claim in Loop 2300 in an REF segment and use F8 as the qualifier.

Both the void and the replacement claims must be included in the same file transmission.

Please Note: The replacement claim should include the full request amount, not only the difference between the previous payment and the expected payment.

For more information about this transaction, please see Section 3.4 in the appli-

cable MassHealth 837 Companion Guide.

Paper Void Request

If you cannot use the 837 transaction to request a void, you can use the paper MassHealth Void Request Form. Using the Void Request Form in place of a cover letter expedites the processing of the request once it is received by MassHealth. You can download this form from the MassHealth Web site from the Provider Forms link under the MassHealth Regulations and Other Publications section on www.mass.gov/masshealth.

Simply complete the paper form and attach a copy of the paper remittance advice (RA) or electronic 835 RA, indicating which claim to void, and send it to MassHealth. Please Note: If attaching an 835 printout, also specify the corresponding MassHealth invoice type on the printout to avoid a possible claim reject.

For more information on the Void Request Form, refer to *All Provider Bulletin 152* (April 2006) in the MassHealth Provider Library.

Paper Adjustments

To submit a paper adjustment for a claim that has received payment for an incorrect amount, follow the procedures outlined below.

- Complete a new claim form and attach any required documentation. Make sure only one claim line is entered per claim form.
- Do not subtract the original payment from the usual charge, or enter that amount into the Other Paid Amount field, as the processing system will automatically perform the necessary calculation.

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Using the Correct Dates of Service for Eye Exams and Eyeglasses for MassHealth Claims

With the recent expansion of vision-care benefits for MassHealth members as part of Health Care Reform policies introduced in 2006, many providers have experienced claim denials for error 296 (billing deadline exceeded) when submitting claims for eye exams and eyeglasses. A denial for error 296 is issued when the claim is received for processing by MassHealth more than 90 days after the date of service entered on the claim. State law requires that providers submit claims to MassHealth no later than 90 days from the date of service.

After investigating the issue, MassHealth found that some providers were incorrectly billing the same date of service for both the eye exam and the dispensing of eyeglasses, using the date of service on which the eye exam was provided. The problem initially went undetected, as eyeglasses were typically dispensed within 90 days of the eye exam. However, due to the increase in members now covered for this benefit, in some cases the dispensing date has been more than 90 days from

the date of service of the exam. When the provider then billed using the date of service of the exam only, some claims denied for error 296.

The correct submission of a claim to MassHealth requires that the provider bill the date of service of the exam for the exam portion only. The provider must then bill the date that the MassHealth member physically received the eyeglass-

Providers must bill two separate dates of service: one for the eye exam, and one for the dispensing of eyeglasses to the member.

es as the date of service for the dispensing. If these two dates are less than 90 days apart, you may submit two separate claim lines on one claim form no. 9. However, if these two dates are more than 90 days apart, you must submit two separate claim no. 9 forms. The 90-day filing

deadline is applied to the earliest date of service shown on any single claim form.

Billing under the same date of service for both the eye exam and the dispensing of eyeglasses is not in compliance with MassHealth regulations. MassHealth regulations at 130 CMR 450.231(A) and (B) clearly define the provider requirement to bill the actual respective dates of service for both eye exams and custom-made goods, such as eyeglasses.

You can review the regulations at 130 CMR 450.231(A) and (B) online by selecting the MassHealth Regulations link from the MassHealth Regulations and Other Publications section on the MassHealth home page. Click on MassHealth Provider Regulations, then 450: All Provider under Current MassHealth Regulations.

If you have questions, you can contact MassHealth Customer Service at providersupport@mahealth.net or call 1-800-841-2900.

Home Health Providers: When to Submit an Explanation of Benefits Form with Your Claim

MassHealth would like to remind home-health providers when it is necessary to attach an explanation of benefits (EOB) or explanation of Medicare benefits (EOMB) when submitting paper claims to MassHealth.

As MassHealth is the payer of last resort, providers must show diligent effort to obtain a payment from other resources before billing MassHealth. An EOB or EOMB would qualify as demonstrating diligent effort to obtain payment from another resource.

Any changes or “qualifying events” would also require a provider to obtain coverage determination. “Qualifying events” are defined as any changes in a member’s condition or circumstance that may trigger a change in insurance coverage. Examples of “qualifying events” are listed in *Transmittal Letter (TL) HHA-33* (June 2002).

If a member’s condition or coverage type has changed, the provider is required to

request and obtain an EOB or EOMB, as applicable, for coverage determination. The EOB or EOMB should be sent to MassHealth at the following address within 10 days of receiving notification of denial from the insurer:

MassHealth
Home Health Claims
The Schraffts Center
529 Main Street, 3rd Floor
Charlestown, MA 02129.

For claim form no. 9, the Patient Status field is used when the provider has determined that the service is not covered by Medicare and/or the other commercial insurer. The applicable condition code must be entered in this field to indicate why the other insurer denied coverage. If an entry has been made in this field, it is not necessary to attach the EOB or EOMB to the paper claim when submitting the claim to MassHealth. Appropriate home health patient status codes are transmitted in *Home Health Agency Bulletin 41*

(November 2003).

However, if the claim is submitted more than 90 days from the date of service, the claim should be submitted on paper along with the other insurer’s EOB. Please refer to *Home Health Agency Bulletin 41* for more information.

Electronic Billing

To bill these types of claims electronically using the 837I transaction, providers should enter the condition code in lieu of patient status codes in the applicable loop. Please review *Home Health Agency Bulletin 41* (November 2003) for instructions.

Additional Information

If you would like to read additional communications about this topic, please refer to *TL HHA-33* (June 2002) and *Home Health Agency Bulletin 41* (November 2003), available in the MassHealth Provider Library on www.mass.gov/masshealth.

■ We Need Your National Provider Identifier

As of May 23, 2007, MassHealth will be prepared to accept the National Provider Identifier (NPI) as the primary identifier for claims submission. Effective May 23, 2007, for applicable provider types, all paper and electronic claims submitted to MassHealth must contain an NPI, unless otherwise noted in our contingency plan, described later in this text. MassHealth needs your NPI information now to update your provider file. To avoid possible claim-processing delays, make sure MassHealth has your NPI information as soon as possible, using the provider NPI data-collection tools posted on www.mass.gov/masshealth/npi. Once you have completed the appropriate provider NPI spreadsheet, you can e-mail it to npi@mahealth.net.

Providers can use the NPI spreadsheet tool to send their NPI details to MassHealth Customer Service.

Please Note: Nonemergency transportation providers and rest homes are considered “atypical” as designated by the NPI Enumeration rule. Therefore, they do not need to send NPI information to MassHealth. For additional information on exempt providers, pharmacy, municipal Medicaid, and dental providers, please review *All Provider Bulletin 164* (May 2007) at www.mass.gov/masshealth/npi.

NPI Contingency Plan

In accordance with the Guidance on Compliance with the HIPAA National Provider Identifier Rule issued by the Centers for Medicare and Medicaid Services (CMS) on April 2, 2007, MassHealth has developed an NPI contingency plan. The purpose of this contingency plan is to work with providers to ensure that all of their NPI data is processed and validated, and that system testing can occur, which should minimize the impact to providers’ business processes.

The federally mandated deadline to obtain your NPI and share it with all partners with whom you conduct business remains May 23, 2007. Therefore, providers should not delay the process of obtaining an NPI, sharing an NPI, or making the necessary business-process changes to transmit an NPI on transactions as a result of this contingency plan. On May 23, 2007, MassHealth will be ready to accept NPI-compliant claims, eligibility-verification, and claims-status transactions. If any of the following conditions apply to a MassHealth provider, that provider may use its seven-digit MassHealth provider number on HIPAA standard transactions and paper-claims submissions on and after May 23, 2007:

- the provider has not received an NPI;
- the provider is not ready to submit transactions with NPI;
- the provider has not shared the NPI with MassHealth; and
- the provider has not received confirmation from MassHealth on its NPI submission. (In this case you may submit both NPI and your MassHealth number, until you receive your confirmation.)

If any of these conditions apply, you are required to share your contingency plan with MassHealth. Requests for contingency plans should be sent to npi@mahealth.net. MassHealth will not deny transactions or interrupt payments if a valid MassHealth provider number is submitted instead of an NPI, according to the preceding criteria. The MassHealth deadline for full NPI compliance for all HIPAA standard transactions and paper claims is September 30, 2007. At that time, any electronic or paper claim transactions received without an NPI will be denied.

The NPI contingency plan will ensure that there is enough time to process and validate information to minimize impacts to provider’s business procedures.

Changes to MassHealth Claim Forms and Remittance Advices

MassHealth has modified its paper claim forms to include fields for NPI and taxonomy. Supplies of the new paper claim forms can be requested by accessing the Order Provider Publications Web page or by calling MassHealth Customer Service. Updated instructions for completing MassHealth claim forms are being developed and will be posted to the Web as soon as they are ready. Refer to the NPI Web page at www.mass.gov/masshealth/npi for instructions to determine where to enter your NPI and taxonomy information on the applicable paper claim forms that you submit to MassHealth on or after May 23, 2007.

MassHealth will continue to remit 835 transactions to the MassHealth provider number until June 30, 2007. However, starting July 1, 2007, MassHealth will remit 835 transactions to the provider’s NPI, if NPI information was submitted. Paper remittance advices will not show the provider’s NPI, but will detail adjudicated claims to the current MassHealth number until further notice.

Refer to the NPI Web page at www.mass.gov/masshealth/npi for all the latest news and information.

Although the NPI will be used on all claims submitted to MassHealth, you will still need and may use your current MassHealth provider number for certain MassHealth-specific transactions.

For more information on business functions that will not change and how NPI will affect your MassHealth billing procedures, review *All Provider Bulletin 164*.

Electronic or Paper: All You Need to Know About Voids, Adjustments, and Resubmittals *(continued from page 1)*

- Check the Adjustment box at the bottom of the new claim form.
- Enter the most recent TCN in the Adjustment/Resubmittal box at the bottom of the claim form.
- Attach any required documentation to the claim form and mail it to the following address:

MassHealth
ATTN: Adjustments
P.O. Box 9118
Hingham, MA 02043.

Previously Denied Claims

If the claim was originally submitted within 90 days of the date of service on the claim, you can resubmit the previously denied claim on paper following the procedure outlined below.

If the date of service, revenue code, pay-to-provider, RID, or service code is

not changing, a TCN is not required on the resubmitted claim. Just complete a new claim form and attach any required documentation, and send the claim to MassHealth at:

MassHealth
ATTN: Resubmittals
P.O. Box 9118
Hingham, MA 02043.

However, if the date of service, revenue code, or service code is changing, the former TCN must be entered on the claim form. Enter the TCN in the Resubmittal field on the new claim form, making sure only one claim line is entered per form. Send the claim with any required documentation to the above MassHealth address.

More Than 90 Days from the Date of Service on the Claim

If the claim type, RID, or pay-to-provider

number is changing and the date of service is more than 90 days from the date on the claim, you must request a 90-day waiver.

Attach any required documentation to the claim form and mail it to:

MassHealth
ATTN: 90 Day Waivers
P.O. Box 9118
Hingham, MA 02043.

For more information on previously denied claims submitted more than 90 days from the date of service, or the date on the Explanation of Benefits (EOB), consult the appropriate provider billing tips flyer from the Billing Tips section under the Customer Service link in Information for MassHealth Providers on www.mass.gov/masshealth.

MassHealth Reminders

Managed Care Organizations (MCO) and Wrap Services

Members enrolled in a MassHealth MCO may have some wrap services directly covered by MassHealth. These are determined by the member's coverage type. Some of the covered services include eyeglasses and other visual aids, personal care attendant services, and continuous skilled nursing. Please bill MassHealth directly for covered wrap services, since attaching an MCO's explanation of benefits (EOB) to the claim is no longer necessary.

Submitting Acute Inpatient Hospital Claims for Clinical Review

As stated in *Acute Inpatient Hospital Bulletin 116* (August 2000), AIH providers should send claims for clinical review when:

- the medical record supports that the member was admitted for a non-behavioral medical treatment;
- the principal diagnosis upon discharge is behavioral; and
- the claim is for a MassHealth member enrolled on the service date(s) with

the Massachusetts Behavioral Health Partnership (MBHP).

For claims that meet the above criteria that may have been denied for error 539 (the mental-health or substance-abuse treatment service that was entered on the claim must be billed to the MBHP), the acute inpatient hospital should still follow these instructions. However, the paper claim, remittance advice indicating the denial for error 539, and medical record should be sent directly to:

Executive Office of Health and Human Services, Office of Medicaid
ATTN: Utilization Management-Clinical Review
600 Washington Street, CTC Room 310
Boston, MA 02111.

Dental Providers and Provider Verification Forms

The dental third-party administrator (TPA), Doral, mailed a Provider Verification Form to all active MassHealth Dental Providers in January 2007. To accurately update your provider file information, Doral needs to receive a completed form as soon as possible. If you have not returned your Provider Verification Form, please mail it as soon as possible to:

Doral
ATTN: MassHealth Dental Program
12121 North Corporate Parkway
Mequon, WI 53092.

If you have questions or need assistance, contact Doral Customer Service at 1-800-207-5019.

Reminder for Institutional Part B Crossover Claims

MassHealth has received questions from the provider community on the pricing policy of Part B institutional claims.

After reviewing the situation for payable institutional Part B crossover claims, MassHealth pays the full patient responsibility, including coinsurance and deductible. This will remain in effect until the correct payment methodology is implemented at a future date.

These crossover claims will continue to appear as separate lines on your remittance advice (RA), and began appearing on the pay cycle dated March 27, 2007 (run #1960).