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Update

MassHealth

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. Becoming better educated about the functionalities and resources that MassHealth makes available to providers should help reduce the risk of claims denials. 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 takes precedence.

General Provider Notices

Medicare Crossover Claims

In Legacy MMIS, MassHealth processed only Medicare-paid service lines. In the New Medicaid Management Information System (MMIS), if Medicare made a payment on the claim, the entire crossover claim is processed, including the Medicare-denied service lines. MassHealth has been alerted to a problem affecting Medicare Part B Physician Crossovers. The issue affects claims submitted to Medicare that contain at least two detail lines, where one of the lines is 100% Medicare reimbursable and other lines are for services on which the Medicare Part B deductible is applied or coinsurance is owed. Medicare processes the claim as if the claim were 100% paid, and is excluded from the crossover process. Affected claims would have been processed by Medicare between January 4 and February 11, 2010. Medicare has stated that the affected claims will not be sent in the crossover files. Providers should submit these claims directly to MassHealth. Medicare implemented a fix to correct this issue on February 12, 2010. Please review your MassHealth remittance advice before submitting any Medicare-denied service lines to MassHealth.

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Taxonomy Code Usage

A taxonomy code is sometimes needed to correctly crosswalk a provider's national provider identifier (NPI) number to a NewMMIS provider ID/service location (PID/SL) when a provider has one NPI with multiple PID/SL numbers. If a taxonomy code is needed, MassHealth will assign the taxonomy code and notify the provider. 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 a different taxonomy code, could result in claim denials. If you have a question about whether a taxonomy code is needed for billing, please contact MassHealth's Electronic Data Interchange (EDI) department at 1-800-841-2900 and select option 1, then option 8, and then option 3.

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Referrals—Some Tips for Smoother Submissions

If you receive the error message, "Provider must be in a valid pay status on the date of submission" when submitting a referral on the Provider Online Service Center (POSC), you may be selecting an inactive servicing provider when performing a system search. To locate the correct servicing provider, enter the servicing provider's NPI. Also, be sure to confirm the provider's name and address if more than one provider is linked to the same NPI. As a last tip, please remember to submit a referral under the PID/SL of the provider who is billing the claim. This would generally be a group practice or hospital.

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Eligibility

Be sure to check member eligibility, coverage type, managed care, and Primary Care Clinician (PCC) status before providing services to ensure that you will receive payment for services that you intend to bill on claims that you submit to MassHealth. The Eligibility Verification System (EVS) is available 24 hours a day, seven days a week, except Sunday from 3 A.M. to 6 A.M., via the POSC by clicking on the Manage Members link, then on Eligibility.

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Final Deadline Appeal Submission Requirements

Providers are reminded to submit the MassHealth remittance advice (RA) that reflects error code 0853 (Final Deadline Exceeded - Detail) or 0855 (Final Deadline Exceeded - Header) as evidence of the "final deadline exceeded" denial along with the claim form when filing a Final Deadline Appeal. Prints of claim status or other documentation are not acceptable in lieu of the RA. For more information about final deadline appeal submission requirements, refer to All Provider Bulletin 186, dated April 2009. You can download the bulletin from the Provider Library at www.mass.gov/masshealthpubs.

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POSC

POSC Password and Login

The resolution to an "Invalid Login" message in the POSC or Virtual Gateway may be as simple as needing to reset your password. This message is used as a security measure.

The POSC offers job aids and e-learning courses to assist you in your password and login queries. If you have login or security questions, visit the NewMMIS Web site at www.mass.gov/masshealth/newmmis, then click on the Need Additional Information or Training link, then on Get Trained. Two links provide detailed instruction with these processes, as follows.

Under the POSC E-Learning Courses and Job Aids header, click on either:

- * MassHealth E-Learning Log on Tips; or
- * Provider Information and Navigation under the subheader An Introduction: Provider Information and Navigation.

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Slight Change to Some NewMMIS POSC and Virtual Gateway Screens

Effective February 1, 2010, the Virtual Gateway (VG) and NewMMIS POSC screens you use to log in and create new IDs were given a slightly different look. The SSN field on both systems' screens is now called PIN (personal identification number). However, only the title was changed: it's the same field, and the steps to log in and access your services remain the same. You do not need to change any information that you previously elected for this field. The system will recognize the data that you provided before. Requesting a PIN rather than SSN provides more choices and more security for our users.

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Notices About MassHealth Forms

Locating MassHealth Forms Online

MassHealth has been answering many queries about where to find certain required forms on the Web site. Many of the functions that you may need to perform involving MassHealth forms can be conducted online via the POSC. One of the more common updates that you can easily complete online is to change your mailing address. The NewMMIS job aid, Update Provider Profile, provides helpful instruction on updating your address online via the POSC. You can access the job aid via www.mass.gov/masshealth/newmmis. Click on Need Additional Information or Training, and then on Get Trained. The job aid is located in the Update a Provider Profile link under the Provider Profile Maintenance header. If you are changing your legal entity or check-mailing address, you must send the Change of Address Form along with a W-9 form with your original signature to: MassHealth, P.O. Box 9118, Hingham, MA 02043.

Commonly requested forms, both provider-specific as well as forms applicable to all providers (like the W-9), 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.

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Submitting Adjustments to Paid Claims on the UB-04 Form

MassHealth would like to remind providers of the proper way to request an adjustment to paid claims on the UB-04 paper claim form. When adjusting an institutional claim, the Type of Bill (TOB) frequency code is 7 (Replacement of Prior Claim). The fourth digit of the TOB defines

the frequency of the claim. Enter an A followed by the 13-character internal control number (ICN) assigned to the paid claim in Field 64A (Document Control Number). The ICN appears on the remittance advice on which the original claim was paid. When submitting an adjustment, include all lines that were on the original claim. Correct the line that needs to be adjusted.

Another important reminder about the UB-04 form and proper claims-submissions actions pertains to correct entering of the national provider identifier (NPI). Please be sure to enter the NPI in Field 56 (NPI). MassHealth has noticed that claims are being submitted with the NPI, taxonomy, and other unidentified numbers entered in Field 57A (Other Prv.). Entering incorrect or invalid information in Field 57A will cause your claims to be denied. Field 57A is used by atypical providers who do not have an NPI to enter their PID/SL. If applicable, this field is also used to report other provider identifiers assigned by other health plan payers for TPL and paper crossover claims. Subchapter 5, Part 6 of your MassHealth provider manual gives detailed billing instructions on claim status and correction. For more information about how to complete claim forms, refer to the MassHealth Billing Guides. The billing guides can be found in the Provider Library at www.mass.gov/masshealthpubs. Using these resources will help ensure that your claims process correctly.

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NPI and Paper Claims Submissions (CMS-1500 Form)

When submitting paper claims on the CMS-1500 form, please be sure to enter the NPI in Field 33a (NPI). It has been brought to the attention of MassHealth that claims are being submitted with the NPI, taxonomy, and other unidentified numbers entered in Field 33b (Other ID No.). Entering your NPI or any incorrect or invalid information in Field 33b will cause your claims to be denied. Field 33b is used by atypical providers who do not have an NPI. You should enter the qualifier ID, followed by the PID/SL, in Field 33b. If applicable, this field is also used when the provider has an NPI and is providing taxonomy information. In this case, you should enter the qualifier ZZ followed by the taxonomy code in Field 33b. For more information about how to properly enter your NPI on a CMS-1500 claim form, please refer to the Billing Guide for the CMS-1500. The billing guides can be found in the Provider Library at www.mass.gov/masshealthpubs.

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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.

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Vision Care Materials Order Form (VIS-1)

The VIS-1 form is now available online. Go to www.mass.gov/masshealth and click on the MassHealth Provider Forms link in the Publications panel on the right side of the home page. Forms are listed alphabetically by provider type. This new online format allows providers

to enter data into certain fields (including requesting provider contact information) before printing. Providers are urged to use this new feature when making numerous copies of partially completed VIS-1 forms.

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Data Collection Form

The information you provide to MassHealth about your business and services on the Data Collection Form enables MassHealth Customer Service to contact you for agency-related functions. MassHealth encourages you to take care when completing the Data Collection Forms. Make sure you do not leave out any critical communication information, such as e-mail address or DOB. In addition, please make sure to contact MassHealth Customer Service (1-800-841-2900) if any of the information on the form changes (such as your phone number). Keeping this information current ensures that MassHealth will be able to reach you when necessary.

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Third-Party-Liability (TPL) Cover Letters Are No Longer Required or Accepted by MassHealth

NewMMIS functionality allows MassHealth to edit for other insurance by service code, modifier, place of service, and other claim information. If the service is sometimes covered by the other insurer depending upon the patient's status (for example, home-bound skilled level of care), please refer to your provider manual appendix for "Supplemental Instructions for TPL Exceptions." For questions, please contact MassHealth Customer Service at 1-800-841-2900.

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Nursing Facility Screening Clinical Eligibility Determination for Medicare Coinsurance and Deductibles

Eligibility Operations Memo (EOM) 09-19 (December 1, 2009) communicates Medicare coverage stipulations when a nursing facility (clinical assessment and determination) is needed for determining eligibility for MassHealth nursing facility services. The memo also describes instances when dually eligible members, and individuals on Medicare only, must follow instructions to submit required forms. When an individual with Medicare enters a nursing facility from a hospital, up to 100 days of coverage are available to the individual as long as it is medically necessary. The first 20 days of the stay are covered in full by Medicare, and then a coinsurance payment is required for days 21 through 100 if the member remains clinically eligible.

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Inpatient Hospital Notices

Inpatient Chronic Hospitals Preadmission Screening (PAS) Policy

As a reminder, since May 18, 2009, inpatient chronic hospitals have been required to include a PAS number on all claims submitted to NewMMIS.

For additional information about PAS requirements for inpatient chronic hospitals, refer to 130 CMR 435.408 through 435.410 in the *Chronic Disease and Rehabilitation Inpatient Hospital Manual*.

MassHealth encourages providers to submit PAS requests online through the POSC, instead of using the telephone, fax, or mail. PAS forms can be downloaded from the MassHealth Web site at www.mass.gov/masshealth. Simply complete them on your computer, print, and then fax or mail them.

If you have questions or require further instruction, several preadmission screening job aids have been posted to the Web site at www.mass.gov/masshealth/newmmis. Click on Need Additional Information or Training, then on Get Trained.

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Acute Inpatient Hospitals

Please note that when submitting claims for members who are enrolled in a managed care organization (MCO) and who have exhausted their hospitalization limit, you must include a copy of the MCO explanation of benefits (EOB) as an attachment. MassHealth encourages you to submit your claims and attachments electronically using the direct-data-entry (DDE) functionality through the POSC.

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Physician Notice

Special Reimbursement Rules for Multiple Endoscopic Procedures

CMS uses special reimbursement rules for multiple endoscopic procedures performed for the same patient on the same day during the same session. MassHealth also applies this same payment methodology for the same endoscopic procedures. Multiple endoscopic claims are processed based on the fact that all endoscopies include a diagnostic endoscopy. Endoscopies are grouped into families of codes, each of which includes a code for a diagnostic endoscopy (referred to as the base code). Since the relative value of each endoscopy code includes the value of the base code, MassHealth will reimburse the value of the diagnostic endoscopy only once. The endoscopic procedure with the highest relative fee schedule amount is reimbursed at 100% of the allowable amount. The allowable amount for the base procedure is then subtracted from the allowable amount of the remaining endoscopic procedures billed. When two related endoscopies and an unrelated endoscopy are performed, the special endoscopic payment rules will apply to the related endoscopies. Unrelated endoscopic procedures will be treated as a separate surgery and reimbursed using the payment rules for multiple surgery claims. If you have questions, refer to Transmittal Letter PHY-127 (October 2009).

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Personal Care Management (PCM) Agencies Notice

Claims Submissions

Personal care management (PCM) agencies are reminded that claims submitted by PCM agencies for Service Code T2022 (skills training) must not include a prior authorization (PA) number. PA is not required for any of the service codes used by PCM agencies. However, PCM agencies must ensure that the member has obtained PA from MassHealth for personal care services (T1019) before submitting a claim with Service Code T2022. If you have questions about these instructions, please refer to Subchapter 6 of the Personal Care Manual. To access the manual, go to www.mass.gov/masshealthpubs. Click on Provider Library, then choose MassHealth Provider Manuals.

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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 Remittance Advice Message Text.

General Provider Notice

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.

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Acute Inpatient Hospital Notices

Acute Inpatient Elective Admissions Time Frame for PAS Requests

For PAS requests for elective inpatient acute hospital admissions, see the regulations at 130 CMR 450.208(A)(1). These regulations state that providers must submit requests for admission screening at least seven days before a proposed elective admission. It has been brought to the attention of MassHealth that approximately a third of the PAS requests submitted to Permedion, the MassHealth acute hospital Utilization Management Program (UMP) contractor, do not meet the time frame stated in MassHealth regulations. Although Permedion will try to accommodate PAS exceptions, you may be asked to reschedule the admission if your request does not fall within the required MassHealth time frame.

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PAS Requests and PA Requests: *There's a Difference*

Acute inpatient hospitals and physician providers are reminded that admission screening, also known as preadmission screening (PAS), must be obtained for all elective acute inpatient hospital admissions. The PAS requirements are in addition to any PA requirements that might apply. PAS does not waive or replace any other MassHealth requirements, including PA. A specific procedure or treatment may separately require PA. Therefore, for an elective acute inpatient hospital admission, a member will always need a PAS and may also need an additional PA for a specific treatment or procedure performed during the admission. MassHealth Acute Inpatient Hospital Bulletin 137 (dated September 2009) addresses both PAS and PA. Related MassHealth regulations may be found in the Provider Library at www.mass.gov/masshealthpubs as described below.

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For MassHealth Regulations related to PAS

- * Click on MassHealth Provider Regulations, then click on the Acute Inpatient Hospital link under the Current MassHealth Regulations header, and locate 130 CMR 415.405 (Utilization Management Program) and 415.414 (Utilization Review).
- * Click on MassHealth Provider Regulations, then click on the All Provider link under the Current MassHealth Regulations header, and locate 130 CMR 450.207 (Utilization Management Program for Acute Inpatient Hospitals) and 130 CMR 450.208 (Utilization Management: Admission Screening for Acute Inpatient Hospitals).
- * PAS regulations can also be accessed from the MassHealth Provider Manual link in the Provider Library.

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For MassHealth Regulations related to PA

- * Click on MassHealth Provider Regulations, then click on the Physician link under the Current MassHealth Regulations header, and locate 130 CMR 433.408 (Prior Authorization).
- * Click on MassHealth Provider Regulations, then click on the All Provider link, under the Current MassHealth Regulations header, and locate 130 CMR 450.303 (Prior Authorization)
- * PA regulations can also be accessed from the MassHealth Provider Manual link in the Provider Library. To view related regulations, click on Physician Manual. Locate Subchapter 5, Administrative and Billing Instructions, Part 2—Prior Authorization. In addition, Subchapter 6, PHY Service Codes, lists the codes for services that require PA.

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Acute Inpatient Elective Admissions Contractor

As MassHealth informed you in earlier remittance advices (RAs), Permedion assumed operations as the MassHealth acute hospital UMP contractor on 11/2/2009. Masspro continues to be the contractor for the chronic/rehab Utilization Management Program. Acute hospital PAS requests

faxed to Masspro will not be processed. Documentation to support the need for the acute elective inpatient admission must be supplied at the time of the request for PAS. Please submit PAS and documentation to Permedion via the POSC, phone, or fax.

1-877-735-7416 (Permedion Phone)

1-877-735-7415 (Permedion Fax)

Permedion
HMS Government Services
510 Rutherford Ave.
Charlestown, MA 02129

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Hospice Providers Notice

Hospice Out-of-County Billing

When submitting a DDE claim for services provided to out-of-county eligible members, the out-of-county information must be submitted as an attachment with the DDE claim. Attachments can be submitted along with your claims, using DDE.

For out-of-county electronic data interchange (EDI) claims in Loop 2300, enter the Note Code in Segment NTE01 and the Free Form Description in Segment NTE02. Refer to the HIPAA Implementation Guide for the 837I transaction for detailed instructions. For out-of-county paper claims, the provider must indicate in Field 80 (Remarks) the county where the hospice service was furnished. For more information on submitting paper claims for out-of-county services, please refer to the UB-04 Billing Guide, located in the Provider Library at www.mass.gov/masshealthpubs. Click on MassHealth Billing Guides for Paper Claim Submitters.

All out-of-county claims, regardless of submission type, must include the modifier TN (rural/out of service area) and will be suspended for manual pricing.

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Pharmacy Providers Notice

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 (May 6, 2009), or call ACS at 1-866-246-8503.

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Chronic Disease and Rehabilitation Outpatient Providers Notice

NDC 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.

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Home Health Agency and Independent Nurse Notice

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 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.

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Recently Published Bulletins and Transmittal Letters

The following messages have been excerpted from bulletins and transmittal letters (TLs) 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.

- **All Provider Bulletin 199** (Dec. 2009): **Elimination of Full Paper Mailing of Bulletins and Transmittal Letters (TLs)** communicates MassHealth's decision to discontinue automatically mailing paper copies of bulletins and TLs to providers starting in February, but to continue to notify providers by e-mail or postcard when a bulletin or TL has been posted on the MassHealth Web site. 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 publication 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. For more information about this change, refer to the following publications.

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- ◇ **All Provider Bulletin 201** (Feb. 2010) communicates changes that allow providers to use the new Carrier Code Request Form to report a commercial health insurance carrier that is not currently on the carrier code list in Appendix C of every MassHealth provider manual. Completed forms should be faxed to 617-886-8134. The new carrier code is available for use in NewMMIS immediately.
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- ◇ **All Provider Bulletin 202** (Feb. 2010) communicates information about the Credit Balance Overpayment Policy and administrative fines for failure to return credit balances within 60 days of receipt. The bulletin also informs providers that until March 31, 2010, MassHealth would waive its right to impose administrative fines on credit balances not timely returned, and included a Credit Balance Response Form to be used by providers to identify such credit balances.
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- ◇ **Community Health Center Bulletin 64, Durable Medical Equipment Bulletin 16, and Physician Bulletin 88** (Jan. 2010) clarify the coverage of certain enternal-nutrition products for MassHealth members who may also be eligible for these products (also referred to as regular and special formulas) when provided by the Department of Public Health's (MDPH's) Women, Infants and Children (WIC) Nutrition Program. The bulletin describes members who may qualify for the WIC Program to include pregnant, postpartum, and breastfeeding women, infants, and children under the age of five, and details both WIC and MassHealth coverage guidelines. In addition, PA documentation requirements are described.
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- ◇ **All Provider Bulletin 200: Federal Medical Integrity Provider Audits** (Jan. 2010) discusses the CMS national program under which federal contractors, called Audit Medicaid Integrity Contractors (Audit MICs), will perform field and desk audits in order to identify any overpayments. IPRO has been awarded an Audit MIC contract to conduct audits in Massachusetts, beginning in February 2010, and continuing through the next five years. Providers are selected for audits based on data analysis by other CMS contractors, or on a referral from MassHealth. Those providers selected for an audit will receive a notification letter from IPRO. The bulletin further communicates the purpose of the IPRO audit; which providers will be subject to audit; what a provider should do if it receives a notification letter that it has been selected for audit; the process that will follow the completion of the audit; and additional resources for more information regarding the program.
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- ◇ **All Provider Bulletin 198** (Dec. 2009) communicates expiration details and reset instructions for passwords to the EVS. It also provides information about the November EVSpC upgrade. Providers should have upgraded their installed versions of EVSpC and EVScall software to Version 4.10, following instructions located in the *MassHealth EVSpC Version 4.10 Software Upgrade Guide* located at C:\Program Files\EVSpC.
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- ◇ **School-Based Medicaid Bulletin 18** (Nov. 2009) communicates additional information on the requirements of the School-Based Medicaid program to include:
 - * TPA and school-based Medicaid program provider execution requirements;

- * clarification on documentation requirements for per-unit service claim submission and updates to that coding;
- * updates on personal care services;
- * details on written requests for service agreements; and
- * clarification of the definition of “unit.”

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- ◇ **TL PIH-18 and TL NF-55** (Dec. 2009) communicate revised billing instructions for **psychiatric inpatient hospitals** and **nursing facilities** submitting 837I transactions, paper claims, and DDE claims for members who have Medicare or commercial insurance, or who were on medical leave of absence (MLOA), and whose services are determined to be not covered by the primary insurer. These revisions are effective December 15, 2009. In addition, the revised appendix lists exceptions that need to be considered when billing MassHealth, Medicare, or commercial insurance, explaining the need for providers to make diligent efforts to obtain payment from other resources and to bill MassHealth as the payer of last resort.

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- ◇ **TL AOH-24** (Feb. 2010) communicates revisions to the service codes in Subchapter 6 of the *Acute Outpatient Hospital Manual* to include deletions, additions, and updates of the payable HCPCS codes effective on or after Jan. 1, 2010. The TL also indicates updated billing information for acute outpatient hospitals (AOHs), including their hospital-licensed health centers and other provider-based satellites.

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- ◇ **TL CDR-25: Chronic Disease and Rehabilitation Inpatient Hospital Manual** (Feb. 2010) communicates a revised set of billing instructions for submitting 837I transactions, paper claims, and DDE claims for members who have Medicare or commercial insurance, and whose services are determined not covered by the primary insurer effective February 1, 2010.

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- ◇ **TL DEN-83** (Jan. 2010) communicates revisions to the MassHealth dental regulations and service codes and descriptions, effective for dates of service on or after October 1, 2009. Under the revisions, MassHealth will pay dental providers for a visit to a nursing facility once per member per day, in addition to the actual services performed. Subchapter 6 revisions include clarifying billing procedures for oral and maxillofacial surgeons using Current Procedural Terminology (CPT) codes, and adding service code D9410—“house/extended care facility visit to a nursing facility.” To download these publications from the Provider Library, go to www.mass.gov/masshealthpubs.

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- ◇ **TL All-177: Overpayments Determined by Another Agency** (Jan. 2010) communicates amendments to the MassHealth administrative and billing regulations about overpayments. The amended regulations state that where an overpayment amount is based on a determination by a federal or state agency (other than MassHealth), a provider may contest only the factual assertion that the federal or state agency made such a determination and not the amount or basis for such determination. The revisions are effective February 15, 2010.

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- ◇ **TL CHC-87/TL PHY-128/TL FPA-44: 2010 HCPCS** (Jan. 2010) communicate revisions to the service codes and descriptions in Subchapter 6 of the *Community Health Center Manual*, the *Physician Manual*, and the *Family Planning Agency Manual* (respectively), effective for dates of service on or after January 1, 2010. A CHC provider or a physician (respectively) may request PA for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5), for a MassHealth Standard or CommonHealth member younger than 21 years of age, even if it is not designated as covered or payable in the *Community Health Center Manual*, *Physician Manual*, or *Family Planning Agency Manual* (respectively).
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- ◇ **TL LAB-34** (Jan. 2010)/ **TL IDTF-8** (Feb. 2010) communicate revisions to the service codes in the *Independent Clinical Laboratory Manual* and the *Independent Diagnostic Testing Facility Manual*, respectively. CMS has revised HCPCS for 2010, effective January 1, 2010.
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And for your members...

This column communicates information about MassHealth offerings that your members might enjoy. MassHealth encourages you to share this information with enrolled members in hopes that knowledge of these resources will enhance their overall MassHealth experience. To download a copy of the following announcements, go to www.mass.gov/masshealth, click on MassHealth Regulations and Other Publications, then on Member Eligibility Library. The Web page includes instructions and a sign-up link to automatically receive e-mail notification of published eligibility operations memos (EOMs).

- **EOM 09-21: Change to the Asset Limit for MassHealth Senior Buy-In and MassHealth Buy-In Applicants and Members** (Dec. 15, 2009). Effective January 1, 2010, the asset limit for MassHealth Senior Buy-In (QMB), MassHealth Buy-In for Specified Low Income Medicare Beneficiaries (SLMBs), and MassHealth Buy-In for Qualifying Individuals (QIs), will be increased to the following amounts:
 - ◇ individual—\$6,600; and
 - ◇ couple—\$9,910.

MassHealth regulations at 130 CMR 519.010 and 519.011 are being revised to update these figures. For more information, you can download a copy of EOM 09-21.
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- **MassHealth and the Health Care Reform – Individual Mandate Requirement for 2009** EOM 10-02 (Jan. 1, 2010) communicates additional 2009 Massachusetts tax filing requirements that will affect MassHealth members. As in 2008, taxpayers must demonstrate that they had health insurance for each month in 2009 if it is affordable for them. To avoid penalties, the taxpayer's health insurance must meet the required minimum creditable coverage (MCC) as set by the Commonwealth Health Insurance Connector Authority (Health Connector). Taxpayers are required to complete Schedule HC ("health care") when filing their personal Massachusetts

income taxes. MassHealth has issued Form MA 1099-HC to required members as assistance in completing the schedule.

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- **Requirement for State Children's Health Insurance Program (SCHIP) Members to Verify Citizenship and Identity** EOM 10-01 (Jan. 1, 2010) communicates changes effective January 1, 2010, that require children under age 19 with family gross income between 150% and 300% of the federal poverty level (FPL) to verify citizenship and identity. Children born to MassHealth-eligible women, members receiving Health Safety Net (HSN), and undocumented members will continue to be exempt from citizenship and identity verification requirements.

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- **Medex Premium Rate Increase** EOM 09-20 (Dec. 15, 2009) announces the addition of two new plans being offered this year, Basic without Prescription Coverage and Core Plus without Prescription Coverage. The EOM describes the Medex plans, PACES codes, old and new quarterly rates, and new monthly premiums. The new monthly premium is the amount allowed as a patient-paid amount (PPA) deduction after other deductions that get priority under MassHealth regulations at 130 CMR 520.026. Fees for special billing arrangements that cause a premium to exceed these amounts are not allowable PPA deductions.

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- **Revisions to Regulations about MassHealth Family Assistance** Eligibility Letter (EL) 193 (Dec. 1, 2009) communicates revisions to regulations about benefits for certain MassHealth Family Assistance members to include: dental services as described in 130 CMR 420.000, which are now available to children under age 19 who are eligible for Family Assistance premium assistance payments, effective October 1, 2009. Transmittal Letter (TL) ALL-176: Dental Benefits for Certain MassHealth Members also describes these changes.

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