MassHealth Update

A Newsletter for MassHealth Providers

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Prescription Drug Coverage Change for Medicare & MassHealth Eligible Members

Effective January 1, 2006, MassHealth will no longer be the primary payer of prescription-drug coverage for members who also qualify for Medicare insurance. However, MassHealth will continue to pay for all over-the-counter doctor-prescribed medications that are listed under the Nonlegend Drug List, drugs in benzodiazepine and barbiturate classes, as well as specific vitamins. Please refer to the MassHealth Drug List section of the MassHealth Web site for additional information.

Members should be aware of this change, as Medicare sent a letter in October informing them of their new coverage plan. If members believe they have been assigned an incorrect plan, and/or wish to switch to another prescription plan, they should take action to change their plan by December 31, 2005. MassHealth members can change their plan coverage at any time.

To sign up for a new prescription plan, the member should contact the direct number of the desired plan. Once successfully changed, the new plan will take effect the first day of the following month. When choosing an alternate plan, members should consider the following:

- coverage of necessary prescriptions;
- if their pharmacy is in the network;
- the cost of the premium (if applicable); and
- the name of the new plan.

This information is presented in the *Medicare and You* booklet that was also sent to members in October. Please note that special rules apply to Medicare Advantage, Program of All-Inclusive Care for the Elderly (PACE), Senior Care Options (SCO), and those who received medical coverage from a previous employer or union, so these members should contact their plans directly for additional Part D information.

MassHealth members will receive additional help in covering the extra costs (if any) of the new drug plan. There will be no monthly premiums for members who enroll in a basic plan with a premium of up to $30.27 per month. If the member's income level is equal to or lower than 100% of the federal poverty level (FPL) the copay can be up to $3; for members with incomes over 100% of the FPL, copays can be up to $5.

If you have any additional Medicare questions, you can visit the Medicare Web site at www.medicare.gov or call 1-800-633-4227. If you have any MassHealth-related questions, or would like additional information about MassHealth's role in prescription coverage, please visit www.mass.gov/masshealth or contact MassHealth Customer Service at 1-800-841-2900.

Checking Claim Status Using REVS

MassHealth would like to thank all of our providers currently using the self-service Recipient Eligibility Verification System (REVS) option for verifying claim status. For providers not currently taking advantage of this 24-hours-a-day, seven-days-a-week service, please read on to learn how you can check your claims status via REVS.

The claim-status feature enables you to inquire about the status of MassHealth benefit claims at your convenience. The REVS system can check claim status for the past three years. For easier viewing, claims are listed in six-month increments to limit the amount of responses. A claim-status request may be made using any of the following methods:

- transaction control number (TCN);
- patient account number (PAN); or
- MassHealth member ID number (RID).

MassHealth recommends conducting searches using the TCN, when it is available, and/or entering the service code with the initial billed amount, as this limits the responses to those most applicable to the search criteria.

In the claim-status response, detailed information is displayed concerning the status of benefit claims. By submitting a request, you learn the following:

- provider number and provider name;
- nine-digit MassHealth member ID number (RID);
- member's full last name, full first name, and middle initial;
- date of birth on record for the member;
- gender on record for the member;
- last date that the status of the claim was updated;
- amount submitted on the claim;
- payment made by MassHealth;
- date that the claim was adjudicated by MassHealth;
- date that the remittance advice for this claim was sent to the provider;
- provider's internal tracking number for that MassHealth member;
- dates of service submitted on the claim;
- service code submitted on the claim; and
- units of service submitted on the claim.

Checking Claim Status Using REVS *(continued from page 1)*

Once a successful search has been executed, a list of claims matching the entered search criteria will be displayed on the screen. Claim status is broken down into three sections: the first displays the date and provider number/ID under which the claim was submitted; the second shows all the adjudicated claims matching the search criteria in the "Summary Table of Claims"; and the third contains all the individual claim details.

The status of a claim is available through REVS after it has been adjudicated by MassHealth. If you have questions regarding a claim, MassHealth recommends first checking REVS to review the status.

Checking claim status via REVS is another automated solution by MassHealth designed to present our providers with both new and enhanced self-service options. To learn more about REVS, or to start verifying claim status now, please go to www.massrevs.eds.com.

Please be sure to include the ".eds" extension when entering the REVS URL into your Web browser, as www.massrevs.com is a separate site not affiliated with MassHealth.

REVS Increases Date of Service Eligibility

Effective September 1, 2005, the Recipient Eligibility Verification System (REVS) has increased the dates of service for checking member eligibility, from the preceding six months to the preceding 13 months. This change is in direct response to your provider requests. We are confident this enhancement for checking date of service will help with your billing needs. Some of the benefits of using REVS for member eligibility include:

- saving time by no longer relying on MassHealth Enrollment Centers (MECs) or the REVS Help Desk for eligibility checks;
- ability to determine if a Medical Benefit Request application form needs to be completed for a potential new member; and
- detailed eligibility history to clarify potential claims issues.

Checking member eligibility is extremely important when providing services. Failure to do so may result in a provider not being reimbursed for services provided if the member was not eligible for the care received. REVS gives you easy access to current and complete member eligibility information on the date you provide services to prevent such situations. Some of the eligibility information that can be obtained from REVS includes:

- member-eligibility status;
- member MassHealth coverage type;
- managed-care information;
- coverage restrictions;
- other insurance information;
- long-term-care information; and
- member's local office ID number.

This verification eligibility enhancement is applicable to the Web REVS, REVS PC software, Automated Voice Response System, eligibility operator, and third-party vendors like NEHEN verification systems. However, please note eligibility verification through the Point of Service (POS) devices will remain at six months.

For more information about this improved service, please review the September message text that appeared on remittance advices, or you can view it on the Web at www.mass.gov/masshealth by clicking on "MassHealth Regulations and Other Publications," and then "Provider Library." If you have any questions about this information, please call the REVS Help Desk at 1-800-462-7738, option 2, then option 5.

MassHealth wants to help simplify your administrative process, so please give us your ideas or suggestions that can help us better serve you. You can e-mail us at providersupport@mahealth.net.

Phasing Out Secure File Delivery Application

MassHealth would like to remind those providers currently using our Secure File Delivery Application (SFDA) that it will be discontinued effective December 31, 2005. Current SFDA users are able to retrieve their transactions via the mass.gov/masshealth Web site. If you are a provider currently using SFDA, a member of the Customer Service Team should have already contacted you to assist you in accessing your transactions via mass.gov/masshealth.

MassHealth now provides more self-service options through mass.gov/masshealth. The need for SFDA transaction retrieval and Bulletin Board System (BBS) transaction submission and retrieval have been eliminated with the implementation of the secure transaction Web page that allows MassHealth trading partners to download and upload files in one place.

Even though the method is changing from SFDA to mass.gov, you still receive the same great benefits:

- quicker receipt of files;
- paperless system; and
- secure, private delivery of files.

All providers and other trading partners are encouraged to submit claims and receive outbound transactions through the Web. Web transaction exchange is our recommended solution in lieu of disks, CDs, paper, and the BBS retrieval system.

If you currently use the SFDA and have not received information about this change, or if you want to begin submitting claims and retrieving transactions through the Web, please call MassHealth Customer Service at 1-800-841-2900 or send an e-mail to EDI@mahealth.net.

Automated Solutions: Electronic Funds Transfer

Are you interested in accessing reimbursement funds faster, reducing the administrative burden of processing checks, and/or avoiding the chance of checks getting lost or stolen? If so, sign up for the Electronic Funds Transfer (EFT) option offered by MassHealth if you have not already done so.

EFT allows MassHealth to deposit your payments directly into your bank account, a huge benefit over the traditional paper-check system. In addition, you have more control over where you choose to receive your remittance advices. With paper checks, the remittance advice is sent to the same address where the checks are received, regardless of your preference. If you elect EFT, your remittance advices can be sent to any address that you choose.

To receive deposits directly into your bank account, submit a signed copy of our EFT application, which you can download from our Web site. Simply fill out the EFT form, including your signature and bank routing (ABA transit) and account number, and return it to MassHealth with a voided check.

If you need a copy of this form mailed or faxed to you, call MassHealth Customer Service at 1-800-841-2900.

After all your information has been correctly submitted and processed by MassHealth, you will begin receiving deposits in 14 days. If you provided an e-mail address on your application, you will receive a confirmation e-mail once your application is approved.

Streamline your cash flow right now: Go to www.mass.gov/masshealth and sign up for EFT!

Submitting Electronic Claims That Require Attachments

MassHealth is committed to building an environment for the provider community that promotes and supports full electronic claims submission. In keeping with this standard, MassHealth would like to remind providers that claims requiring attachments can also be submitted electronically. Although an electronic standard for claims attachments has not yet been finalized by the Centers for Medicare and Medicaid Services (CMS), MassHealth has developed an alternative method for the handling of these types of electronic claims.

Whenever an electronic claim requiring an attachment (e.g., invoices, surgical notes) is received by MassHealth, the claim suspends for review and a Claims Attachment Form (CAF) is mailed to the provider. This form contains all relevant claim details such as the member name, MassHealth ID number, date of service, error number, reason for attachment request, and provider information. Providers must return the CAF with the required attachment within 45 days of the CAF date. Once received by MassHealth, the electronic claim and paper attachment process together.

Please note that "attachment" does not refer to Coordination of Benefits (COB) attachments. COB claims must be billed according to the criteria contained in our 837 Companion Guides.

CAFs and attachments should be mailed to the following address.

MassHealth Customer Service
Attention: Claims
P.O. Box 9118
Hingham, MA 02043

More information about electronic claims submission with claims attachments is available at www.mass.gov/masshealth in the "Automated Solutions" section in "Information for MassHealth Providers."

State Gives $500,000 to OutReach Efforts for MassHealth Expansion

On October 4, 2005, Health and Human Services Secretary Timothy Murphy announced the awarding of $500,000 in grants to 22 organizations across the state to increase MassHealth enrollment.

Of the 460,000 people living in the Commonwealth without health coverage, it has been estimated that 106,000 would qualify for MassHealth but have not applied for it.

"This important grassroots initiative will provide critical access to people who are already eligible for MassHealth, but are not enrolled. Insurance programs such as this provide better outcomes for patients and offer greater efficiency for providers."-Secretary Murphy

Each of the grantees has tailored programs specific to people and regions they serve. To buttress training provided by MassHealth, grantees will use novel outreach approaches, including health fairs, public notices, multi-lingual collaborations with YMCAs, YWCAs, hospitals, community service organizations, soup kitchens, homeless shelters, clinics, schools, and businesses, as well as print, radio, and television marketing campaigns.

The grants are administered by EOHHS's Office of Medicaid. In collaboration with this grant initiative, the Blue Cross Blue Shield of Massachusetts Foundation recently distributed $250,000 in grants to community organizations for similar outreach.

"Support from the Commonwealth and Blue Cross Blue Shield of Massachusetts will enable organizations already serving hard-to-reach uninsured populations to focus on getting more eligible individuals enrolled in MassHealth," said Phillip Gonzalez of the Foundation.

"Our new partners will play a significant role in bringing health care to thousands of needy families in the Commonwealth." -Secretary Murphy

Providers' Most Frequently Asked Questions: September & October

If a billing intermediary electronically submits claims to MassHealth on my behalf, can both the submitter and I receive the 997, the functional acknowledgement transaction?

Only the entity submitting claims to MassHealth is able to receive the 997. However, the electronic 835 remittance advice and/or the electronic supplemental remittance advice sent by MassHealth can be retrieved by both the submitter and the provider.

My claim denied for edit code 103 on my remittance advice. What does that mean and how can I rectify it?

Edit code 103, which only appears on 835 supplemental and paper remittance advices (RAs), indicates that the claim was previously submitted and paid by MassHealth. In order to determine the run that your claim was paid on, refer to your RA. On the RA, directly underneath the line that details your denial, there should be a second line with the phrase "Conflicting Claim Run XXXX." This line indicates when the claim was previously paid.

Where can I get the descriptions for error messages?

All of the error messages that appear on your paper remittance advice can be found in Subchapter 5 of your provider manual. Error descriptions are also updated monthly and made available under the "Claims Processing Data" link in the "Invoice & Claims Submission" section of the mass.gov/masshealth Web site.

Dealing with Incorrect Member Insurance

In situations where providers are aware that a member has inaccurate insurance information on file, please ask the member to contact MassHealth Customer Service to verify that MassHealth records are correctly updated. Failure to update this information will result in a claim denial during the adjudication process. To update member insurance information, MassHealth requests that providers or members send some type of documentation validating the correct insurance. Acceptable forms of documentation include a copy of the member's insurance ID card or information stating the member's group or policy details.

The proper procedure for removing third-party-liability (TPL) information from a member's file is to fill out the TPL Indicator form and fax the termination letter along with the form to the TPL Unit at 617-357-7604. Or the member can call MassHealth Customer Service at 1-800-841-2900. Please note that attaching the coverage-terminated letter to the claim without including the TPL Indicator form will not update the member's file.

The TPL form can be downloaded from the mass.gov/masshealth Web site. If you need a copy of this form mailed or faxed to you, please contact MassHealth Customer Service at 1-800-841-2900.

New on mass.gov/masshealth

Keep an eye out for three great new online enhancements that will be coming to the mass.gov Web site in the upcoming weeks. The new Web-based self-service features will allow you to:

- order or download most MassHealth forms directly from the Web site;
- register or request provider training (currently available for nurses); and
- manage and request updates to your MassHealth provider file information at any time.

These options will improve the ease and efficiency of your MassHealth interactions, so take advantage of all the features that the **mass.gov/masshealth Web site** has to offer.

MassHealth Reminders

- Any claims being mailed to MassHealth must be addressed to P.O. Box 9118, Hingham, MA 02043.
- When mailing **split eligibility claims** to the MassHealth Hingham address, please include a cover letter indicating split eligibility.
- For those providers submitting **UB92s with benefits-exhausted attachments,** please include a cover letter indicating that benefits are exhausted.
- For those providers submitting crossover claims, please remember to circle the lines to be processed on the Explanation of Medicare Benefits (EOMB). Also, for Part B claims please include a HCFA 1500 form with matching data.
- When copying **third-party-liability and/or Medicare EOBs,** please ensure that they are legible and not cut off or missing data.

Remittance Advice Highlights

- **Adult day health** rates have been revised as MassHealth has adopted rates certified by the Division of Health Care Finance and Policy (DHCFP). New fee schedules can be obtained from the DHCFP Web site at **www.mass.gov/dhcfp.**
- **Independent nurses** can now take advantage of electronic billing and keep their same payment schedule. Click on the link under the "News & Updates" box on the MassHealth Web site home page for more information.

To review these and other message texts, please go to www.mass.gov/masshealth, choose "MassHealth Regulations and Other Publications," and click on "Provider Library.".

E-mail: providersupport@mahealth.net
Web: www.mass.gov/masshealth

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