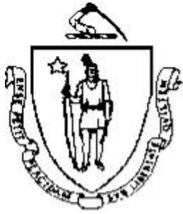
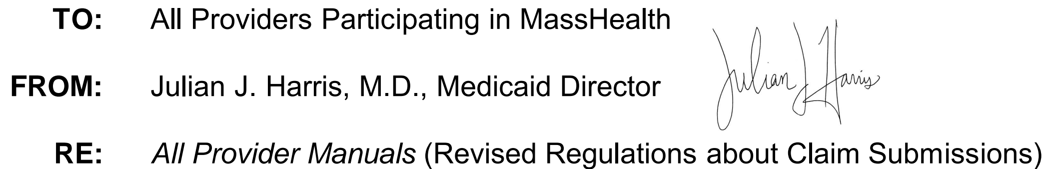


Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-187
December 2011



TO: All Providers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: *All Provider Manuals* (Revised Regulations about Claim Submissions)

This letter transmits revisions to the administrative and billing regulations at 130 CMR 450.302. The revisions specify that providers who do not have an approved electronic claim waiver are required to submit their claims electronically. Details of the waiver policy are included as part of the revised regulations.

The revised regulations are effective for claims received on or after January 1, 2012.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

All Provider Manuals

Pages iii, 3-1, 3-2, 3-3, and 3-4

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

All Provider Manuals

Page iii — transmitted by Transmittal Letter ALL-113

Pages 3-1 through 3-4 — transmitted by Transmittal Letter ALL-154

3. BILLING REGULATIONS

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450.301: Claims

(A) Except as provided in other program regulations, a claim for a medical service may be submitted only by the provider that provided the service. In the absence of a specific exception or qualification, 130 CMR 450.301(A) and (B) apply.

(1) An individual practitioner may not claim payment under his or her own name and provider number for services actually provided by another individual, whether or not the individual who provided the service is also a participating provider, or is an associate, partner, or employee of the individual practitioner.

(2) An individual practitioner may not claim payment under his or her own name and provider number for medical services provided by the individual practitioner and for which the practitioner is paid by another entity (for example, hospital, clinic, long-term-care facility, pharmacy, home health agency, health maintenance organization, community health center, psychiatric day treatment program, day habilitation center, and adult day care center). In such cases, payment may be claimed only by the institution or facility.

(B) A provider may submit claims only where:

(1) the payment for the services claimed is not otherwise claimed by any other MassHealth provider; and

(2) payment or any other compensation for the delivery of such services is not received by any provider from any other source.

450.302: Claim Submission

(A) (1) Electronic Claims. All claims submitted to the MassHealth agency for payment must be submitted electronically in a format designated by the MassHealth agency, unless the provider has been approved for an electronic claim submission waiver.

(2) Paper Claims.

(a) Any paper claims submitted by a provider who does not have an approved electronic claim submission waiver, pursuant to 130 CMR 450.302(A)(3), are denied.

(b) Any paper claims submitted by a provider who has an approved electronic claim submission waiver must be submitted on the claim form designated by the MassHealth agency and according to its administrative and billing instructions.

(3) Waiver Criteria. The MassHealth agency grants a provider an electronic claim submission waiver if any of the following criteria apply.

(a) The provider has submitted an average of fewer than 20 claims per month over the previous 12 months.

(b) The provider is experiencing temporary technical difficulties related to upgrading their current billing system or installing a new one.

(c) The provider is experiencing temporary technical difficulties related to testing or interfacing with the MassHealth agency's claims processing system.

(d) The provider does not have Internet access or a computer.

(e) The provider is experiencing temporary disruption in service, for at least five business days, caused by a natural disaster or utility work.

(f) The provider attests to the MassHealth agency that its staff responsible for claims submission have a disability that prevents the submission of electronic claims that cannot be easily mitigated with reasonable accommodation.

(g) The provider has an extenuating circumstance in which submitting electronic claims would impede the provider's ability to participate in MassHealth.

(4) Waiver Duration. An electronic claim submission waiver is valid for 12 months from the date of issue. Providers who continue to experience circumstances that necessitate a waiver must apply for another waiver at least 30 days before the expiration of their current waiver, in order to avoid a possible interruption in payment.
(5) Waiver Fee. There is no fee for the first electronic claim submission waiver. The MassHealth agency may assesses an administrative fee based on paper claim volume for any subsequent electronic claim submission waiver granted to a provider.
(6) Waiver Request Review Process. After review of a provider's request for an electronic claim submission waiver, the MassHealth agency notifies the provider in writing of its decision. If the waiver request is incomplete, the MassHealth agency asks the provider for more information. If the provider does not submit the requested information to the MassHealth agency within 30 days of the request, the MassHealth agency denies the waiver request. A provider may reapply for an electronic claim submission waiver with new or additional information.

(B) All claims submitted by a group practice must clearly identify by provider number the individual practitioner who actually provided the services being claimed.

(C) A group practice may submit claims only for services provided by individual practitioners who are MassHealth providers and who have been enrolled and approved by the MassHealth agency as a participant in the group.

450.303: Prior Authorization

In certain instances, the MassHealth agency requires providers to obtain prior authorization to provide medical services. These instances are identified in the billing instructions, program regulations, associated lists of service codes and service descriptions, provider bulletins, and other written issuances from the MassHealth agency. Such information, including but not limited to the MassHealth Drug List, may be available on the MassHealth Web site, and copies may be obtained upon request. The provider must submit all prior-authorization requests in accordance with the MassHealth agency's instructions. Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment, such as member eligibility or resort to health-insurance payment.

(A) The MassHealth agency acts on appropriately completed and submitted requests for prior authorization within the following time periods.
(1) For pharmacy services—by telephone or other telecommunication device within 24 hours of the request for prior authorization. The MassHealth agency will authorize at least a 72-hour supply of a prescription drug to the extent required by federal law. (See 42 U.S.C. 1396r-8(d)(5).)
(2) For transportation to medical services—within seven calendar days after a request for service, or the number of days, if less than seven, necessary to avoid any serious and imminent risk to the health or safety of the member that might arise if the MassHealth agency did not act before the full seven days have elapsed.
(3) For private duty nursing services—within 14 calendar days after a request for service.
(4) For durable medical equipment—within 15 calendar days after a request for service.
(5) For all other MassHealth services—within 21 calendar days after a request for service.

(B) The following rules apply for prior-authorization requests.

(1) The date of any prior-authorization request is the date the request is received by the MassHealth agency, if the request conforms to all applicable submission requirements, including but not limited to the form, the address to which the request is sent, and required documentation.

(2) If a provider submits a request that does not comply with all submission requirements, the MassHealth agency will inform the provider

(a) of the relevant requirements, including any applicable program regulations;

(b) that the MassHealth agency will act on the request within the time limits specified in 130 CMR 450.303 if the required information is received by the MassHealth agency within four calendar days after the request; and

(c) that if the required information is not submitted within four calendar days, the MassHealth agency's decision may be delayed by the time elapsing between the four days and when the MassHealth agency receives the necessary information.

(3) A service is authorized on the date the MassHealth agency sends a notice of its decision to the member or someone acting on the member's behalf.

(C) The MassHealth agency will not act on requests for prior authorization for

(1) covered services that do not require prior authorization; or

(2) noncovered services, except to the extent that MassHealth regulations specifically allow for prior-authorization requests.

450.304: Claim Submission: Signature Requirement

Every paper claim form submitted for payment must be signed by the provider that provided the service or the provider's agent on behalf of the provider that provided the service. A provider that accepts payment of a claim is presumed to have authorized the submission of the claim on his or her behalf.

(130 CMR 450.305 and 450.306 Reserved)

450.307: Unacceptable Billing Practices

(A) No provider may claim payment in a way that may result in payment that exceeds the maximum allowable amount payable for such service under the applicable payment method.

(B) Without limiting the generality of 130 CMR 450.307(A), the following billing practices are forbidden:
(1) duplicate billing, which includes the submission of multiple claims for the same service by the same provider or multiple providers;
(2) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more-comprehensive service for which a single rate of payment is established; and
(3) submitting claims under an individual practitioner's provider number for services for which the practitioner is otherwise entitled to compensation.

(130 CMR 450.308 Reserved)

450.309: Time Limitation on Submission of Claims: General Requirements

(A) In accordance with M.G.L. c. 118E, § 38, all claims must be received by the MassHealth agency within 90 days from the date of service or the date of the explanation of benefits from another insurer. When a service is provided continuously on consecutive dates, the date from which the 90-day deadline is measured is the latest date of service.

(B) For claims that are not submitted within the 90-day period but that meet one of the exceptions specified below, a provider must request a waiver of the billing deadline (a 90-day waiver) pursuant to the billing instructions provided by the MassHealth agency. The exceptions are as follows:
(1) a medical service was provided to a person who was not a member on the date of service, but was later enrolled as a member for a period that includes the date of service; and
(2) a medical service was provided to a member who failed to inform the provider in a timely fashion of the member's eligibility for MassHealth.

(C) When a medical service was provided to a MassHealth member in another state by a provider that is not enrolled in MassHealth, the MassHealth agency will consider a claim for such service to have been timely submitted if all of the following apply:
(1) the medical service was provided in accordance with 130 CMR 450.109;
(2) the provider submits an application to the MassHealth agency to become a participating provider within 90 days after the date of service and the MassHealth agency approves the application; and
(3) the provider submits the claim for payment within 90 days after the date of the notice from the MassHealth agency approving the provider's application.

(130 CMR 450.310 through 450.312 Reserved)