

Vendor Session Questions and Answers

General

Q:	When will MassHealth begin to accept HIPAA 5010 production files?
A:	January 1, 2012
Q:	What are the “Pass” criteria for submitting HIPAA 5010 production files?
A:	Submitters must have a majority of their claims in the Paid status, in the 4010 production environment.
Q:	Will MassHealth test by specialty type?
A:	MassHealth will test all scenarios that cover a cross section of all our provider types.
Q:	Will MassHealth test only with billing intermediaries?
A:	MassHealth will test with all trading partners that have submitted transactions directly to MassHealth within the last 12 months.
Q:	Do we have to submit only claims with NPIs during testing?
A:	All claims must use the NPI where required.
Q:	Will MassHealth issue 835s more frequently during testing?
A:	835s will be issued at a minimum on a weekly basis during our testing phases.
Q:	Will MassHealth test 276 transactions?
A:	Yes. Please refer to our Web site at www.mass.gov/masshealth/5010 to understand the full scope of our testing.
Q:	Does MassHealth have a disaster plan in place in case we are not ready to go on 01/01/2012?
A:	MassHealth will be ready for 01/01/2012. We will leverage our previous experience with the implementation of NewMMIS to ensure we meet this date. Contingencies will be invoked as required.
Q:	Will MassHealth be accepting dual transactions?

A:	No.
Q:	How will testers know the status of their test submissions?
A:	A 999 acknowledgement will be available for all successful test file submissions. Additionally, MassHealth will outreach to testers directly by phone or e-mail to communicate the status of the test file. If you are testing 837 transactions, you can also review the status of your claims by performing a claim status inquiry in our 5010 test environment.
Q:	Will there be a separate contact number for any questions about 5010 transactions?
A:	Yes. The number will be provided to the participants involved in that testing phase when the testing phase begins.
Q:	What is the time frame for 5010 testing?
A:	5010 testing will be conducted from July 2011 through December 2011.
Q:	Will the zip code allow us to enter the leading zeros or will we have to enter the correct four digits?
A:	The first five digits must be a valid zip code. The last four digits can be zeros, while valid numbers are preferred.
Q:	Will MassHealth test coordination of benefits (COB) transactions?
A:	Yes.

837I

Q:	In Section 3.8.2 of the 837I Companion Guide, the element CL101 was changed with A2, to be “Priority (Type) of Admission or Visit” rather than “Admission Type Code,” but the code set used has stayed the same.
A:	MassHealth will update the companion guide based on what the Addendum reflects.
Q:	In Section 3.8.2 of the 837I Companion Guide, the element CL102 was changed with A2, to be “Point of Origin for Admission or Visit” rather than “Admission Source Code,” but the code set used has stayed the same.

A:	MassHealth will update the code set based on what the Addendum reflects.
Q:	In Section 3.8.2 of the 837I Companion Guide, for the element 2310 NM109, it states “Enter NPI.” Should we enter the value “NPI” or the provider's NPI?
A:	Providers should enter their NPI number in NM109. MassHealth will update the companion guide to clarify this.
Q:	We currently do not submit a diagnosis code, but it is required on all 5010 claims. Do we need to submit one?
A:	5010 submissions require a diagnosis code on all claims. If a diagnosis code is not submitted, it will fail HIPAA compliance and the claim will not process.
Q:	Should we test the ability to void and replace claims?
A:	Testing should reflect your normal business activity with MassHealth. If that normal business activity includes voiding and replacing claims, you should test this functionality.
Q:	The Patient Reason for Visit field (2300 HI01-1=PR) is required for all outpatient claims, but I do not see any reference to the segment in the companion guide.
A:	MassHealth defers to the requirements as stated in the 837I Implementation Guide. This field is required when the claim involves outpatient visits.

270/271

Q:	In Section 2.2, Paragraph 3 of the 270/271 Companion Guide, the first sentence states that if the provider sends all the data elements in the 270, then MMIS will process the inquiry based on the order mentioned above (ID, SSN, Name/DOB/Gender). However, the very next statement reads, “If all data elements are provided, a search will be made using only the Member Identifier...MMIS will not perform multiple searches based on the data provided in the 270 request.”
A:	MassHealth performs searches in a hierarchical manner. If all data elements for a search are entered, the Member ID is used to find a match. If no match is found then it attempts to search by the secondary search elements to find a match.
Q:	In Section 3.2.1 of the 270/271 Companion Guide, there is reference to PRV02 being “PXC.” Does this mean that MassHealth requires the taxonomy for the Submitting Provider?

A:	The 270/271 Implementation Guide states that, “If not required by this implementation guide, may be provided at sender’s discretion but cannot be required by the receiver.” This field is not required by MassHealth for this transaction type.
Q:	In Section 3.2.3 of the 270/271 Companion Guide, for Other Insurance - 2110C REF, MassHealth states that they will return the Other Insurance Policy Holder's name when REF01 = IL. However, according to Technical Report 3 (TR3), REF03 I “Required when REF01 = 18, 6P, or N6, and a name needs to be associated with the corresponding identifier. If not required by this implementation guide, do not send.”
A:	MassHealth will update the 270/271 Companion Guide to change possible qualifier value of GP to 6P, as well as the value for Qualifier of 1L to “other insurance policyholder name.” A6 will be removed as a qualifier for 5010.
Q:	Copay Cap Pharmacy/NonPharmacy uses EB01=D. What is the difference between CoPay (EB01=B) and this?
A:	This is a feature that MassHealth has displayed since 4010 implementation. The EB01=D value indicates if a member has met their copayment cap amount. EB01 represents the copayment required.
Q:	Appendix D indicates that you process true batch requests through the Provider Online Service Center (POSC). How about via the Healthcare Transaction Service (HTS) Web service?
A:	True batch requests are currently processed only through the POSC.
Q:	For the other insurance plan 2110C loop, is the insurance plan name indicated for EB05, the same as indicated for the 2120C NM103 within the same EB loop?
A:	No. NM103 should contain the Plan Name and EB05 should contain the Type of Coverage.
Q:	The long term care 2110C loop is using the EB01 value of X. Where is the documentation for the coded value that is being sent in EB05?
A:	The coded value being sent is documented in the 270/271 Companion Guide. It includes the Management Minutes Category (MMC) and Management Minutes Questionnaire (MMQ) score in the 2110C section, under the Long Term Care portion of the response.
Q:	For the patient paid amount 2110C loop, which is using the EB01 = G for Out of Pocket (Stop Loss), this value is usually sent as a limit at which point the insured is no longer paying out of pocket. If the patient paid amount is being sent with this loop, how will the provider know what the recipient’s stop loss limit is?

A:	MassHealth returns a copay cap response as well. (See next question.)
Q:	For the copay cap status pharmacy 2110C loop, which is using the EB01 = D for benefit description, the EB05 description (“copay cap status pharmacy”) does not include a description of the benefit. How will the provider know the meaning of “met” and “not met” without a description?
A:	Value of “met” and “not met” are to indicate if a member has met the cap for copayments or has not met that cap. MassHealth will update the companion guide with further clarification.
Q:	Is the minimum set of service types identified for the 5010 Technical Report 3 (TR3) going to be returned?
A:	Yes.
Q:	For the behavioral health 2110C loop, which is using EB01 = W for other source of data, this appears to be an unexpected use of the code as this code is typically used to identify an entity that has supplied information related to the benefits being identified.
A:	MassHealth defines the code of W – Other Source of Data, as behavioral health.

276/277

Q:	In Section 3.2.2 of the 276/277 Companion Guide, 2100B NM108 states that you expect it to be either XX or SV. However, these are no longer valid values under the 5010 mandate. It must be 46, which is the ETIN. What does MassHealth expect for NM109 in this case?
A:	MassHealth will update the companion guide to reflect the qualifier of 46. NM109 - Information Receiver Electronic Transmitter Identification Number (ETIN) is your 10-character Submitter ID or your 10-character Provider ID/Service Location.
Q:	In Section 3.2.2 of the 276/277 Companion Guide, can you please clarify what 2200D TRN02 is?
A:	This value reflects the Claim Status Tracking Number, which MassHealth will echo in the 277 based on the 276.
Q:	In Section 3.2.2 of the 276/277 Companion Guide, descriptions for 2200D REF01/02 seem to be out of sync.
A:	A value of "1K" in REF01 is the Payer Claim Control Number.

Q:	In Section 3.2.2 of the 276/277 Companion Guide, 2200D DTP01 = type..., should be “472” not “232472.”
A:	MassHealth will update the companion guide to reflect the correct value.
Q:	Section 3.2.2 of the 276/277 Companion Guide refers to 2210D SVC01-1. Does this mean you are able to support line level inquiries? If so, how does that work and what are the required elements?
A:	MassHealth will remove this, as we do not use this loop.