# MassHealth Update

## Contents

# Important Announcements and Updates

*The items below highlight recent announcements, changes to policy and procedures, and descriptions of system, processing, and billing updates that may affect your daily business with MassHealth. These items summarize official agency issuances that govern provider participation. Please refer to the official agency issuances for complete details. In the event of a conflict between this update and any official agency issuance, the official agency issuance governs.*

### Important Reference Changes

MassHealth has updated a resource that references required enrollment documentation: the *Tips for Completing the Massachusetts Substitute W-9 Form*. The *Tips* communicate instructions for completing the Massachusetts Substitute W-9 Form appropriately. You can download a copy of the *W-9 Tips* from the MassHealth Web site at www.mass.gov/masshealth, by clicking on the MassHealth Provider Forms link, in the Publications panel on the right side of the home page.

### Elimination of Full Paper Mailing of Bulletins and Transmittal Letters (TLs)

Effective February 1, 2010, to save costs and to act in an environmentally responsible manner, MassHealth will no longer issue paper copies of bulletins and TLs to providers, but will continue to notify providers by e-mail or postcard when a bulletin or TL has been posted on the MassHealth Web site. E-mail is the fastest and easiest way to get this information from MassHealth. For any publication dated on or after February 1, 2010, providers who have chosen to automatically receive paper mailings will instead receive a postcard notification of the publication. The postcard will include information on how to access an online copy of the publication and how to request a paper copy.

MassHealth would like to encourage providers who have not already done so to make the transition to online access of bulletins and TLs. You can view these publications online at www.mass.gov/masshealthpubs. Click on Provider Library, then choose MassHealth Bulletins or MassHealth Transmittal Letters, as applicable.

You can contact MassHealth to indicate your preferred communication method for receiving notification of new bulletins or TLs at any time, by visiting the Web site at www.mass.gov/masshealth. In the Online Services box on the right side of the screen, click on Provider Preferred Communication Method. Please note that MassHealth
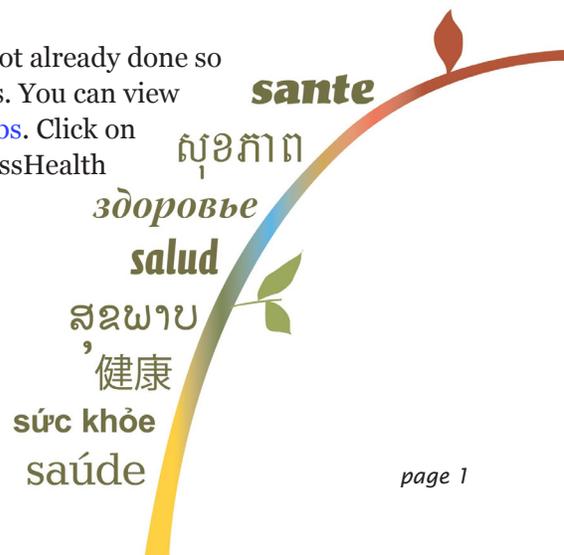
is able to accept only one e-mail or street address per provider ID/service location (PID SL). In addition, group practices must sign up under the PID SL assigned to the group practice. You may also contact MassHealth Customer Service at 1-800-841-2900 to indicate your selection. For more information please refer to All Provider Bulletin 199 (December 2009).
-Top-

## Federal Medicaid Integrity Program Provider Audits

Under 42 U.S.C. §1396u-6, the Centers for Medicare & Medicaid Services (CMS) has contracted with Audit Medicaid Integrity Contractors (Audit MICs) to conduct provider field and desk audits throughout the country to identify and recover overpayments in an effort to decrease the payment of inappropriate Medicaid claims. Audits are designed to ensure that Medicaid payments are for covered services that were actually provided, properly billed, and documented. This CMS auditing program supplements the normal ongoing claim-review processes conducted by Medicaid agencies to identify and recover claims overpayments and fraudulent patterns.

Any Medicaid provider may be audited, including, but not limited to, fee-for-service providers and managed care entities. Providers will be selected for audits based on data analysis by other CMS contractors or a referral by the state Medicaid agency.

CMS awarded the Audit MIC contract for the New England States to IPRO of Lake Success, NY. Audits could start as soon as February 2010 and will be conducted as part of an ongoing five-year program.

IPRO will send a letter to notify providers that have been selected for either a desk or field audit. If you are selected for audit, you should gather the requested documents as instructed in the letter. Audit MICs, such as IPRO, have the authority to request and review copies of provider records, interview providers and office personnel, and have access to provider facilities. Requested records must be made available within requested time frames. Providers will be contacted to schedule an entrance conference.

Following the audit, IPRO will prepare a draft audit report for CMS's review. Before CMS finalizes the report, MassHealth, as well as the provider, will have an opportunity to review and comment. Once the report is finalized, CMS will issue the report to MassHealth for collection of overpayments.

The Medicaid Integrity Program Provider Audit Fact Sheet (June 2009) addresses questions that a provider may have regarding the audit process, and can be accessed via e-mail at MedicaidIntegrityProgram@cms.hhs.gov. Some of the information noted in the fact sheet includes

- instructions about what a provider should do upon receipt of a Notification Letter that the provider has been selected for audit;
- an explanation of what process will follow the completion of the audit;
- a list of who the Audit MICs are;
- frequently asked questions about the procedure; and
- background on the program.

In addition to the fact sheet, a number of other informative program-related links are available at this site. You may also access the CMS Web site for a general overview of the Medicaid Integrity Program at www.cms.hhs.gov/MedicaidIntegrityProgram/.

MassHealth and CMS are working together in a number of ways to inform providers of this program. A MassHealth representative presented at the January MassHealth Training Forums (MTFs) and Provider Advisory Group Meetings (PAGs). More information is also communicated in All Provider Bulletin 200 (Federal Medicaid Integrity Program Provider Audits), dated January 2010.

## NewMMIS System-Generated PCC Referrals

When submitting a referral for a servicing provider, the referring provider must perform a system search to locate the correct servicing provider using the servicing provider's national provider identifier (NPI) number. If more than one provider is linked to the same NPI, the referring provider should confirm the servicing provider's name, address, and provider type. The referral should always be listed under the servicing provider who is billing the claim (i.e., the billing provider, usually a group or hospital).

## Claims

- *Electronic:* If you submit your claims electronically and are eager to check the status of a certain claim but do not want to await receipt or posting of the RA, you can view the claim's status immediately via direct-data entry (DDE) in the POSC. Status for batched claims submitted directly to MassHealth via 837 electronic transactions can be viewed within an hour of submission. Any denied batch claims will post with the HIPAA adjustment reason code following the financial cycle (usually on Fridays). Please note that the adjudication cycle differs from the payment cycle. Denied or suspended claims appear on the next RA following adjudication. Approved-to-pay claims appear on the RA once payment is released. MassHealth typically issues payments three weeks after a claim has been adjudicated as paid. Therefore, paid claims will not appear on the same RA as denied or suspended claims submitted on the same batch file. Please refer to guidelines listed in the MassHealth companion guides located on the NewMMIS Web site.

- *Paper:* To submit an adjustment on a paper claim or on a claim submitted in legacy MMIS (adjustments for legacy MMIS claims must be submitted on paper), you must send a corrected claim on paper as an adjustment according to the MassHealth UB-04 billing guidelines found on the NewMMIS Web site. Any claims submitted in NewMMIS can be viewed and replaced in the POSC. A new UB-04 TPL paper billing support document that outlines required fields and additional instructions has been added to the NewMMIS Web site, and is accessible by clicking on the Need Additional Information or Training, then on Updated Billing Guides, Companion Guides, and Other Publications, then on Special Instructions for Submitting Claims on the UB-04 for Members with Other Health Insurance.

### Eligibility

Providers are encouraged to routinely confirm member eligibility before providing services. Some of the areas to check include eligibility, coverage type, managed care, and PCC status. Confirmation of eligibility reduces the risk of denied claims. To check member eligibility or the status of an adjudicated claim online, use your user ID and password to access the Eligibility Verification System (EVS) 24 hours a day, seven days a week, except Sunday from 3 A.M. to 6 A.M. You can access EVS via the POSC by clicking on the Manage Members link, then on Eligibility.

-Top-

### POSC Password and Login Questions Changes

The POSC offers some helpful instruction in the form of e-learning courses and job aids to assist you in your password and login queries. To access this information, visit the NewMMIS Web site at www.mass.gov/masshealth/newmmis, and click on the Need Additional Information or Training link, then on Get Trained.

If you are a POSC primary user experiencing issues creating, removing, updating, or resetting subordinate account passwords, please make sure that all the information you are entering on behalf of the subordinate is current and correct. Some of the fields that must be entered when resetting passwords for your subordinate users include the e-mail address and DOB. For more instruction on this topic, please refer to the job aids listed under the Provider Security heading.

-Top-

### Explanation of Benefits (EOB)

Remember to carefully check the adjusted section of the RA for both header and line detail EOBs. The presence of an EOB indicates an error on the submitted adjusted claim. If an adjustment is submitted and there is an error on the replacement claim, MassHealth will recoup the original payment and deny the replacement claim. Please resubmit the claim correcting the error listed on the RA.

-Top-

### Locating MassHealth Forms Online

MassHealth has been answering many queries about where to find certain required forms on the Web site. Forms applicable to all provider types as well as provider-specific forms may be downloaded at www.mass.gov/masshealth by clicking the MassHealth Provider Forms link on the right side of the home page, in the panel called Publications. Forms are listed alphabetically by provider type.

-Top-

### Nursing Facilities and Residential Care Facilities: Casemix and Management Minute Questionnaires (MMQs)

When creating a "discharge" record in NewMMIS, the system automatically carries over the MMQ category submitted to MassHealth on the most recent MMQ transaction. Please note that the category does not affect the discharge record.

- NewMMIS will reject an MMQ that has remained in pending status for three months. You will be required to send a new MMQ at that time.

- The 2010 ICD-9 codes have been in effect since 10/01/09 and should be used on all MMQ submissions. The ICD-9 codes included on the MMQ are used for statistical tracking purposes.

- New audited casemix scores are posted to NewMMIS within a month of a facility visit from an audit nurse. Please refer to these casemix scores for correct billing rates.

- It is not possible to populate facility information via a DDE MMQ submission.

- There is no longer a separate claim-processing period designated solely for nursing facilities.

- Since NewMMIS automatically deducts any patient-paid amounts (PPAs), providers should not include the PPA on their adjusted claims submissions.
-Top-

## Banner Message Announcements

*The messages listed below appeared on weekly remittance advices (RAs) as applicable to the services you provide as a MassHealth provider, since Update's last publication (November/ December). Messages can be accessed and downloaded from the Provider Library at* www.mass.gov/masshealthpubs. *Click on Provider Library, then on Remittance Advice Message Text.*
-Top-

### All Providers: Please remember to check View Broadcast Messages in the POSC

It is important that you make it a part of your routine to check Broadcast Messages daily for any critical information or communications that MassHealth has posted. POSC Broadcast Messages are one of the primary methods MassHealth uses to communicate timely updates to providers. To access Broadcast Messages, sign on to the POSC, click on Manage Correspondence and Reporting, and then click on View Broadcast Messages.
-Top-

### Pharmacy Providers: Claims for Secondary Payment for Medicare Part B Covered Items

Pharmacy providers are reminded that, effective July 1, 2009, any claim for a Medicare-B covered drug, durable medical equipment, or medical supply that is payable through the Pharmacy Online Processing System (POPS), for when MassHealth is being billed as the secondary payer and Medicare B is the primary payer, must be processed through POPS. For

more information, go to www.mass.gov/masshealth/pharmacy, click on the Pharmacy Facts link, then on Pharmacy Facts 2009, then on Pharmacy Facts 50 [05/06/09], or call ACS at 1-866-246-8503.
-Top-

## Chronic Disease and Rehabilitation Outpatient Hospital Providers: National Drug Code Requirement on Chronic Disease and Rehabilitation Outpatient Claims

Effective September 15, 2008, MassHealth implemented a change requiring national drug code (NDC) units and appropriate descriptors on all outpatient claims for drugs billed with a Healthcare Common Procedure Coding System (HCPCS) Level II code. This requirement also applies to Medicare crossover claims. MassHealth reviews all outpatient and crossover claims for compliance with this requirement. Claims that do not have this information will be denied, or subject to recoupment. For additional information, please refer to MassHealth Chronic Disease and Rehabilitation Outpatient Hospital Bulletin 4, dated August 2008, in the Provider Library at www.mass.gov/masshealthpubs.
-Top-

## Home Health Agency and Nursing Providers: Prior-Authorization (PA) Numbers No Longer Required on Claims Submissions for Service Codes T1002 - T1003

Providers submitting claims for continuous skilled nursing services, single-rate night shift, and single-rate weekends (T1002 UJ and T1003 UJ) are no longer required to include a PA number, as instructed in a previous remittance advice (RA). Claims containing Service Codes T1002, T1002 UJ, T1003, and T1003 UJ may now be submitted with or without a PA number as NewMMIS is able to properly process the claims without this information.
-Top-

## Hospice Billing Tips

MassHealth has posted the Hospice Billing Tips for Paper Claims, EDI Transactions, and DDE Claim Submissions. This listing instructs providers on how to submit claims via those avenues. Some of the tips include dates-of-service billing guidelines, required line and field entries, and related resources. To access the Hospice Billing Tips from the MassHealth Web site, click on the Information for MassHealth Providers link, then on MassHealth Customer Service for Providers, then on Billing Information, and finally on Billing Tips.
-Top-

## All Providers with the Exception of Dental Providers: Taxonomy Code Usage

Taxonomy codes identify the type of services or specialty that a health care provider offers to patients. Providers should submit claims with a taxonomy code only when MassHealth has specifically directed them to do so. Submission of a taxonomy code when not required or submission of an incorrect taxonomy code could result in claim denials. A taxonomy code is sometimes needed to correctly crosswalk an NPI to a NewMMIS provider ID/service location

(PID SL) when a provider has one NPI with multiple PID SLs. If a taxonomy code is needed, MassHealth will assign the taxonomy code and notify the provider.

-Top-

## Recently Published Bulletins and Transmittal Letters

*The messages below have been excerpted from bulletins and transmittal letters that have been published since Update's last publication (November/December). For more information or to access and download other bulletins and transmittal letters from the Provider Library, go to* www.mass.gov/masshealthpubs.

- **TL CHC-86 (community health centers) and TL-MHC-40 (mental health centers)** contain billing instructions for claims submitted for dually entitled (Medicare/MassHealth) members receiving behavioral-health services provided by clinicians who are not Medicare-certified providers. Clinicians who do not meet Medicare's clinical criteria are considered "noncertified" and are ineligible to bill Medicare for their services, effective October 1, 2009.

- **TL ADH-24 (adult day health providers)** communicates revised service codes and modifiers. These revisions include changes to per-diem service codes for attending the adult day health program for a full day (six hours or more). In addition, it includes a second set of billing codes, delineated by 15-minute increments, that ADH providers must use for members attending the adult day health program for less than six hours per day, effective November 15, 2009.

- **TL ALL-174** announces changes to directory contact information for purchasing ICD-9-CM, CPT, and HCPCS code books. Purchases should now be made through the following venues.

| Old address | New address |
|---|---|
| Ingenix | Ingenix |
| 13931 Willard Road | www.shopingenix.com |
| Chantilly, VA 20151 | |
| 800-765-6588 (tel.); 801-536-1009 (fax) | |

| Old address | New address |
|---|---|
| American Medical Association | American Medical Association's Unified |
| Order Department | Service Center |
| P.O. Box 930876 | 1-800-621-8335 |
| Atlanta, GA 31193-0876 | www.amabookstore.com |
| 800-771-7199 (tel.); 863-582-6845 (fax) | |

- **TL ALL-175** explicitly establishes an administrative review process for disputes concerning MassHealth pay-for-performance payment amounts for acute hospitals, managed care organizations (MCOs), primary care clinicians (PCCs), and prepaid inpatient health plans (PIHPs). These amendments are effective January 1, 2010. The regulation provides that, if the provider properly follows the regulation's provisions, MassHealth will conduct a review of the contested pay-for-performance payment amounts and issue a final written determination. The provider may appeal this decision to the Office of Medicaid Board of Hearings. If the outlined procedures are not followed and administrative remedies are not exhausted first, the provider loses the right to an adjudicatory hearing or judicial review.

-Top-