MassHealth

MassHealth Hospice Provider Training Resource Guide

Hospice Webinar
May 6, 2015

Agenda

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II. MassHealth Provider Library

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IV. Hospice Election Form

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XV. Interchange Control Number (ICN)

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XVII. Metrics and Reports

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XIX. Final Deadline Appeals

XX. Best Business Practices

XXI. MassHealth Resources

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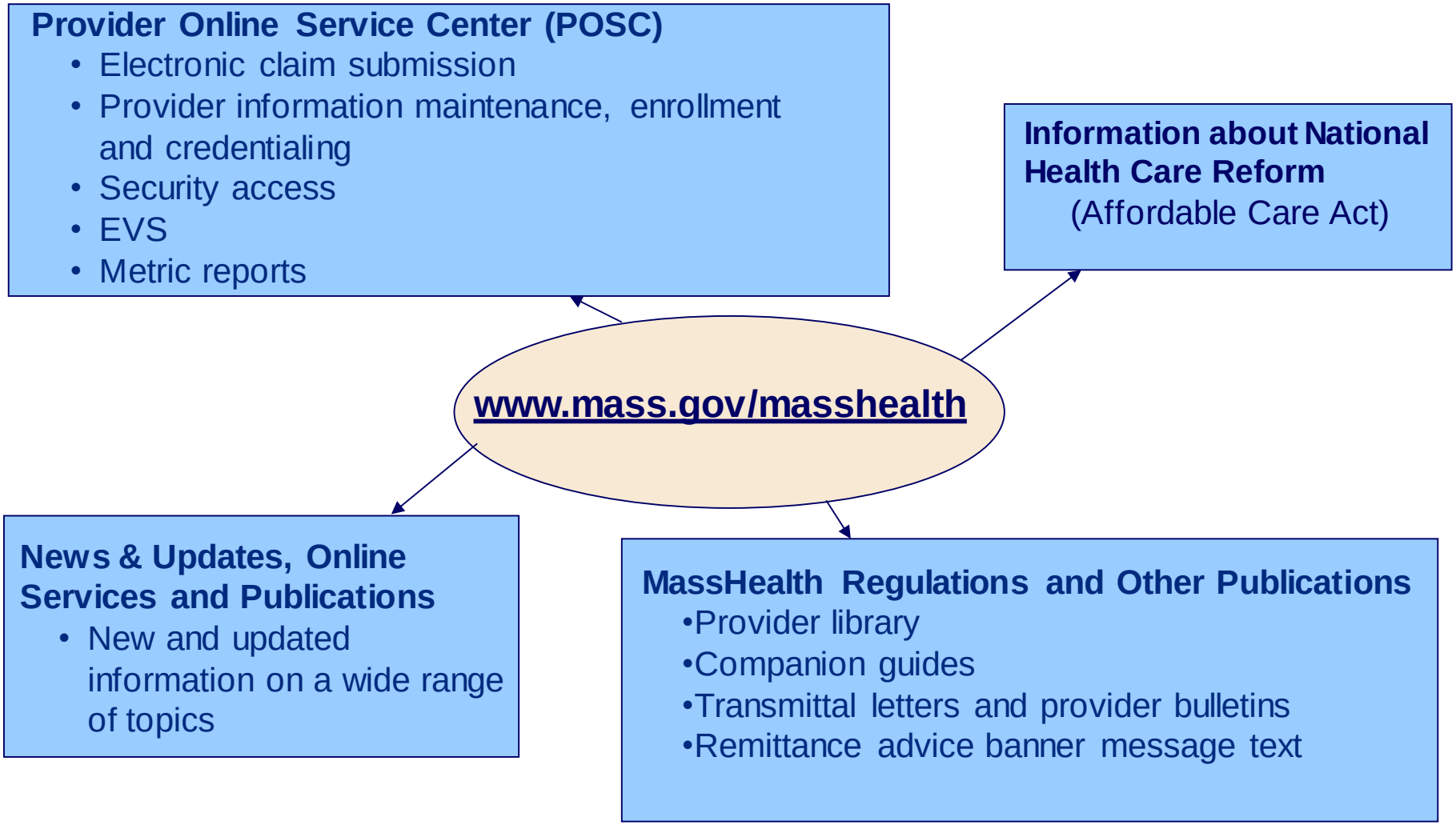
www.mass.gov/masshealth



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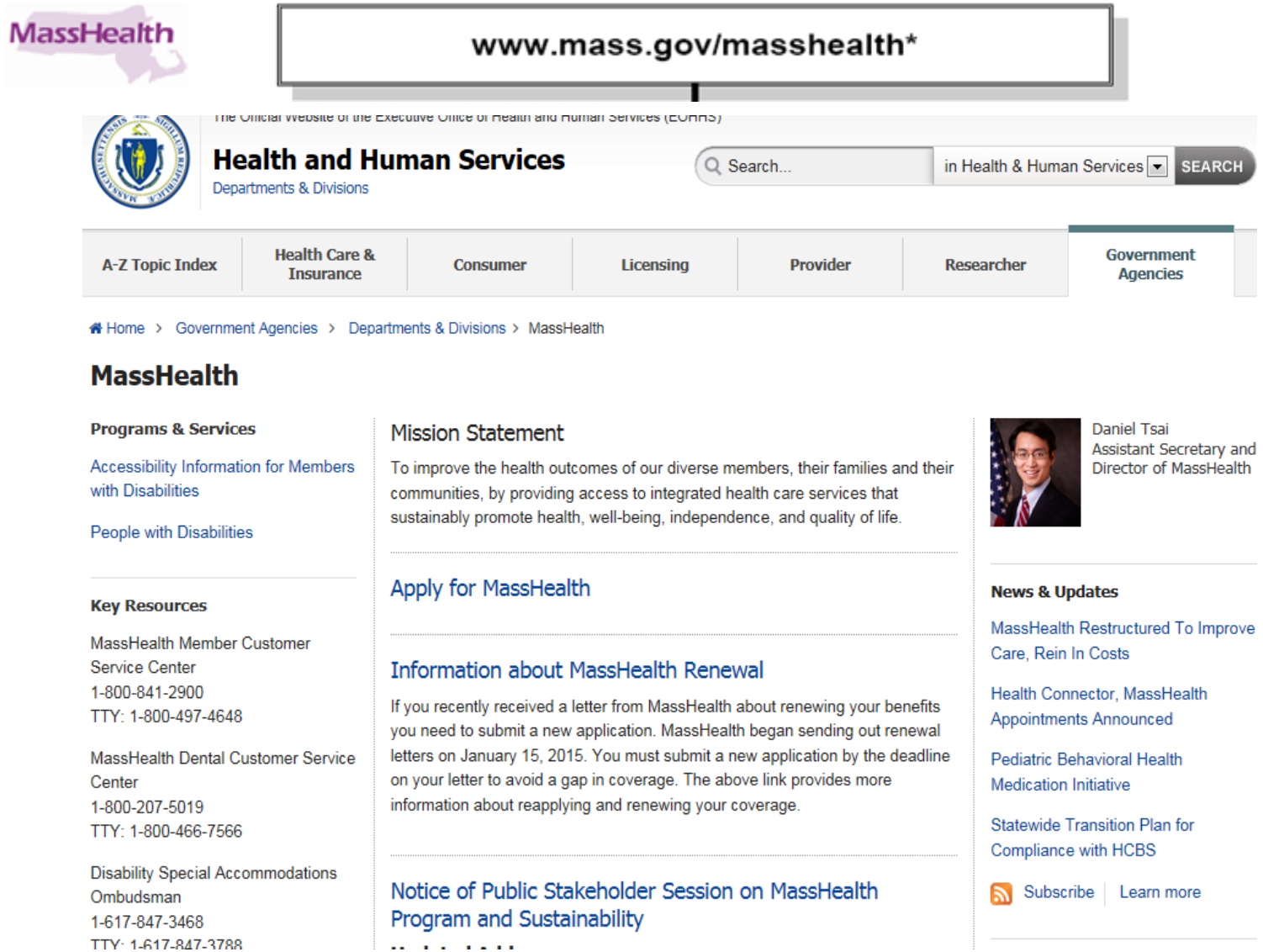
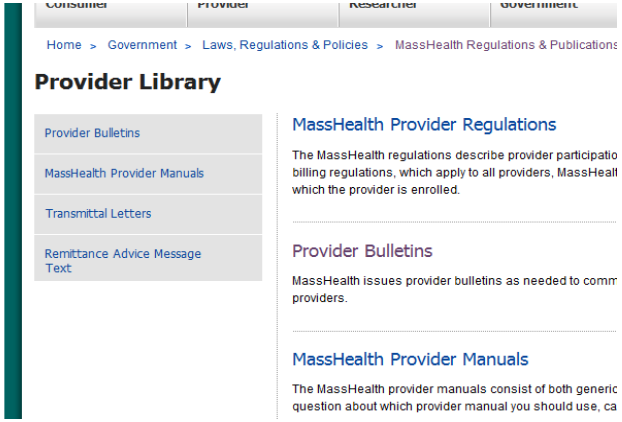


MassHealth Provider Library

- The MassHealth Provider Library is accessible via the following link: www.mass.gov/masshealthpubs
- Included in the Provider Library are a number of resources pertinent to the processing of claims, the understanding of MassHealth policies and regulations and account reconciliation
  - Provider Manual Transmittal Letters
  - MassHealth Bulletins
  - Payment and Guideline Tools
  - Remittance Advice Message Text
  - MassHealth Provider Manuals



MassHealth Provider Manuals

- MassHealth Provider Manuals for each provider type*are available on the Web at www.mass.gov/masshealthpubs in the Provider Library.
  - Subchapters 1 – 3 are the Administrative and Billing Regulations
  - Subchapter 4 is the Program regulations
  - Subchapter 5 is the Administrative and Billing Instructions
  - Subchapter 6 is the Service Codes
  - Appendix A is the Contact Information Directory (Additional Appendices are listed according to provider type)
- There is also a link to the rate information established by EOHHS (101 CMR.343)

MassHealth All Provider Manual

Subchapters 1-3 contain the MassHealth Member Coverage types, 130 CMR 450.105 A-H

- All nine coverage types are identified in this section:
  - MassHealth Standard
  - MassHealth CarePlus
    - MassHealth CarePlus members must enroll with a MassHealth managed care provider in accordance with 130 CMR 508.001(A)
  - MassHealth Buy-In
  - MassHealth Senior Buy-In
  - MassHealth CommonHealth
  - MassHealth Prenatal
  - MassHealth Limited
  - MassHealth Family Assistance

Example of covered services list

(A) MassHealth Standard.
(1) Covered Services. The following services are covered for MassHealth (see 130 CMR 505.002 and 130 CMR 519.002).
(a) abortion services;
(b) acute inpatient hospital services;
(c) adult day health services;
(d) adult foster care services;
(e) ambulance services;
(f) ambulatory surgery services;
(g) audiologist services;
(h) behavioral health (mental health and substance abuse) services;
(i) Chapter 766: home assessments and participation in team meeting

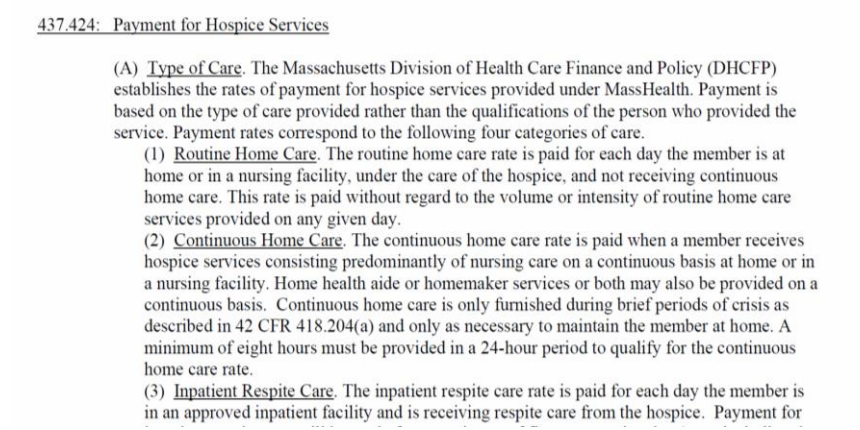
- The allowed services within each coverage type are identified
- You may also access the Chart of MassHealth Covered Services under Information for MassHealth Providers on the MassHealth website

MassHealth Hospice Provider Manual

MassHealth

- Subchapter 4 contains the Hospice Program Regulations
- Some of the program regulation information identified in this section*:
  - Certification of Terminal Illness
  - Eligibility for Hospice Services
  - Hospice Election
  - Administration and Staffing requirements
  - Covered Services
  - Payment for Hospice Service
  - Record Keeping requirements

Example of Payment for Hospice Services



437.424: Payment for Hospice Services

(A) Type of Care. The Massachusetts Division of Health Care Finance and Policy (DHCFP) establishes the rates of payment for hospice services provided under MassHealth. Payment is based on the type of care provided rather than the qualifications of the person who provided the service. Payment rates correspond to the following four categories of care.

(1) Routine Home Care. The routine home care rate is paid for each day the member is at home or in a nursing facility, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

(2) Continuous Home Care. The continuous home care rate is paid when a member receives hospice services consisting predominantly of nursing care on a continuous basis at home or in a nursing facility. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in 42 CFR 418.204(a) and only as necessary to maintain the member at home. A minimum of eight hours must be provided in a 24-hour period to qualify for the continuous home care rate.

(3) Inpatient Respite Care. The inpatient respite care rate is paid for each day the member is in an approved inpatient facility and is receiving respite care from the hospice. Payment for

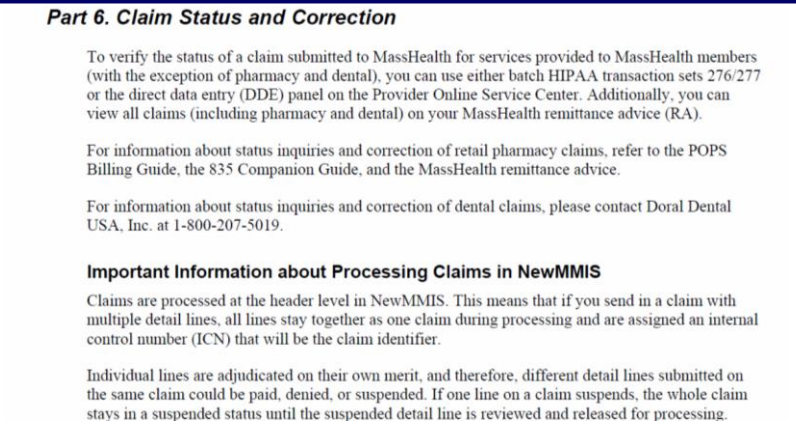
* Please see Subchapter 4 for full Hospice program regulations

MassHealth Hospice Provider Manual

MassHealth

- Subchapter 5 contains the Administrative and Billing Regulations
- The Administrative and Billing Instructions are divided into seven parts
  - Part 1. Eligibility
  - Part 2. Prior Authorization*
  - Part 3. Billing MassHealth
  - Part 4. Required Forms and Documentation
  - Part 5. Claim Status and Payment
  - Part 6. Claim Status and Correction
  - Part 7. Other Insurance

Example of Part 6 – Claims Status and Correction



Part 6. Claim Status and Correction

To verify the status of a claim submitted to MassHealth for services provided to MassHealth members (with the exception of pharmacy and dental), you can use either batch HIPAA transaction sets 276/277 or the direct data entry (DDE) panel on the Provider Online Service Center. Additionally, you can view all claims (including pharmacy and dental) on your MassHealth remittance advice (RA).

For information about status inquiries and correction of retail pharmacy claims, refer to the POPS Billing Guide, the 835 Companion Guide, and the MassHealth remittance advice.

For information about status inquiries and correction of dental claims, please contact Doral Dental USA, Inc. at 1-800-207-5019.

Important Information about Processing Claims in NewMMIS

Claims are processed at the header level in NewMMIS. This means that if you send in a claim with multiple detail lines, all lines stay together as one claim during processing and are assigned an internal control number (ICN) that will be the claim identifier.

Individual lines are adjudicated on their own merit, and therefore, different detail lines submitted on the same claim could be paid, denied, or suspended. If one line on a claim suspends, the whole claim stays in a suspended status until the suspended detail line is reviewed and released for processing.

* *Not Applicable to Hospice*

MassHealth Hospice Provider Manual

MassHealth

Subchapter 6 contains the Hospice Service Codes

- The service codes are the codes that Hospice providers are allowed to use for billing claims to MassHealth*

Example of Subchapter 6 – Hospice Service codes

601 Service Codes and Descriptions

Service Code-Modifier	Service Description
T2042	Hospice routine home care; per diem (within the county in which the provider is located)
T2043	Hospice continuous home care; per hour (within the county in which the provider is located)
T2044	Hospice inpatient respite care; per diem
T2045	Hospice general inpatient care; per diem
T2046	Hospice long term care, room and board only; per diem
T2042 TN	Hospice routine home care; per diem (outside the county in which the provider is located)
T2043 TN	Hospice continuous home care; per hour (outside the county in which the provider is located)

** Hospice Revenue Code sets are found in the MassHealth UB-04 Billing Guide found in the Provider Library*

Additional Service Code Information

Out of County Modifier (TN)

If a provider serves a member outside of the county where their DBA office is located, they are required to bill at hospice county rate where the member resides. This is only applicable to hospice clients served in the community, it does not apply to hospice in nursing facilities or hospitals. When billing for out of county services, hospice provider must use the modifier (TN) to indicate out of county routine care (T2042) or continuous home care (T2043). The provider needs to include the member's county in the claim. Direct Data Entry (DDE) claims must have the county submitted as an attachment. Batch 837I claims* must have the county in Loop 2300 (enter the note code in Segment NTE01 and the Free Form Description in Segment NTE02). Claims will suspend for manual pricing.

HOSPICE PRICING FOR SERVICE CODE T2046 – *message text issued March 2012*

MassHealth implemented automated pricing for hospice services on claims submitted with Service Code T2046 (Hospice long term care, room and board only; per diem) for members receiving hospice services in a nursing facility. MassHealth's claim processing system is now able to calculate the correct payment for the member's casemix score and the nursing facility's rate for that casemix score, multiplied by the number of units at 95 percent, less any applicable patient paid amount (PPA). Providers should continue to bill for services using Service Code T2046 as usual.

** Refer to the HIPAA Implementation Guide for the 837I transaction and MassHealth Companion Guide for detailed instructions*

Additional Service Code Information

Leave of Absence (LOA) days (for members in a Skilled Nursing Facility)

If a member has medical-leave-of-absence (MLOA) days or nonmedical-leave-of-absence (NMLOA) days in the statement billed period, bill the revenue code for the MLOA days or NMLOA days on a separate line with the appropriate LOA revenue code only and number of days. Do not enter HCPCS code as it may cause the claim to pay incorrectly. In accordance with 130 CMR 456.00, MassHealth pays the LOA rate for these days. Providers who may have been paid incorrectly need to address these claims immediately.

Reminder

Hospice providers cannot bill a hospice room and board or MLOA days for any day that it bills at the hospice inpatient respite care rate or general inpatient care rate for hospice services it provided to a member.

** Refer to the MassHealth UB-04 billing guide for additional detailed instructions including applicable code sets.*

MassHealth Hospice Provider Manual

MassHealth

The Hospice Provider Manual also contains Appendices with additional information for providers

- The following Appendices are listed in the Hospice Provider Manual
  - Appendix A: Directory - This appendix contains the names, addresses, and telephone numbers of units, agencies, and contractors that you may need to contact in the course of doing business with MassHealth.
  - Appendix B: Enrollment Centers - This appendix lists for each of the four regional MassHealth Enrollment Centers the address, telephone and fax numbers, responsibilities, and towns they serve.
  - Appendix C: Third-Party-Liability Codes - This appendix contains lists of third-party-liability (TPL) coverage-type codes and carrier codes to help you identify a member's other insurance. The MassHealth Recipient Eligibility Verification System (REVS) reports TPL coverage-type and carrier codes for all applicable insurance coverage listed on file for each member.
  - Appendix U: DPH-Designated Serious Reportable Events That Are Not Provider Preventable Conditions - This appendix lists events that are designated by the Massachusetts Department of Public Health (DPH) as “Serious Reportable Events (SREs)” in accordance with 105 CMR 130.332 (or 105 CMR 140.308, as applicable) that are not considered “Provider Preventable Conditions” (PPCs) under MassHealth.

MassHealth Provider Manual

MassHealth

Appendices listed in the Hospice Provider Manual (continued)

- Appendix V: MassHealth Billing Instructions for Provider Preventable Conditions - This appendix describes the MassHealth billing instructions for Provider Preventable Conditions (PPCs), as they apply to providers. The appendix is subdivided into three parts: (1) billing instructions for PPCs for inpatient hospitals; (2) billing instructions for PPCs for outpatient hospitals and freestanding ambulatory surgery centers; and (3) billing instructions for PPCs for all other MassHealth providers.

- Appendix W: EPSDT Services Medical and Dental Protocols and Periodicity Schedules - This appendix lists the services required under the Early and Periodic Screening, Diagnosis and Treatment (EPDST) Program, and the ages at which those services must be provided.

- Appendix X: Family Assistance Copayments and Deductibles - MassHealth will pay for certain copayments, deductibles, and coinsurance amounts for certain MassHealth Family Assistance members under age 19. This appendix describes who is eligible, the types of copayments, deductibles, and coinsurance amounts that are covered, and how to bill for these services.

- Appendix Y: EVS Codes and Messages - This appendix lists the active Eligibility Verification System (REVS) codes and their respective service restriction messages.

- Appendix Z: EPSDT/PPHSD Screening Service Codes – This appendix gives the Early and Periodic Screening, Diagnosis and Treatment codes and Preventive Pediatric Health-care Screening and Diagnosis codes.

Provider Bulletins and Transmittal Letters

MassHealth

Provider Bulletins

MassHealth issues provider bulletins as needed to communicate procedures, reminders, and other information to MassHealth providers.

Transmittal Letters

Transmittal letters contain changes to MassHealth provider manuals. They summarize the change, contain revised pages for the provider manual, and tell providers how to update their manuals with the new pages.

Provider Bulletins and Transmittal Letters are available on the Web at www.mass.gov/masshealthpubs in the Provider Library. The provider bulletins and transmittal letters that appear on this Web site are listed by month and year, then alphabetically by provider type.

MassHealth providers can sign up to receive e-mail notification when new provider bulletins are posted to this Web site. To sign up click the "Choose Your Preferred Method for Receiving Notification of Provider Bulletins and Transmittal Letters" link.

Hospice Election Form

As directed under 130 CMR 437.412(C), hospice providers must submit a completed and signed MassHealth Hospice Election Form according to the form's instruction, before billing for MassHealth members who elect hospice services. This form must be completed whenever a MassHealth member chooses to elect or stop hospice services, to disenroll from hospice services, or to change hospice provider.

If you do not submit a completed and signed Hospice Election Form the member will not be properly coded to the hospice provider's ID/service location (PID/SL). Claims submitted by a hospice provider for members who are not coded under the hospice provider's PID/SL will be denied with edit 2800 (Member not tied to hospice for date of service).

All applicable sections of the election form must be completed: A, B1, B2, C, D, and E.

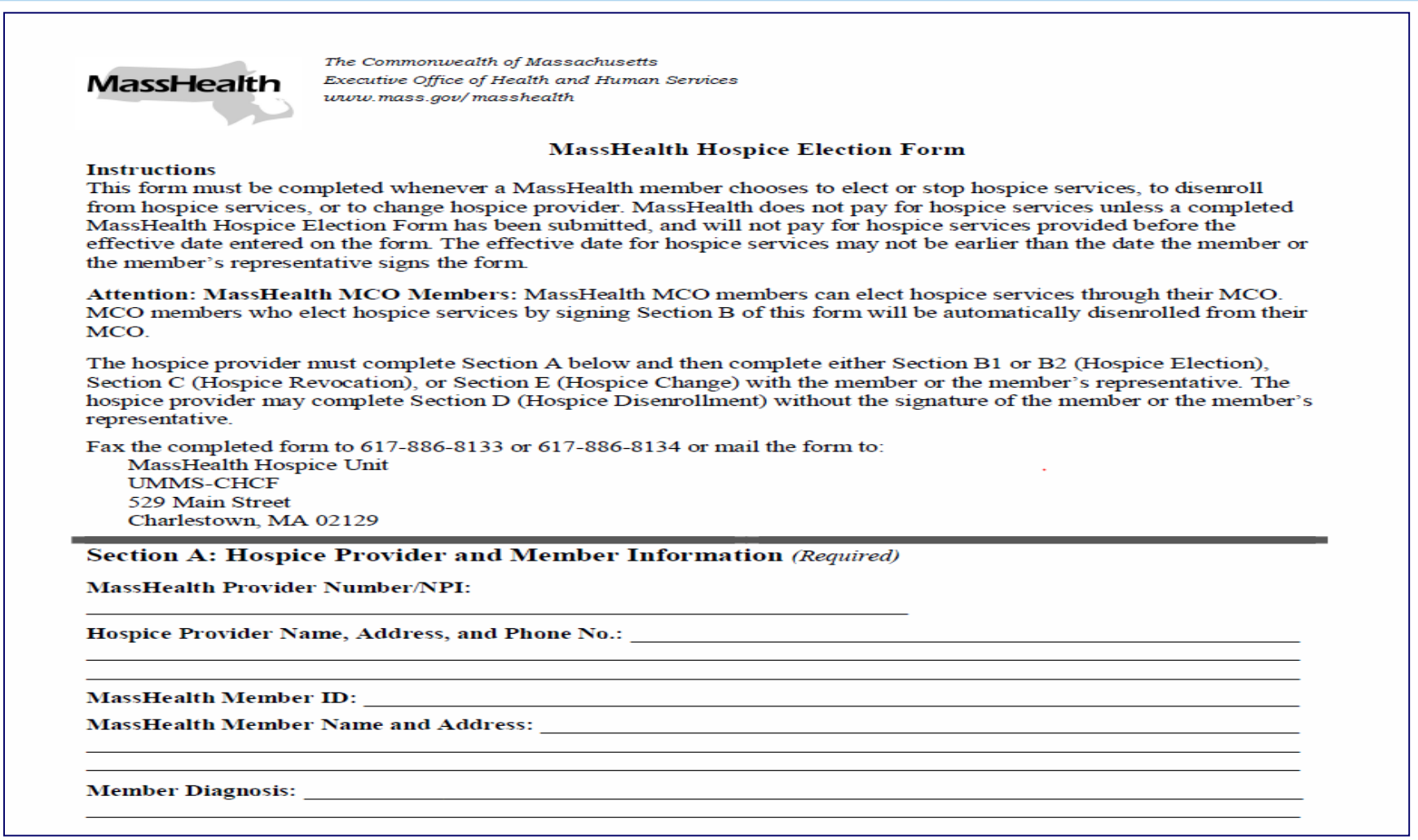
To download a copy of the MassHealth Hospice Election Form (HOS-1) from the MassHealth Web site homepage (www.mass.gov/masshealth), click the MassHealth Provider Forms link in the Publications panel.

You can fax* the completed form to: (617) 886-8402 OR mail the form to:

MassHealth Hospice Unit
UMMS-CHCF
529 Main Street
Charlestown, MA 02129

** Providers are strongly advised to keep all copies of fax receipt confirmations on file*

Hospice Election Form



MassHealth

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth Hospice Election Form

Instructions
This form must be completed whenever a MassHealth member chooses to elect or stop hospice services, to disenroll from hospice services, or to change hospice provider. MassHealth does not pay for hospice services unless a completed MassHealth Hospice Election Form has been submitted, and will not pay for hospice services provided before the effective date entered on the form. The effective date for hospice services may not be earlier than the date the member or the member's representative signs the form.

Attention: MassHealth MCO Members: MassHealth MCO members can elect hospice services through their MCO. MCO members who elect hospice services by signing Section B of this form will be automatically disenrolled from their MCO.

The hospice provider must complete Section A below and then complete either Section B1 or B2 (Hospice Election), Section C (Hospice Revocation), or Section E (Hospice Change) with the member or the member's representative. The hospice provider may complete Section D (Hospice Disenrollment) without the signature of the member or the member's representative.

Fax the completed form to 617-886-8133 or 617-886-8134 or mail the form to:
MassHealth Hospice Unit
UMMS-CHCF
529 Main Street
Charlestown, MA 02129

Section A: Hospice Provider and Member Information *(Required)*

MassHealth Provider Number/NPI: _____

Hospice Provider Name, Address, and Phone No.: _____

MassHealth Member ID: _____

MassHealth Member Name and Address: _____

Member Diagnosis: _____

Hospice Election Form

Section B: Hospice Election *(Complete this section when the member chooses hospice services.)*

Section B(1): Hospice election for MassHealth members aged 21 and older:

Effective date of hospice election: ___/___/___

Member Statement

I agree to get all care for my terminal illness from the hospice provider named above. I know that hospice services are for my care and comfort, and not for curing me. I understand that unless I sign a form to stop hospice services, I have to get all care for my terminal illness from the hospice provider.

_____ ___/___/___

Signature of Member or Member's Representative *Date*

HOS-1 (Rev. 11/10)

Check one of the following boxes and print the name.

☐ Member: _____

☐ Member's representative: _____

Section B(2): Hospice election for MassHealth members under 21 years of age.

MassHealth members under age 21 who elect hospice services have coverage for curative treatment and all medically necessary services for which they are eligible.

Effective date of hospice election: ___/___/___

Member Statement

I agree to get all care for my terminal illness from the hospice provider named above. I know that hospice services are for my care and comfort. I understand that unless I sign a form to stop hospice services, I have to get all care for my terminal illness from the hospice provider.

_____ ___/___/___

Signature of Member or Member's Representative *Date*

_____

Printed Name of Member or Member's Representative

Hospice Election Form

Section C: Hospice Revocation *(Complete this section when the member decides to stop hospice services.)*

Effective date of hospice revocation: ___/___/___

Member Statement

I want to stop receiving hospice services and begin receiving MassHealth benefits from any MassHealth provider. I know that by signing this form, MassHealth will not pay for hospice services for me as of the revocation date. I can still get hospice coverage later if I sign up again.

_____ ___/___/___

Signature of Member or Member's Representative *Date*

Check one of the following boxes and print the name.

_____

Printed Name of Member or Member's Representative

Section D: Hospice Disenrollment *(Complete this section to disenroll the member from hospice.)*

Effective date of hospice disenrollment: ___/___/___

Select reason for disenrollment:

- ☐ Death *(The member has died.)*
- ☐ Loss of eligibility *(The member is no longer in a MassHealth benefit plan that covers hospice services, or the member is not eligible for MassHealth.)*
- ☐ Health-care needs changed *(The member's health condition has improved and the six-month prognosis has changed.)*
- ☐ Enrolled in all-inclusive managed care plan *(The member's health-care needs will be managed by the plan.)*
- ☐ Other *(If the reason is none of the above, explain the reason in detail.):*

_____

_____

_____

Signature of Hospice Provider Staff Person Completing the Form

Hospice Election Form

Section E: Hospice Change *(Complete this section when the member is changing hospice providers.)*

A newly designated hospice provider must complete Section A and this section, including getting a date and signature from the member or the member's representative, and submit the completed form to MassHealth at the address appearing above.

Effective date of hospice discharge from previous hospice provider: ___/___/___

Effective date for the newly designated hospice provider: ___/___/___

Member Statement

I want to change to a different hospice provider.

The hospice provider I have now is: _____

The hospice provider I want to change to is: _____

_____ ___/___/___

Signature of Member or Member's Representative *Date*

Check one of the following boxes and print the name.

_____

Printed Name of Member or Member's Representative

LTC and Hospice

MassHealth

List of Long Term Care - detailed information

It is **important** that the member be listed as coded to the Hospice – otherwise claims will deny (ex. Edit 2800)

For members in Skilled Nursing Facilities (SNFs):

It is **important** that the SNF has submitted the MMQ for the member otherwise the claim will deny for pricing errors (Ex. Edit 6006)

Additional Eligibility Information

MassHealth

Management Minutes Questionnaire (MMQ)

Nursing Facilities are required to submit the MMQ data to MassHealth. In addition, the facility is also required to submit the specific time established MMQ updates to MassHealth. If the MMQ data, updates, or MMQ errors are not submitted or addressed by the nursing facility staff, the Hospice Unit will not be able to enter the Hospice Election Form data into MMIS. Hospice providers should be vigilant in their communications with nursing facility staff regarding members that have enrolled in hospice. Failure to do so could impact both Hospice election and claims payment.

Managed Care Organizations (MCOs)

For members enrolled in a MassHealth-contracted managed care organization (MCO) who choose hospice services, the hospice must comply with the MCO's requirements for the delivery of hospice services.

MassHealth

For Long Term Facilities

- **MassHealth Medicaid Management Software (MMQ) it will no longer be available after 9/30/15. You must transition to another submission method before that date.**
  - You must transition to another submission method before that date. Please review the job aid and a list of submission options to select the method that best supports your needs. Please transition immediately:
    - **MMQ webpage:** http://www.mass.gov/eohhs/provider/reporting-to-state/report-tools/management-minutes-questionnaire.html
    - **MMQ Job Aid webpage:** http://www.mass.gov/eohhs/docs/masshealth/provlibrary/pocs-job-aids/sco-pace-submit-mmq.pdf
    - **MMQ File Specification webpage:** http://www.mass.gov/eohhs/docs/masshealth/provlibrary/draft-nf-d-icd-10.pdf

Payment Tiers

- Section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices.
- Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice provider that does not comply with the quality data submission requirements.
- No change for MassHealth for FY2015 (Federal FY)
- Will update providers for FY2016 (will need access to quality reporting data)

MassHealth Program Integrity

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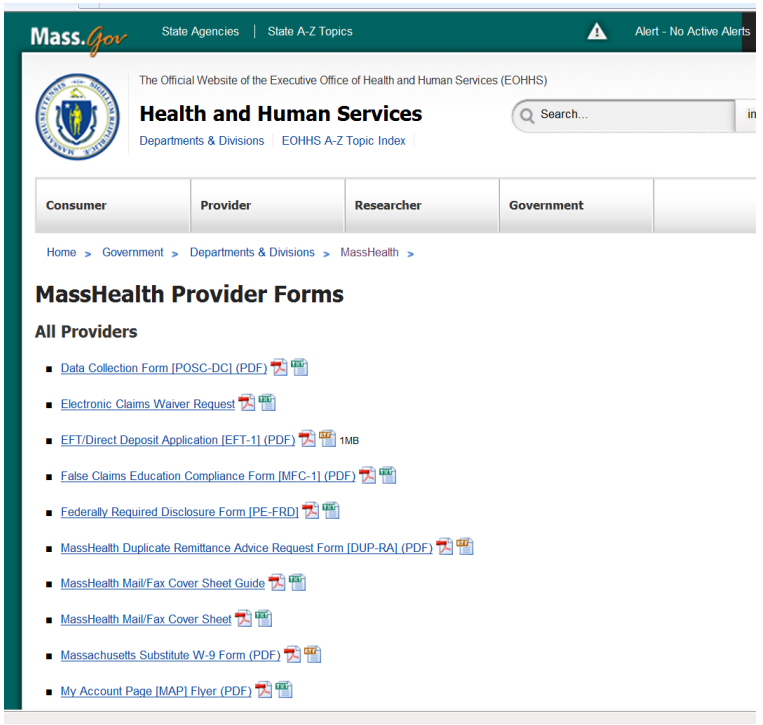
Examples of Algorithms

- Improper rate charge
- Duplicate home health agency services along with Hospice
- DME claims for supplies while Member is receiving Hospice services
- Dual Eligible Members: Need payment from Medicare
- Extended Care Hospice: Check for extended stays
- Hospice T2042 (Routine Care) with T2045 (General IP care)
- Hospice T2045 over-utilization (>5 consecutive days)
- Diagnoses needs to be considered terminal (change in Medicare policy on diagnoses)

MassHealth Provider Forms Page

- MassHealth website contains a link to the Provider Forms page. Several commonly used forms can be located on this page.
- To access the page, go to www.mass.gov/masshealth and select the MassHealth Provider Forms link under the Publications heading on the right side of the page.
- Some of the forms found on this page include
  - 90 Day Waiver form
  - Provider Change of Address Form
  - Third Party Liability Indicator Form
  - Provider Overpayment Disclosure Form
  - Federally Required Disclosure Form



MassHealth

Provider File Integrity

- Any change in your relationship with MassHealth must be communicated immediately to Provider Enrollment and Credentialing to maintain accurate information on your provider file.
- All updates must be submitted in writing to:

  MassHealth
  Attn: Provider Enrollment and Credentialing
  PO Box 9162
  Canton, MA 02021
  or faxed to 617-988-8974

- Include your MassHealth Provider Identifier (PID) Service Location (SL) Number on all correspondence
- Always keep all information accurate, including:
  - Addresses: legal entity, doing business as, check and remittance and informational mailing
  - Telephone numbers
  - Licensure and certifications

Provider Disclosure

MassHealth

Provider Disclosure Statement

- All provider organizations are required to comply with Federal, State and local laws and regulations (42 CFR sections 431.107, 447.10 and 455.100 through 455.106; and section 1902(a)(9) of the Social Security Act).
- Subsequently, entities must disclose to EOHHS the identity of any person who:
  - Has ownership or control interest in the provider organization, or is an agent or managing employee of the provider, and of those people; and
  - Those who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs (42 CFR 455.106 paragraph (a))

Provider Disclosure

MassHealth

Federally Required Disclosures

MassHealth has implemented the Federally Required Disclosure Form. This form supports the reporting of the federal and state mandates to disclose information.

The Federally Required Disclosure Form will be required for:

- All enrollments
- Updates when information has changed and must be reported to MassHealth

The new regulations implemented as part of ACA require the SSN and date of birth to be included for certain people listed on the form. Forms that do not contain the SSN and dates of birth will be returned as incomplete.

MassHealth

MMIS POSC Overview

The Medicaid Management Information System (MMIS) enables both the provider community and MassHealth to shift from a paper-based operation to an electronic-based business model through a variety of e-business tools available through the Web-based MMIS Provider Online Service Center (POSC).

Goals and Benefits

- "Provider Online Service Center" – One stop Shopping
- Automate manual processes
- Real-time Direct Data Entry (*DDE)* claims processing

To take full advantage of the benefits of the *Provider Online Service* Center, providers will need access to the Internet.

MMIS POSC Overview

How do I get to the POSC?

- Directly link to site at:

  https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/appmanager/provider/desktop

- Connect via the MassHealth Website at: www.mass.gov/masshealth listed under "Online Services"

- Access through Virtual Gateway site link at:

  https://gateway.hhs.state.ma.us/authn/index.jsp

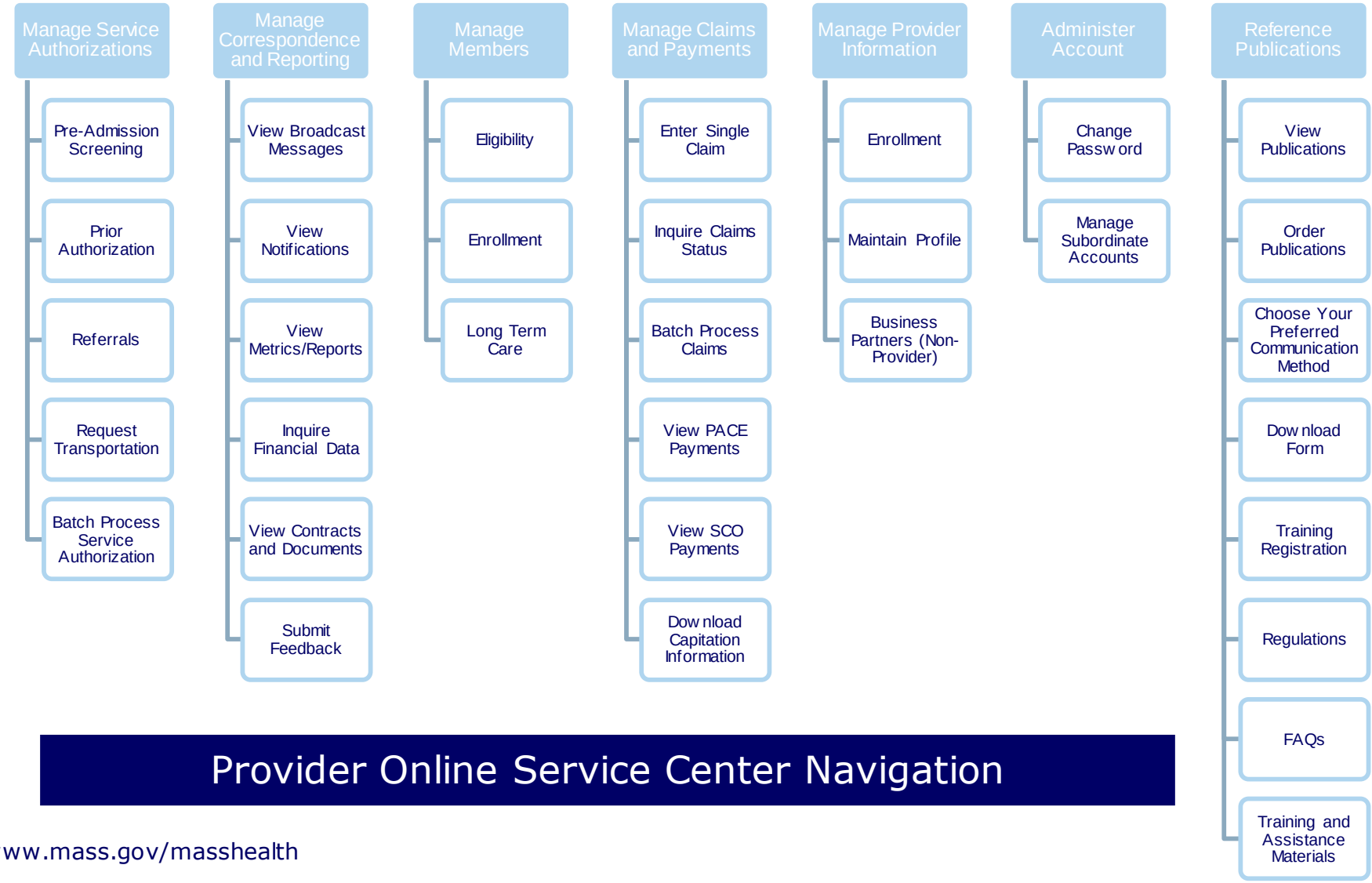
MMIS POSC Overview

Provider Online Service Center

MMIS POSC Overview

Provider Online Service Center

MMIS POSC Overview



Provider Online Service Center Navigation

MMIS POSC Overview

Job Aids

Multiple job aids exist to assist providers in understanding how to navigate the POSC portal including the DDE application.

To access the job aids, visit www.mass.gov/masshealth/newmmis Click "Need Additional Information or Training" link then click "Get Trained"

Some of the job aids include

- Provider Online Service Center Overview
- Verify Member Eligibility
- Update Provider Profile
- Create Subordinate Account
- Institutional Claim Submission with MassHealth
- View Remittance Advice Reports

Eligibility Verification

Eligibility Verification System (EVS)

- Accessed through the Provider On-Line Service Center.
- A web based application that enables MassHealth providers to verify member eligibility.
- Available 24 hours a day, seven days a week.
- Easy access to the most current and complete member eligibility information including
  - MassHealth Coverage Type
  - Third Party Liability Information
  - Hospice Election information

Eligibility Verification

MassHealth

Eligibility Verification System (EVS)

- It is important to note that in the eligibility interface, the member eligibility details are displayed on two different tabs. One tab is for "**Member Information**" such as member demographic data. The other tab is for "**Eligibility**" information including such as the dates of coverage and the coverage types.

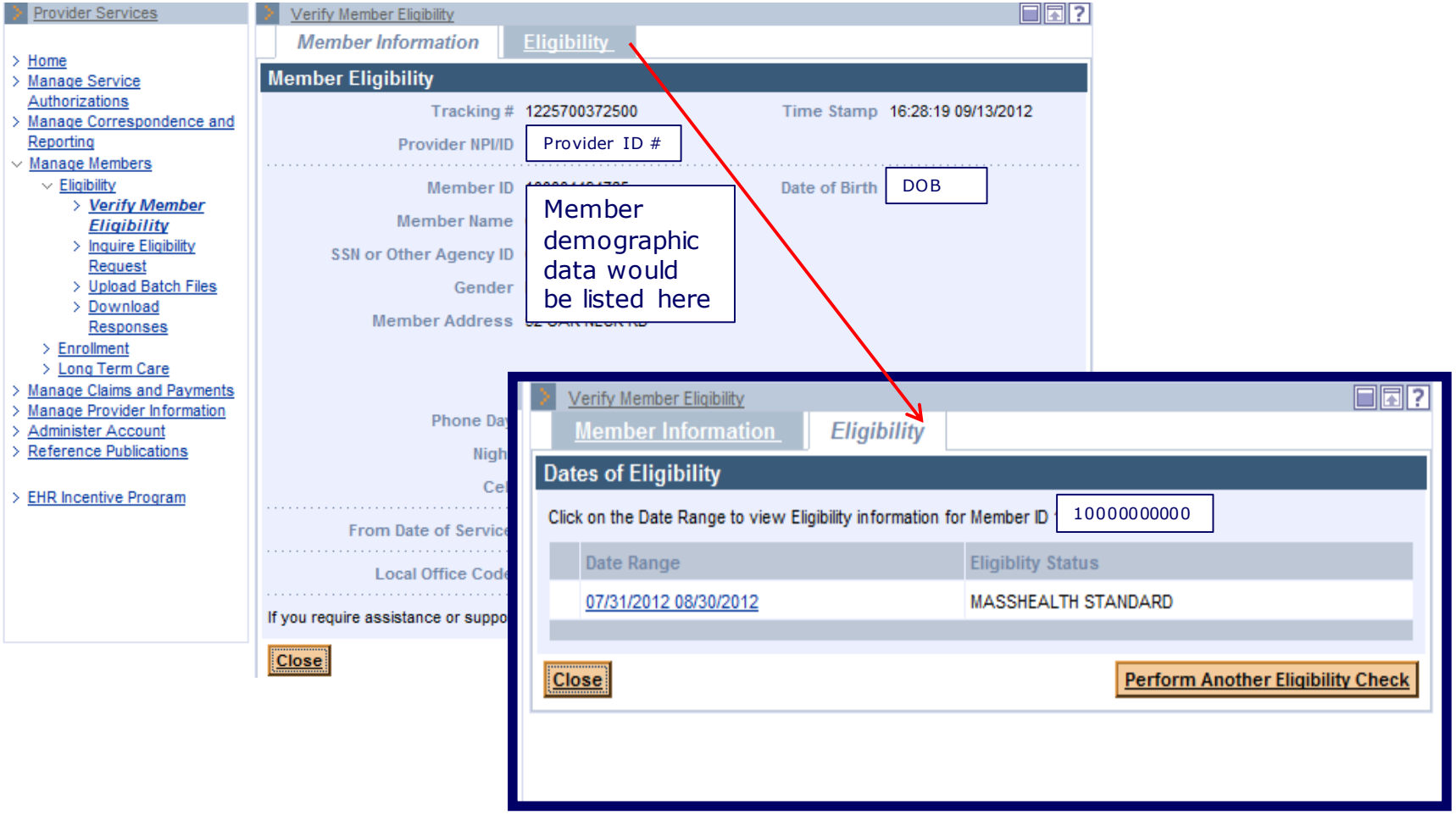
- Printing out the eligibility verification screens for in-facility filing is no longer necessary, as the POSC stores all eligibility verification transactions that occurred since May 26, 2009

  - To access historical eligibility inquiry details, click on "Manage Members" from the left hand side navigation bar and then on "Eligibility." Finally, click on "Inquire Eligibility Request."

Eligibility Verification

MassHealth

Eligibility Verification



Eligibility Verification

MassHealth

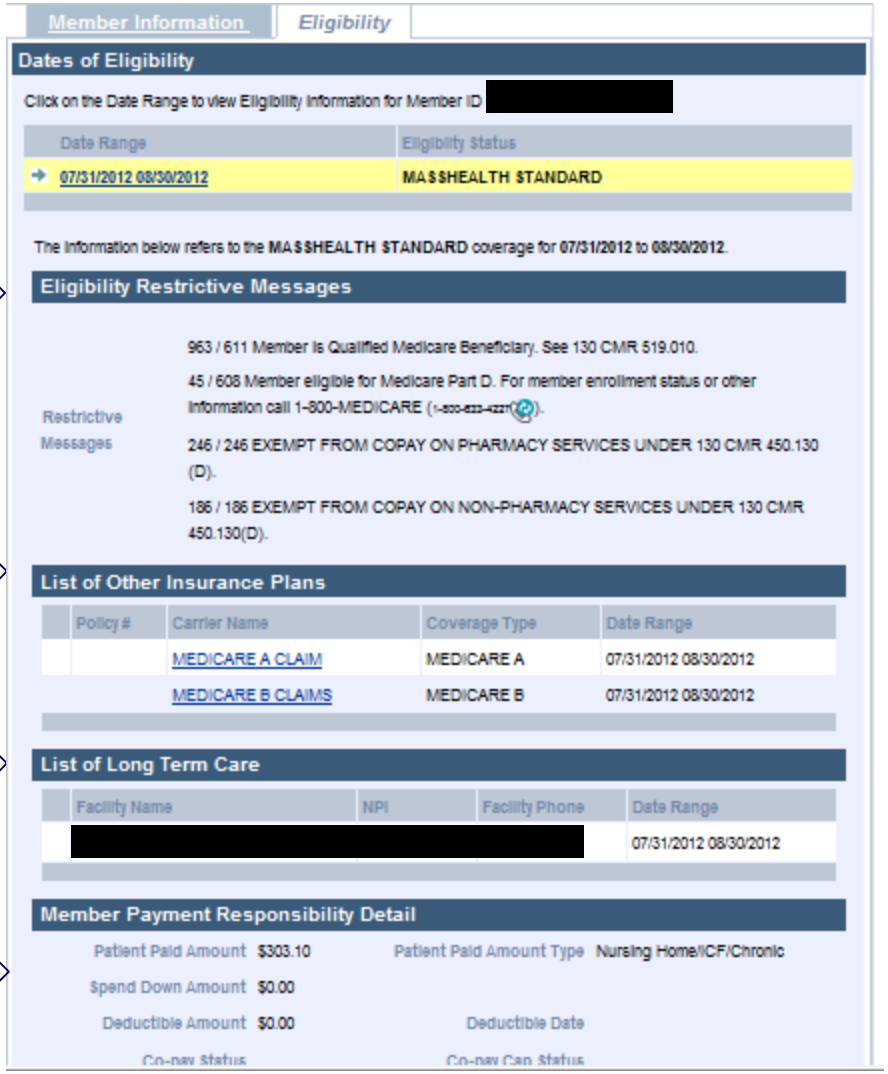
Eligibility Tab - detailed information

Restrictive Messages

Other Insurance information

List of Long Term Care or Managed Care information (such as SCOs or MCOs)

Member payment information such as Patient Pay Amount (PPA)



MassHealth

MMIS Billing/Claim Submission

MassHealth requires that all claims are submitted electronically.

Providers who are unable to submit electronic claims must request and receive an approved electronic submission waiver

All Provider Bulletin 217 outlines Waiver Process policy

Waiver form is available on the MassHealth Provider Forms web page or by calling MassHealth Customer Service at 1-800-841-2900

MassHealth

MMIS Billing/Claims Submission

Billing Timelines

30 Days:	Usual turnaround time for claims submitted directly to MassHealth
60 Days:	Usual turnaround time for Medicare/MassHealth crossover claims forwarded to MassHealth by GHI to be processed and appear on a Remittance Advice (RA)
90 Days:	Initial claims must be received by MassHealth within 90 days from the date of service; if another insurance was billed before MassHealth, it is ninety days from the date on the EOB
12 Months:	Final submission deadline for claims submitted directly to MassHealth. This period begins on the date of service (DOS).
18 Months:	Final submission deadline for claims submitted to another insurance carrier, prior to MassHealth. This period begins on the DOS.
36 Months:	Final submission deadline for crossover claims

MassHealth

MMIS Billing/Claims Submission

Provider Online Service Center includes

- Direct Data Entry (DDE) for claims - real time DDE claims processing provides the user with an immediate disposition of the claim upon submission
- Denied claims may be corrected and resubmitted as soon as they are adjudicated
- DDE is the submission option for claims that require attachments
- Electronic Data Interchange (EDI) 837 I&P transactions

Direct Data Entry (DDE)

Submitting claims via DDE

- MassHealth has incorporated a number of automated solutions into the POSC, including the ability to bill claims electronically without cost to the provider
- Direct Data Entry (DDE) can be used by providers for all of their claim submissions or for only some of their claim submissions
  - Can be used to submit *Coordination of Benefit* claims, i.e. when the member has more than one insurance
  - Can be used to submit claims when attachments are required
  - Can be used to submit adjustments
  - Can be used to resubmit denied claims

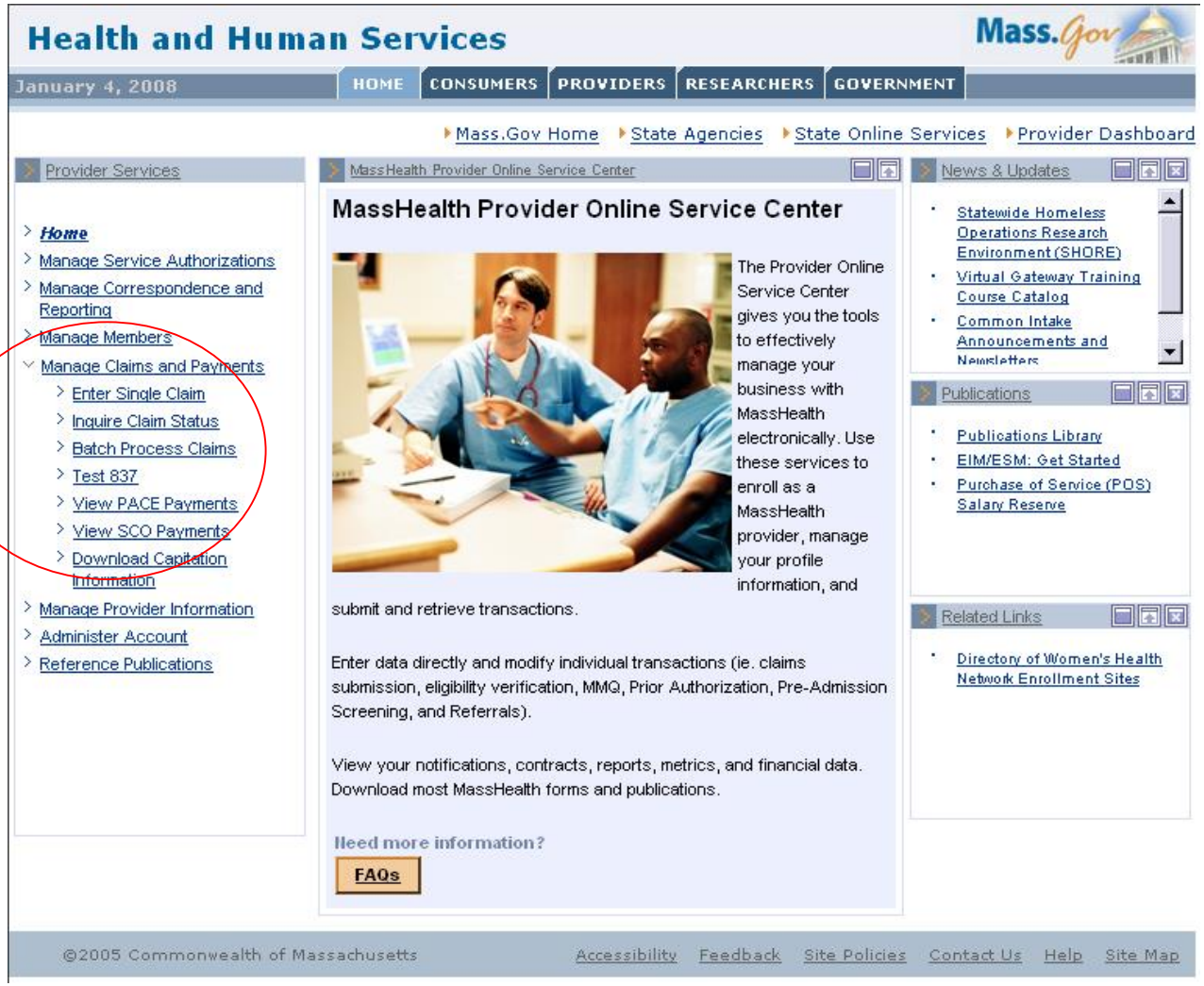
MassHealth

Direct Data Entry (DDE)

- Submitting a claim through Direct Data Entry (DDE) is an efficient way to quickly determine the outcome of a claim
  - Real Time Claims Status
  - Easy Resubmission Options
- When using this application, one must initially choose what type of claim they will be entering
  - Institutional or Professional
  - Each choice results in a slightly different interface, which affords a unique set of claim entry rules

MassHealth

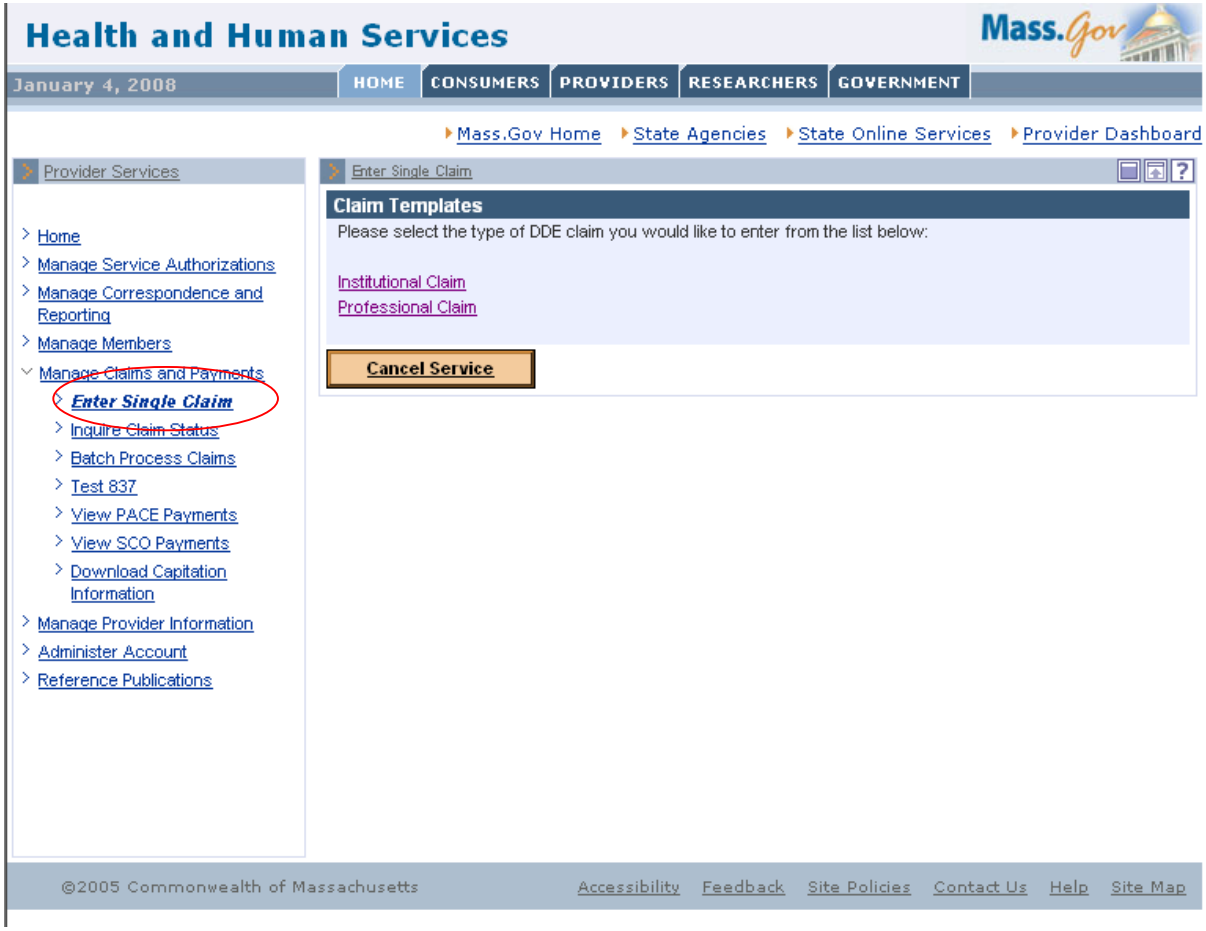
Manage Claims and Payments



MassHealth

Manage Claims and Payments

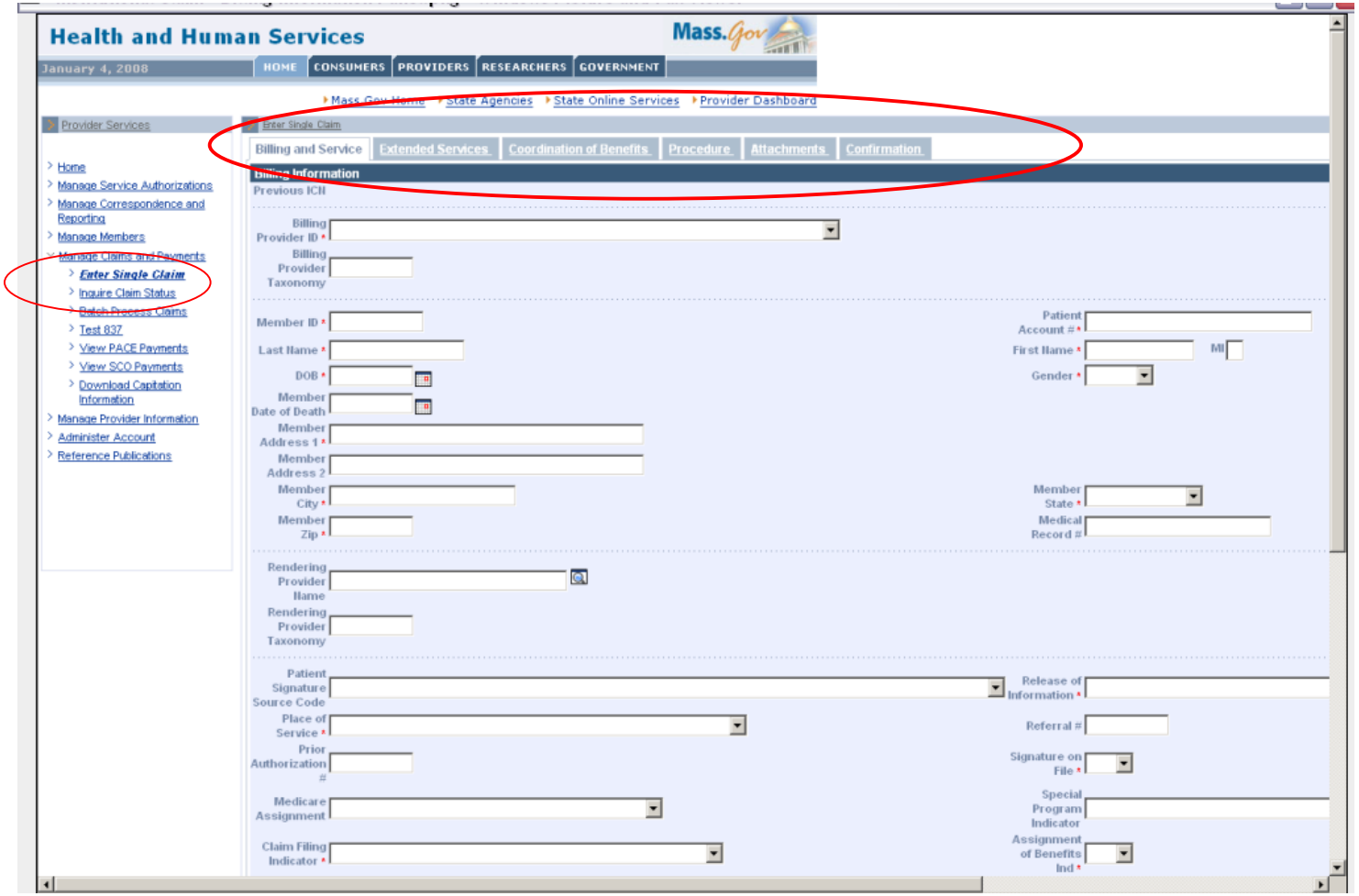
Enter Single Claim



MassHealth

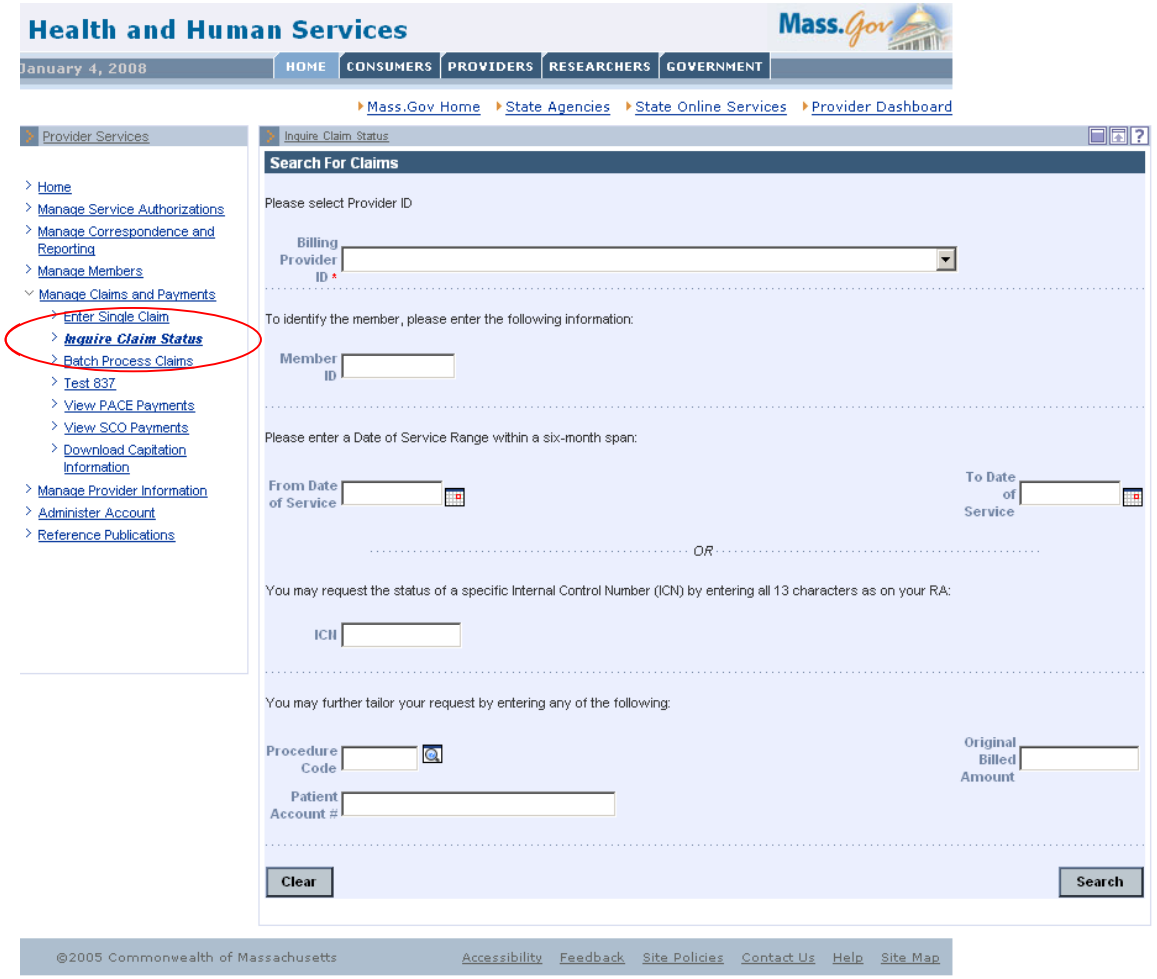
Manage Claims and Payments

Enter Single Claim



Manage Claims and Payments

Inquire Claim Status



Interchange Control Number (ICN)

- The MMIS Interchange Control Number (ICN) is a 13 digit number assigned to each claim adjudicated by MassHealth with built in logic for identifying specific claims and receipt dates

ICN Format: *RR YY JJJ BBB SSS*

- Top 10 Region Codes

10	Paper Claims With No Attachments
11	Paper Claims With Attachments
20	Electronic Claims With No Attachments
21	Electronic Claims With Attachments
22	Internet Claims With No Attachments
23	Internet Claims With Attachments
52	Mass Adjustments-Non Check Related
59	Internet/Electronic Voids or Adjustments

MassHealth

Remittance Advice (RA)

What is a Remittance Advice (RA)?

- A report that provides claims processing status to providers indicating if the claim status is paid, denied or suspended
- The RA is utilized by providers in order to reconcile their accounts with MassHealth
- Available on the Provider On-Line Service Center for viewing, downloading & printing
- The RA also provides message text and financial information

MassHealth

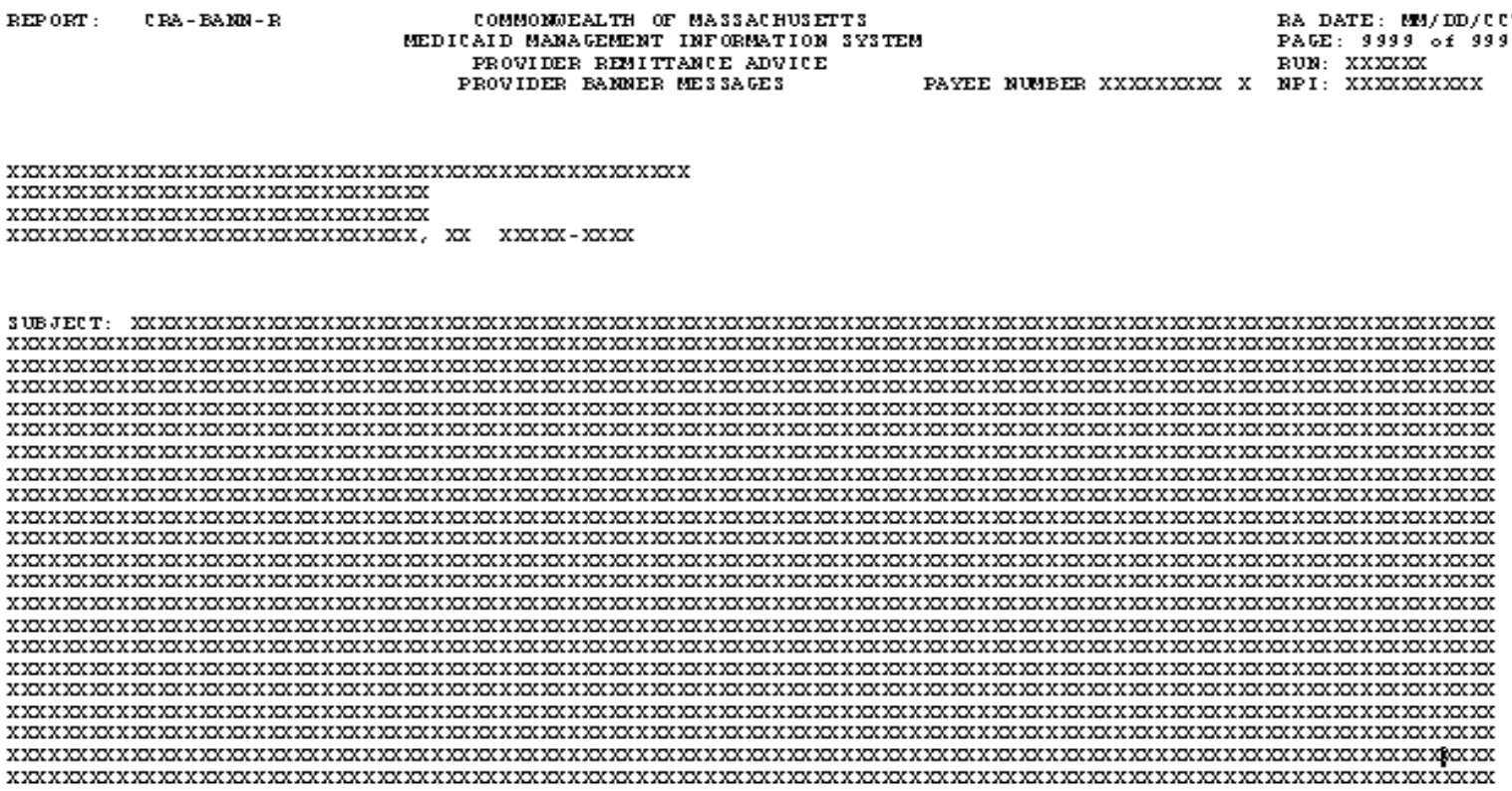
Remittance Advice (RA)

The PDF remittance advice (RA) is posted to the Provider Online Service Center (POSC)*

- Providers will need to download this document from the Provider Online Service Center.
  - ❑ Sign on to the POSC
  - ❑ Click on "Manage Correspondence and Reporting"
  - ❑ Click "View Metrics and Reports"
  - ❑ Choose a provider name from the drop down list
  - ❑ Hit Search
  - ❑ The View Claims Metrics/Reports panel appears for the provider

* Please note that the POSC will only post the PDF remittance advice (RA) for 6 months. Providers are advised to save the PDF RAs in a separate location.

Remittance Advice (RA)



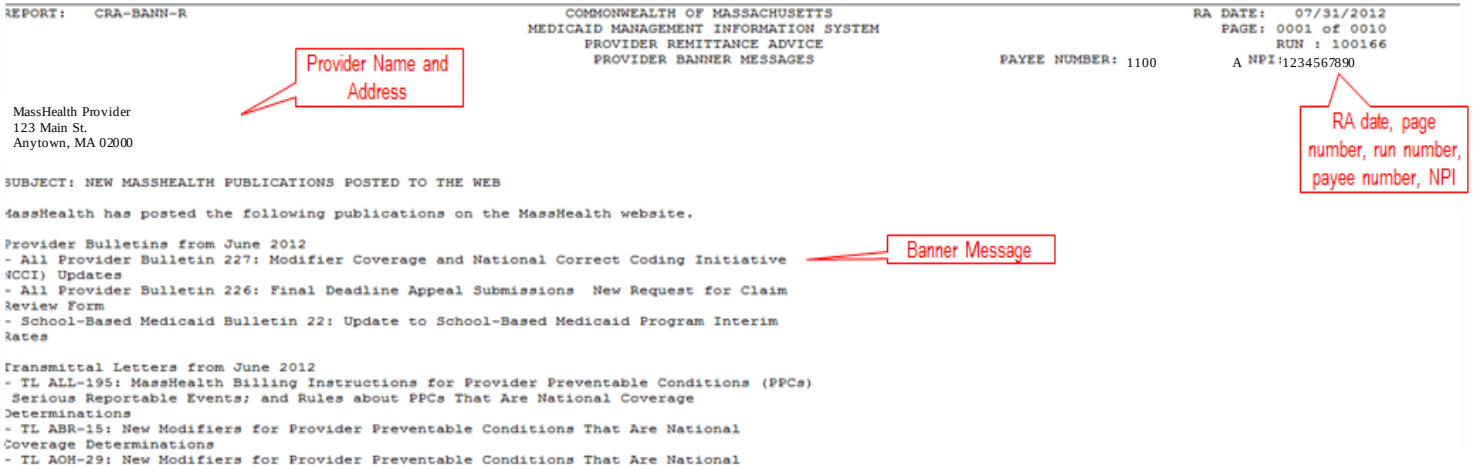
- *The Remittance Advice will tell you if there was an error that prevented your claim from processing. A message will tell you what was wrong. For Instance, code 0203- Member ID number missing/invalid.*
- *See the billing tip flyer Using Remittance Advices to Reconcile Your Accounts for further details*

Remittance Advice (RA)

Read Remittance Advice (RA) on the Provider Online Service Center

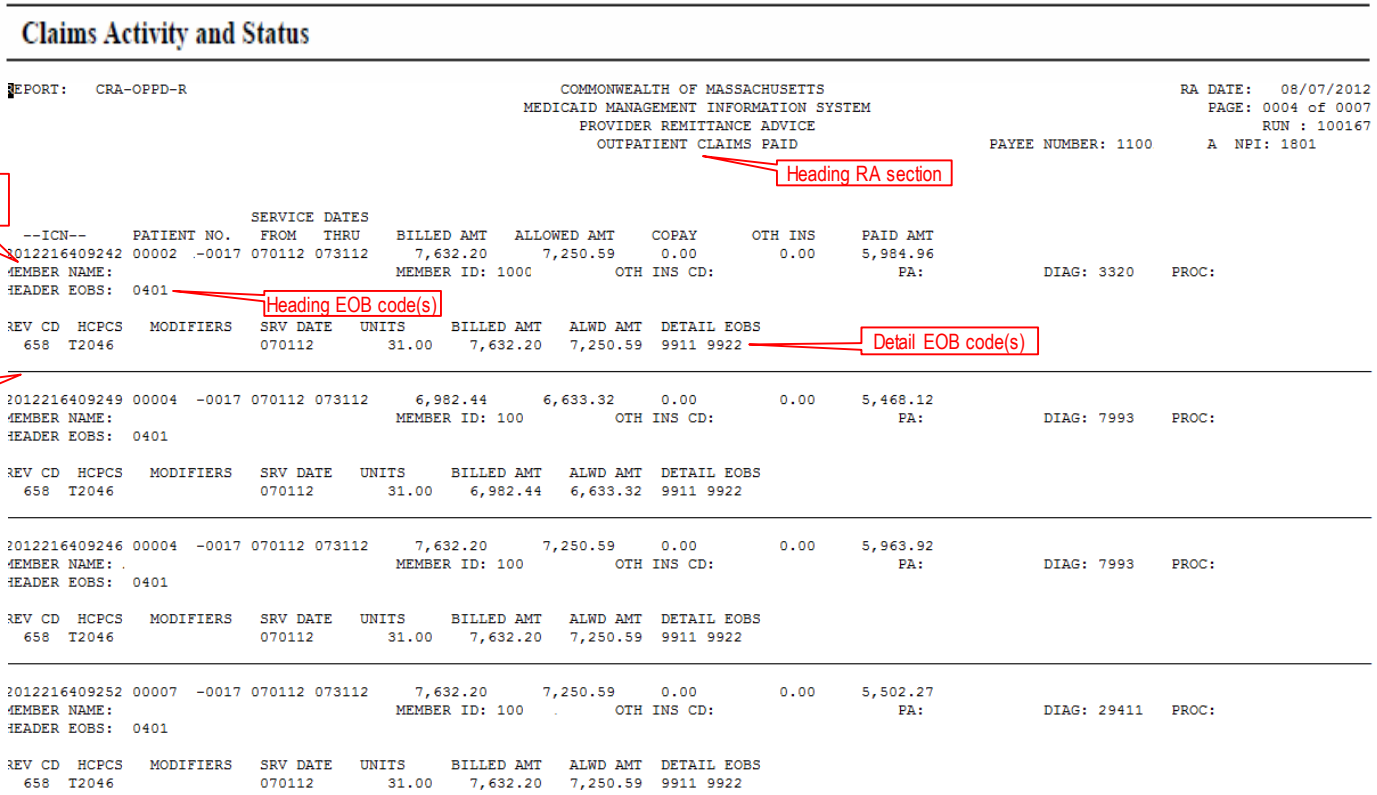
Note: Some pictures are narrowed.

Address/Banner



```
REPORT:    CRA-BANN-R                COMMONWEALTH OF MASSACHUSETTS                RA DATE:    07/31/2012
                                  MEDICAID MANAGEMENT INFORMATION SYSTEM           PAGE:  0001 of 0010
                                        PROVIDER REMITTANCE ADVICE                      RUN : 100166
                                        PROVIDER BANNER MESSAGES      PAYEE NUMBER: 1100      A NPI:1234567890

MassHealth Provider
123 Main St.
Anytown, MA 02000

SUBJECT: NEW MASSHEALTH PUBLICATIONS POSTED TO THE WEB

MassHealth has posted the following publications on the MassHealth website.

Provider Bulletins from June 2012
- All Provider Bulletin 227: Modifier Coverage and National Correct Coding Initiative
NCCI) Updates
- All Provider Bulletin 226: Final Deadline Appeal Submissions  New Request for Claim
Review Form
- School-Based Medicaid Bulletin 22: Update to School-Based Medicaid Program Interim
Rates

Transmittal Letters from June 2012
- TL ALL-195: MassHealth Billing Instructions for Provider Preventable Conditions (PPCs)
 Serious Reportable Events; and Rules about PPCs That Are National Coverage
Determinations
- TL ABR-15: New Modifiers for Provider Preventable Conditions That Are National
Coverage Determinations
- TL AOH-29: New Modifiers for Provider Preventable Conditions That Are National
```

Remittance Advice (RA)



Claims Activity and Status

REPORT: CRA-OPPD-R

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
OUTPATIENT CLAIMS PAID

RA DATE: 08/07/2012
PAGE: 0004 of 0007
RUN : 100167
PAYEE NUMBER: 1100 A NPI: 1801

Heading RA section

Claim and member information

--ICN--	PATIENT NO.	SERVICE DATES FROM	THRU	BILLED AMT	ALLOWED AMT	COPAY	OTH INS	PAID AMT
2012216409242	00002 -0017	070112	073112	7,632.20	7,250.59	0.00	0.00	5,984.96

MEMBER NAME: MEMBER ID: 1000 OTH INS CD: PA: DIAG: 3320 PROC:

HEADER EOBS: 0401

Heading EOB code(s)

REV CD	HCPCS	MODIFIERS	SRV DATE	UNITS	BILLED AMT	ALWD AMT	DETAIL EOBS
658	T2046		070112	31.00	7,632.20	7,250.59	9911 9922

Detail EOB code(s)

Another claim (separated by line)

2012216409249	00004	-0017	070112	073112	6,982.44	6,633.32	0.00	0.00	5,468.12

MEMBER NAME: MEMBER ID: 100 OTH INS CD: PA: DIAG: 7993 PROC:

HEADER EOBS: 0401

REV CD	HCPCS	MODIFIERS	SRV DATE	UNITS	BILLED AMT	ALWD AMT	DETAIL EOBS
658	T2046		070112	31.00	6,982.44	6,633.32	9911 9922

2012216409246	00004	-0017	070112	073112	7,632.20	7,250.59	0.00	0.00	5,963.92

MEMBER NAME: MEMBER ID: 100 OTH INS CD: PA: DIAG: 7993 PROC:

HEADER EOBS: 0401

REV CD	HCPCS	MODIFIERS	SRV DATE	UNITS	BILLED AMT	ALWD AMT	DETAIL EOBS
658	T2046		070112	31.00	7,632.20	7,250.59	9911 9922

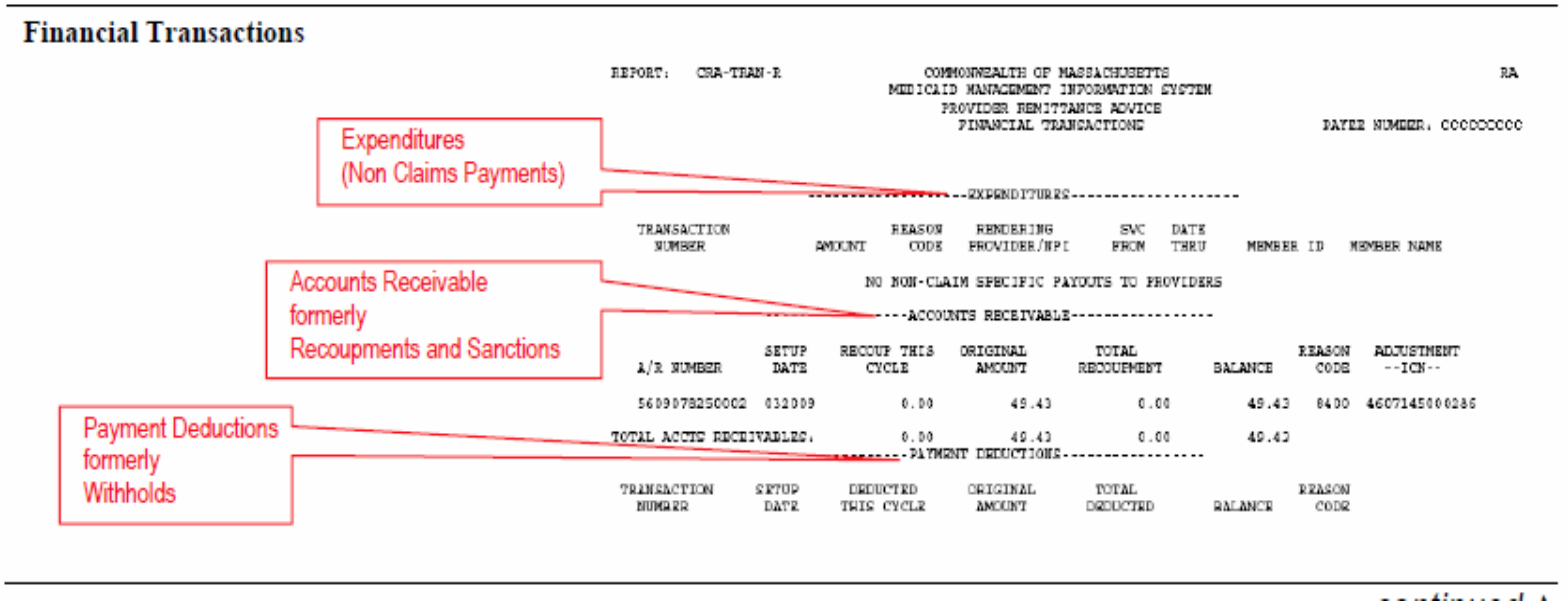
2012216409252	00007	-0017	070112	073112	7,632.20	7,250.59	0.00	0.00	5,502.27

MEMBER NAME: MEMBER ID: 100 OTH INS CD: PA: DIAG: 29411 PROC:

HEADER EOBS: 0401

REV CD	HCPCS	MODIFIERS	SRV DATE	UNITS	BILLED AMT	ALWD AMT	DETAIL EOBS
658	T2046		070112	31.00	7,632.20	7,250.59	9911 9922

Remittance Advice (RA)



Financial Transactions

REPORT: CRA-TRAN-R COMMONWEALTH OF MASSACHUSETTS RA
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS PAYEE NUMBER: CCCCCCCCC

Expenditures (Non Claims Payments)

----------EXPENDITURES----------

TRANSACTION NUMBER	AMOUNT	REASON CODE	RENDERING PROVIDER/NPI	SVC FROM	DATE THRU	MEMBER ID	MEMBER NAME

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

Accounts Receivable formerly Recoupments and Sanctions

----------ACCOUNTS RECEIVABLE----------

A/R NUMBER	SETUP DATE	RECOUP THIS CYCLE	ORIGINAL AMOUNT	TOTAL RECOUPMENT	BALANCE	REASON CODE	ADJUSTMENT --ICN--
5609078250002	032009	0.00	49.43	0.00	49.43	8400	4607145000285
TOTAL ACCTS RECEIVABLES:		0.00	49.43	0.00	49.43		

Payment Deductions formerly Withholds

----------PAYMENT DEDUCTIONS----------

TRANSACTION NUMBER	SETUP DATE	DEDUCTED THIS CYCLE	ORIGINAL AMOUNT	TOTAL DEDUCTED	BALANCE	REASON CODE

Remittance Advice (RA)

MassHealth

TPL Information

- List of any claims affected by TPL
- TPL letter no longer sent

REPORT: CRA-TPLP-R

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
TPL INFORMATION

RA DATE: MM/DD/CCYY
PAGE: 9999 of 9999
RUN: 9999
PAYEE NUMBER XXXXXXXXX X NPI: XXXXXXXXXX

MEMBER NAME / POLICY HOLDER NAME	MEMBER NUMBER / POLICY NUMBER / COVERAGE DATES /	--ICN-- / GROUP NUMBER / COVERAGE TYPE	CARRIER/EMP ID / BILLING ADDRESS	CARRIER/EMPLOYER NAME
JANE DOE	XXXXXXXXXXXX XXXXXXXXXXXXXXXX/ XX/XX/XX - XX/XX/XX /	RRYYJJJBBBSS XXXXXXXXXXXXXXX XXXXX	XXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX, XX XXXXX-XXXX	BLUE CROSS BLUE SHEILD MEDEX GOLD
JANE DOE	XXXXXXXXXXXX XXXXXXXXXXXXXXXX/ XX/XX/XX - XX/XX/XX /	RRYYJJJBBBSS XXXXXXXXXXXXXXX XXXXX	XXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX, XX XXXXX-XXXX	TUFTS MEDICARE PREFERRED

Summary Report

- Summary of all claim and financial activity for each weekly cycle
- Year-to-date totals of all claim and financial activity

REPORT: CRA-SUMM-R

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
SUMMARY

RA

PAYEE NUMBER: CCCCCCCCC

------------------------CLAIMS DATA--------------------------

	CURRENT NUMBER	CURRENT AMOUNT	YEAR-TO-DATE NUMBER	YEAR-TO-DATE AMOUNT
CLAIMS PAID	0	0.00	4	121.65
CLAIM ADJUSTMENTS	0	0.00	0	0.00
TOTAL CLAIMS PAYMENTS	0	0.00	4	121.65
CLAIMS DENIED	0		0	
CLAIMS SUSPENDED	1			
CLAIMS PENDED	0			

----------------------PAYMENT DATA--------------------------

EOB Descriptions

REPORT: CRA-EOBM-R

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
EOB CODE DESCRIPTIONS

RA

PAYEE NUMBER: GGGGGGGGG

List of the EOB codes used in the RA

Description of EOB codes

EOB CODE	EOB CODE DESCRIPTION
0256	MISSING MEDICARE PAID DATEDETAIL
4014	NO PRICING SEGMENT ON FILE
4170	UNITS BILLED GREATER THAN ALLOWED

Metrics and Reports

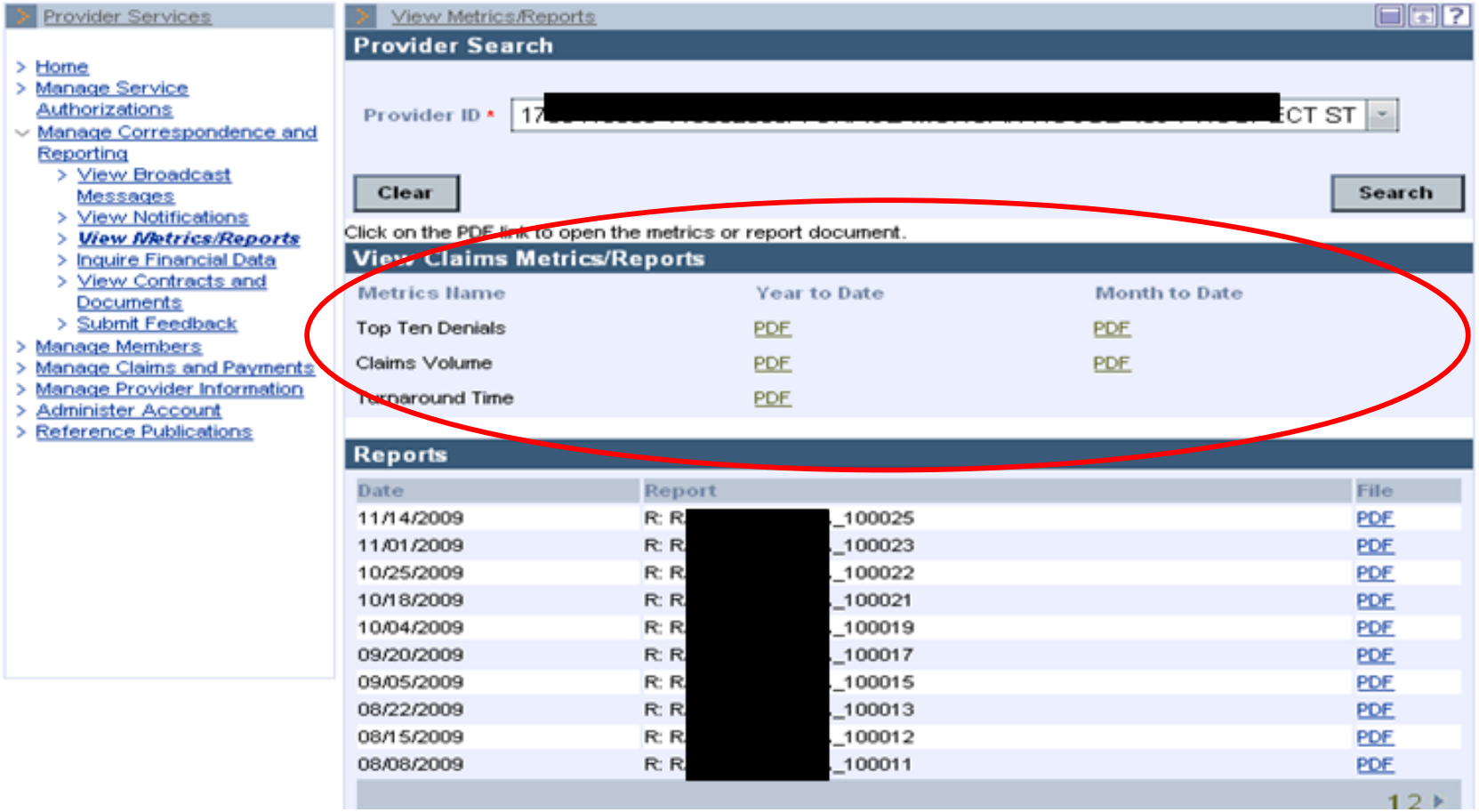
MassHealth

Viewing your Metrics and Reports

- Metrics and reports are tailored to each provider and represent data that has been generated by MMIS
- They are available on the Provider Online Service Center (POSC) through the View Metrics & Reports link, under Manage Correspondence and Reporting
- The following are available:
  - Remittance advices (RAs)
  - Top 10 claims denials
  - Volume, turnaround time and payment reports
  - Financial data
- Please reference the job aid available at www.mass.gov/masshealth/newmmis from the "Need Additional Information and Training" link and the "Get Trained" link

Metrics and Reports

Manage Correspondence and Reporting > View Metrics/Reports



Metrics and Reports

CLAIMS VOLUME REPORT

Report : PRV-0072-R
Process : WEB
Location: PORTAL

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER METRICS CLAIMS VOLUME
REPORT PERIOD: YTD AS OF 11/14/2009

Run Date: 11/20/2009
Run Time: 07:11
Page: 1

PROVIDER NAME : [redacted]

CLAIM VOLUME 110[redacted]

# CLAIMS SUBMITTED	152	# PAID	134	# DENIED	18
% SUBMITTED ELECTRONICALLY	100.0	% PAID	88.158	% TOTAL DENIED	11.842

MASS HEALTH AVERAGE CLAIM VOLUME - FOR PROVIDER TYPE:62

# CLAIMS SUBMITTED	80,853	# PAID	68,051	# DENIED	12,802
% SUBMITTED ELECTRONICALLY	93.426	% PAID	84.166	% TOTAL DENIED	15.834

Metrics and Reports

TURNAROUND TIME REPORT

Report : [redacted]
Process : WEB
Location: PORTAL

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER METRICS - TURNAROUND TIME
REPORT PERIOD: YTD AS OF 11/14/2009

Run Date: 11/20/2009
Run Time: 07:11
Page: 1

PROVIDER NAME : [redacted]

TURNAROUND TIME - YEAR TO DATE

	<30 DAYS	30-60 DAYS	60-90 DAYS	>90 DAYS
DATE OF SERVICE - 1ST DATE OF SUBMISSION				
MASSHEALTH	.466 %	.369 %	.091 %	.074 %
[redacted]	.908 %	.02 %	.02 %	.053 %
DATE OF RECEIPT - DATE OF FIRST DENIAL				
MASSHEALTH	.985 %	.014 %	.001 %	.0 %
[redacted]	.889 %	.111 %	.0 %	.0 %
DATE OF RECEIPT - 1ST PAYMENT DATE				
MASSHEALTH	.999 %	.0 %	.0 %	.0 %
[redacted]	1.0 %	.0 %	.0 %	.0 %

Metrics and Reports

TOP TEN DENIALS REPORT

Report : [redacted]
Process : WEB
Location: PORTAL

COMMONWEALTH OF MASSACHUSETTS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER METRICS - TOP TEN DENIALS
REPORT PERIOD: YTD AS OF 08/22/2009

Run Date: 11/20/2009
Run Time: 07:11
Page: 1

PROVIDER NAME : [redacted]

RANK	ERROR CODE	ERROR DESCRIPTION	CLAIMS DENIED	TOTAL BILLED	PERCENT OF TOTAL CLAIMS DENIED	PERCENT OF TOTAL CLAIMS SUBMITTED
1	4021	PROCEDURE NOT COVERED FOR BENEFIT PLAN	6	$2,742	33.333	3.947
2	2001	MEMBER ID NUMBER NOT ON FILE	6	$2,298	33.333	3.947
3	2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE	3	$1,129	16.667	1.974
4	2802	NO BENEFIT PROGRAM FOR MEMBER FOUND	3	$1,129	16.667	1.974
5	248	PLACE OF SERVICE IS MISSING OR BLANK	2	$2,379	11.111	1.316
6	259	DATE BILLED IS MISSING/INVALID	2	$2,379	11.111	1.316
7	508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS	1	$1,250	5.556	.658
8	4032	PROCEDURE CODE NOT ON FILE	1	$1,250	5.556	.658
9	5044	EXACT DUPLICATE - PHYSICIAN CLAIM	1	$564	5.556	.658

MassHealth

MMIS Top Denials* for Hospice

EDIT	DESCRIPTION	DENIED	CAUSE
2800	MEMBER NOT TIED TO HOSPICE ON DOS	2,764	Eligiblity
4801	PROCEDURE NOT COVERED BY PROVIDER CONTRACT	1,140	Billing Error
2502	MEMBER COVERED BY OTHER INSURANCE-DENY	853	Eligiblity
270	HEADER TOTAL BILLED AMOUNT MISSING	252	Billing Error
4252	ADMIT OR EMERG DIAGNOSIS CODE NOT ON FILE	237	Billing Error
1945	MULT SAK PROV LOCS FOR BILLING PROV SPEC	121	Provider Enrollment
4021	PROCEDURE NOT COVERED FOR BENEFIT PLAN	63	Billing Error
4227	REVENUE NOT COVERED FOR BENEFIT PLAN	55	Billing Error
2001	MEMBER ID NUMBER NOT ON FILE	26	Eligiblity
2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE	18	Eligibility

**Claims adjudicated March 2015

MassHealth

90-Day Waiver Request

When to Submit a 90-Day Waiver Request

You may request a 90-day waiver when the submission date of the claim is beyond 90 days from the service date or the date on an explanation of benefits (EOB) from another insurer and you meet one or more of the following conditions:

- you are changing the member ID number;
- you are changing the pay-to provider number;
- you are changing the claim form/claim type; or
- you are billing the claim for the first time, and meet the criteria outlined in MassHealth regulations at 130 CMR 450.309 through 450.314.

The following circumstances do not require a 90-day waiver:

- claims that will be received within 90 days from the date on a third-party payer's EOB and still within 18 months of the service date; and
- claims that can be resubmitted according to the administrative and billing instructions in Subchapter 5 of your MassHealth provider manual.

MassHealth

90-Day Waiver Request

Providers are encouraged to submit 90-Day waiver requests electronically

How to Submit an electronic 90-Day Waiver Request

- Prepare a new electronic DDE claim
- Enter the appropriate HIPAA delay reason code (please refer to All Provider Bulletin 220)
- Scan any supporting documentation such as copies of retroactive enrollment notices
- Use the attachments tab to upload scanned images and affix to each claim

How to Submit a paper 90-Day Waiver Request

- Prepare a new paper claim form
- Attach to each claim, a copy of all RAs (remittance advices) where the claim has appeared, if applicable
- Attach any other supporting documentation, such as copies of retroactive enrollment notices, to each claim
- Attach the 90-Day Waiver Request Form to each claim stating the reason for the waiver request

The waiver request form can be found at www.mass.gov/masshealth. Click on the link for MassHealth Provider Forms in the lower right panel of the home page. Do not enter resubmittal or adjustment information, and do not enter a former internal control number (ICN).

MassHealth

Final Deadline Appeals

Final Deadline Exceeded Appeal Procedures

Pursuant to M.G.L. c. 118E, s. 38, MassHealth has established procedures for appealing claims with service dates exceeding one year, or 18 months when third-party insurance is involved, that providers believe were denied or underpaid as a result of MassHealth error. The Final Deadline Appeals Board has exclusive jurisdiction to review the appeals in accordance with MassHealth regulations at 130 CMR 450.323.

To be eligible for appeal, your claim must have been denied for error code 853 or 855 (Final Deadline Exceeded). The appeal must be filed within 30 days of the date that appears on the remittance advice on which your claim first denied with error code 853 or 855. In order for your appeal to be approved, you must demonstrate that the claim was denied or underpaid as a result of MassHealth error, and could not otherwise be timely resubmitted.

MassHealth

Final Deadline Appeals

How to Submit an electronic Final Deadline Appeal Request

- Prepare a new electronic DDE claim
- Enter the appropriate HIPAA delay reason code (please refer to All Provider Bulletin 221)
- Scan any supporting documentation such as a cover letter, corrected claim form and all the remittance advices the claim has appeared on (including the 835/855 denial) and any other supporting documentation
- Use the attachments tab to upload scanned images and affix to each claim

How to Submit a paper Final Deadline Appeal Request

If you wish to file an appeal, send a cover letter, a corrected claim form, all the remittance advices the claim has appeared on (including the 853/855 denial) and any other supporting documentation to the following address.

MassHealth
ATTN: Final Deadline Appeals Unit
100 Hancock Street, 6th Floor
Quincy, MA 02171

You can inquire on the status of your appeal request by sending an e-mail to ***fdeappeals@state.ma.us*** or by calling 617-847-3115.

MassHealth

Best Business Practices

- Before mailing any documents, please make copies to keep with your records
- Keep your records in a location where you can easily access
- Keep your records for 6 years
- Keep your MassHealth contact information up to date

MassHealth

ICD-10 Implementation

MassHealth will implement ICD-10 on October 1, 2015

MassHealth Status

- Trading Partner Testing (TPT) is underway
- Training & education sessions for MassHealth's implementation will be held this spring through early fall

How do I determine if I have to do anything to implement ICD-10 with MassHealth?

- If you submit claims to MassHealth you must adopt the ICD-10 code-set
- If you submit batch claims transactions to MassHealth you must modify and test your transactions prior to implementation
- If you use a software vendor or have a relationship with a billing intermediary or clearing house that submits transactions on your behalf, it is equally important that those entities test their software and/or transactions with MassHealth directly.

Provider Readiness

What you should do to prepare for MassHealth's implementation

- Contact the EDI testing team immediately **at 1-855-295-4047 (toll free) or edi@mahealth.net** to schedule your test date
- Confer with your billing intermediary and/or clearing house as required to confirm their readiness for ICD-10
- Review the MassHealth ICD-10 website at https://www.mass.gov/masshealth/icd-10 to obtain and leverage useful information related to MassHealth's implementation (i.e. billing instructions, provider presentations, FAQs, key concepts, etc...). These materials are key to your ability to successfully implement ICD-10 with MassHealth
- Monitor MassHealth communications for critical cut-over information related to prior authorizations, pre-admission screening, and other key transition issues

MassHealth Resources

- **MassHealth Website: www.mass.gov/masshealth**
  - Provider Library of MassHealth publications
    - Provider Manuals
    - Provider Bulletins
    - Billing Guides
- **MMIS Website: www.mass.gov/masshealth/newmmis**
  - Access to POSC job aids
- **Provider Online Service Center (POSC) www.mass.gov/masshealth/providerservicecenter**
  - Online MMIS provider access MassHealth eligibility verification, claim and Provider Information
- **MassHealth Customer Service (800-841-2900)**
  - Customer support (eligibility and claims status inquiries must use the POSC)
  - Or e-mail us at providersupport@mahealth.net
- **MassHealth 5010 Initiative: www.mass.gov/masshealth/5010**
  - Verify changes and updates that were specific to the 5010 initiative

Questions…

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…Answers