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

MassHealth
Transmittal Letter ALL-199
March 2013

TO: All Providers Participating in MassHealth

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

RE: *All Provider Manuals* (Revised Regulations About Electronic 90-Day Waiver and Final Deadline Appeals)

This letter transmits revisions to the Administrative and Billing Regulations at 130 CMR 450.300. The revised regulations are effective for claims received on or after April 1, 2013.

The amendments require providers to submit 90-day waivers and final deadline appeals electronically, unless the provider has been approved for an electronic claim submission waiver. Providers meeting the criteria specified in 130 CMR 450.302(A)(3) may submit hard copy claims upon approval of an electronic claim submission waiver request.

The amendments also require providers to use a standard appeals form when submitting final deadline appeals. The procedures are more fully described in All Provider Bulletin 232 (February 2013).

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website 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 3-3, 3-4, and 3-9 through 3-12

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(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 3-3 and 3-4 — transmitted by Transmittal Letter ALL-187

Pages 3-9 through 3-12 — transmitted by Transmittal Letter ALL-154

(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.

(D) All requests for waivers of the billing deadline submitted to the MassHealth agency for review must be submitted electronically in a format designated by the MassHealth agency, unless the provider has been approved for an electronic claim submission waiver as specified in 130 CMR 450.302(A)(3).

(130 CMR 450.310 through 450.312 Reserved)

450.321: Third-Party Liability: Waivers

The MassHealth agency may waive any requirements of 130 CMR 450.316 through 450.318, as applied to any provider, to institute information-gathering projects and to evaluate methods of exercising the third-party liability recovery options described in 42 CFR 433.139. The MassHealth agency will grant waivers only for projects that are likely to increase the efficient and economical collection of third-party resources and will state the extent of any waiver in the documents establishing such projects.

(130 CMR 450.322 Reserved)

450.323: Appeals of Erroneously Denied or Underpaid Claims

Pursuant to M.G.L. c. 118E, § 38, the MassHealth agency has established the following procedures for appealing claims that the provider believes were denied in error or underpaid. The MassHealth agency's Final Deadline Appeals Board has exclusive jurisdiction to review appeals submitted by providers of claims for payment that were, as a result of MassHealth agency error, denied or underpaid, and that cannot otherwise be timely resubmitted.

(A) Criteria for Filing an Appeal. All requests for appeals submitted to the MassHealth agency for review must be submitted electronically in a format designated by the MassHealth agency, unless the provider has been approved for an electronic claim submission waiver as specified in 130 CMR 450.302(A)(3). To file an appeal with the MassHealth agency's Final Deadline Appeals Board, the provider must meet all of the following criteria.

(1) The provider must have submitted the original claim in a timely manner, pursuant to 130 CMR 450.309 through 450.314.

(2) The provider must have exhausted all available corrective actions outlined in the billing instructions provided by the MassHealth agency.

(3) The date of service for which the appeal is submitted must exceed the filing time limit of 12 months, unless third-party insurance is involved, in which case the filing time limit is 18 months (the final billing deadline).

(4) Claims for dates of service more than 36 months after the date of service are not eligible for an appeal.

(5) The provider must file the appeal within 30 days after the date on the remittance advice that first denied the claim for exceeding the final billing deadline.

(6) The provider must demonstrate that the claim was, as a result of MassHealth agency error, denied or underpaid.

(B) Accompanying Documentation. Along with each appeal of a claim, the provider must submit the following information to substantiate the contention that the claim was, because of MassHealth agency error, denied or underpaid:

(1) a standard appeal form prescribed by the MassHealth agency describing the nature of the MassHealth agency error that resulted in the denial or underpayment of the claim. The statement must include the provider name, provider number, member name, member number, and date of service.

(2) evidence of the claim's original, timely submission and resubmission, if applicable;

(3) a copy of the applicable page from each remittance advice on which the claim was previously processed;

(4) a copy of the remittance advice that indicates that the final submission deadline has passed;

(5) an accurately completed electronic claim or a legible and accurately completed paper claim if the provider has received a waiver of the electronic submission requirement;; and

(6) any other documentation supporting the appeal.

(C) Procedure for Deciding Appeals. All appeals are decided by the MassHealth agency's Final Deadline Appeals Board based upon written evidence submitted by the provider. The provider has the burden of establishing by a preponderance of the evidence that the claims appealed were denied or underpaid because of MassHealth agency error.

(D) Request for an Adjudicatory Hearing. A provider may submit a request for an adjudicatory hearing with a final deadline appeal if there is a dispute about a genuine issue of material fact. The request must include a statement indicating the specific reasons why a hearing should be conducted. The request must include the following information:

(1) a statement identifying the material facts in dispute;

(2) a summary of the evidence that the provider would offer at the hearing to support his or her contentions; and

(3) a statement explaining why the evidence could only be presented at a hearing.

(E) Notification of Approval or Denial of Request for an Adjudicatory Hearing.

(1) If the Final Deadline Appeals Board determines that a hearing is justified, the MassHealth agency will notify the provider of:

(a) the issues of fact for which a hearing has been justified; and

(b) the identity of the person or entity designated by the MassHealth agency to conduct the hearing.

(2) Any hearing hereunder, whether conducted by the Final Deadline Appeals Board or its designee, shall be conducted in accordance with the provisions of 130 CMR 450.244 through 450.248.

(3) If the Final Deadline Appeals Board determines that a hearing is not justified, the MassHealth agency will notify the provider of the reasons why it decided not to hold a hearing.

(F) Decisions of the Final Deadline Appeals Board. The Final Deadline Appeals Board will review each appeal that is properly submitted and notify the provider in writing of its decision. The notification will include a brief statement of the reasons for its decision. The decision will be a final agency action, reviewable pursuant to M.G.L. c. 30A.

450.324: Payment of Claims

The MassHealth agency will make electronic payments payable only to the provider, except as required by law or at the MassHealth agency's discretion.

(130 CMR 450.325 through 450.330 Reserved)

450.331: Billing Agencies

(A) The MassHealth agency will process claims that are submitted by a billing agency on behalf of a provider. At the written request of a provider, the MassHealth agency may also mail payments and remittance advices to a billing agency, but such payments shall be payable to the provider only, and in no event be payable to the billing agency. The MassHealth agency will not make payments to a billing agency.

(B) The MassHealth agency recognizes a billing agency solely and strictly as the provider's agent. A billing agency is not a "provider." A provider's use of a billing agency does not relieve the provider of any responsibility imposed elsewhere in these regulations for the claims that the provider submits or that are submitted on the provider's behalf. Any provider that engages a billing agency for the preparation and submission of claims to the MassHealth agency is fully responsible to the MassHealth agency for all acts by such billing agent with actual or apparent authority to perform such acts, notwithstanding any contrary provisions in any agreement between the provider and the billing agency. In case of any violations of laws, rules, or regulations, or of the provider contract arising out of the acts of the billing agent, the provider will be fully liable as though they were the provider's own acts.

REGULATORY AUTHORITY

130 CMR 450.000: M.G.L. c. 118E, §§7 and 12.