Division of Health Care Finance and Policy
Health Safety Net Claim Update – Claim Denial Reviews
August 24, 2012

HSN providers are responsible for conducting an initial review of denied claims. Claims should only be submitted to the Division after the provider has thoroughly reviewed them and is unable to determine the cause for denial. Providers with questions regarding this claim update should contact the Division's Help Desk at (800) 609-7232 or dhcfphelpdesk@state.ma.us.

General Format & Process:

1. Providers must clearly identify a primary point of contact for responses and questions. The primary contact must be registered with the Division as a contact for downloading hospital or CHC reports.

2. An Excel spreadsheet must be submitted to dhcfphelpdesk@state.ma.us that contains the following information. Providers must ensure that the spreadsheet is formatted to allow leading zeros. To ensure the security of confidential patient information, claims must be submitted in a password protected file with the password being submitted in a separate email. The spreadsheet must include the following -

- Identification of claims as 837I, 837P or 837D.
- TCN (837D)
- ICN & TCN (837I & 837P)
- Claim packages should be broken out by claim types (837I, 837P, 837D)
- Member ID
- Site Org ID
- DOS
- Reason for Denial (eligibility, billing deadlines, covered services, other)

Providers should note that copies of EVS print outs will no longer be required for eligibility denial reviews. For 837I & 837P claims, providers should submit review requests for eligibility denials only. All other claim denial inquiries should be submitted to the MassHealth CST as noted in the 837I & 837P Billing Guides.

Billing Deadline Denials:

Providers should refer to the Date of Service and Claim Submission Date fields when reviewing claim denials to determine whether they have exceeded billing deadlines. Claims submitted after 90 days from the date of service (for original claims) or 90 days from the date of HSN or other Primary Payer denial / EOB will be denied. 837D Billing deadlines should be submitted for claim review only when a provider is contesting that the 90 day timely filing period has expired.

Cases where a provider knows that the 90 day period has expired; however, the provider believes that extenuating and uncontrollable circumstances prevented the timely submission of claims should not be submitted for claim review. Providers should:

- Submit a written waiver request to Tony Sousa, HSN Operations Manager at tony.sousa@state.ma.us.
- The waiver request must contain the following information to be considered
  - Volume of total claims
  - Net HSN charges and total charges
  - HSN fiscal year(s)
  - Specific details regarding the reason the claims were not submitted timely
  - Specific details regarding the steps taken by the provider to prevent issue(s) from recurring.

The Division will review the request and notify providers once a decision has been made. In cases where the request is approved, providers must:

- Submit all "approved" claims in one file with no other claims.
- Inform Tony Sousa, HSN Operations Manager at tony.sousa@state.ma.us once the file has been submitted and identify the submission control id of the file.
- Ensure that all claims have billing deadline errors only. Submitted files containing claims with adjudication errors other than billing deadlines or transaction level failures will not be processed. It is the provider's responsibility to ensure that all errors are corrected and resubmit the file.