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A Newsletter for MassHealth Providers

Update

Improvements at EOHHS

Louis Gutierrez, chief information officer for the Executive Office of Health and Human Services (EOHHS), recently provided an update on the commonwealth's virtual gateway initiative to attendees of the Massachusetts League of Community Health Centers annual conference.

Gutierrez explained that Governor Romney signaled a new approach last year when he announced the creation of an on-line, Internet-accessible virtual gateway as part of the reorganization of EOHHS. This initiative, Gutierrez stated, will make it easier for the public and service providers to access health and human services programs.

The first phase of the initiative will consist of an on-line health and human service catalog, eligibility-screening tool, and a common intake data collection tool for seven EOHHS programs. The catalog and eligibility-screening tool will be available first. The common intake data collection tool is intended for service providers and will be rolled out to provider organizations over time.

Additional on-line tools and EOHHS programs, including service tracking and electronic payment for certain programs, will be added in the future. For more information, about the virtual gateway, visit www.mahealthweb.com/vg.htm.

Prior Authorization for Therapy Services

Effective April 15, 2004, new regulations require providers to obtain prior authorization (PA) from MassHealth before providing more than eight physical therapy visits, eight occupational therapy visits, or 15 speech/language visits to a member within a 12-month period, beginning with the first visit provided on or after April 15, 2004. There is an exception for members who have received PA for therapy before April 15, 2004. For these members, the counting of visits will begin after the visits authorized under the PA have been exhausted or when the PA expires, whichever is sooner.

Providers affected by this regulatory change are: home health agencies, outpatient hospitals (acute and chronic), physicians, rehabilitation centers, speech and hearing centers, and therapists.

These requirements affect MassHealth members of all ages, including children. All members, regardless of age, will be covered for any additional therapy services that are determined to be medically necessary through the PA process.

Please note that MassHealth health plans, BMC HealthNet Plan, Fallon, Network Health, and NHP may have prior-authorization policies that differ from the policy described above. MassHealth members enrolled in these health plans are subject to the prior-authorization policies of their health plan. To learn more about the regulation changes, please visit the provider Web site at www.mahealthweb.com.

Correcting Error 503

The EOB cannot be altered.

Error 503 indicates that there is a discrepancy between the explanation of benefits (EOB) from the other insurer and the MassHealth claim, or in other information from the primary payer. (Note: On the HIPAA-compliant 835 remittance advice transaction, this denial will be reflected as an adjustment reason code "A1" and remarks code "MA92.")

If your claim has been denied with error 503, you should review the MassHealth claim and EOB from the other insurance company, along with information in the following list. Once the discrepancy or problem has been identified, either correct the claim, or obtain a corrected EOB, as needed, and resubmit the claim to MassHealth. Consult Part 5.6 of your MassHealth billing instructions for information on how to correct claims.

The following is a list of the most common reasons a claim might be denied with error 503. For a complete list of the reasons that a claim may be denied with error 503, visit the provider Web site at www.mahealthweb.com. Click on "Billing Assistance," then "Billing Tips," then "Correcting Error 503."

Once the discrepancy or problem has been identified, either correct the claim, or obtain a corrected EOB, as needed, and resubmit the claim to MassHealth.

- The EOB has been altered.
- Crossover claims must have a HCFA-1500 claim form attached.
- The dates of service on the claim do not match those on the EOB.
- The denial/benefits exhausted letter must be dated within the same calendar year as the dates of service on the claim.
- The EOB print is cut off or is missing information.
- The member name on the claim and the EOB do not match.
- The provider name on the claim and the EOB do not match.
- The other paid amount on the claim is less than the paid amount shown on the EOB.
- The paid amount from the EOB is not in the correct field on the claim or is missing.
- The reason for the denial is not listed on the EOB.
- The total charge on the claim is higher than the total charge on the EOB.
- The description of the service on the claim does not match the description on the EOB.

On the HIPAA-compliant 835 remittance advice transaction, this denial will be reflected as an adjustment reason code "A1" and remarks code "MA92."

For additional assistance, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

MassHealth Reminders

Void and Replacement Transactions

Claim adjustments can be submitted electronically in the HIPAA-compliant 837 format using the "Void and Replace" transaction, which is used to correct previously paid claims. (Replacement transactions are not meant to be used for resubmitting denied claims.) If your software includes the ability to submit void and replace transactions, you must contact the MassHealth HIPAA Support Center to test this capability before submitting void and replace transactions. Submit the claim line that you want adjusted as a void (frequency code 8). This claim line should be submitted exactly as when the claim was paid.

Consult the applicable MassHealth 837 companion guide located at www.mahealthweb.com.

In the same file, submit the claim line again as a replacement claim (frequency code 7). The replacement claim should be the corrected claim line, and should include the full amount requested, not the difference between what was paid previously and what you are expecting now. This procedure can be used to change any field on the claim, except for changes to the member ID number, pay-to provider number, or invoice type. We recommend that you share this information with your software vendor or electronic billing intermediary. For additional information, consult the applicable MassHealth 837 companion guide located at www.mahealthweb.com.

Transition to a New Accounting System

Due to the transition to a new accounting system, some MassHealth payments are being split into two payments for a single pay cycle. The transition period is for all pay cycles from July 1, 2004, through August 31, 2004. If you receive payments by check, you may receive two checks, or if you receive payment by EFT, you may receive two EFT deposits for a single pay cycle. For additional information, visit our Provider Web site at: www.mahealthweb.com.

For questions about HIPAA, call the MassHealth HIPAA Support Center at 1-888-848-5068.

Prior Authorization and PCC Referrals

When submitting claims using the HIPAA-compliant 837 format and billing for a service where prior authorization (PA) is required, you must enter "G1" in the REF01 segment of loop 2300 and the 6-digit PA number in the REF02 segment. If the member is enrolled in the Primary Care Clinician (PCC) Plan, you must enter "9F" in the REF01 segment of loop 2300 and the 7-digit referral number in the REF02 segment.

For providers submitting claims in the MassHealth proprietary EMC format, enter the 6-digit PA number in record 40, line A, positions 28 through 45 (left-justified with trailing spaces). The 7-digit PCC referral number should be entered in record 40, line B, positions 46 through 63 (left-justified with trailing spaces). Incorrect information entered in these segments will result in a denied claim.

We recommend that you share this information with your software vendor or electronic billing intermediary.