MassHealth Provider Handbook

COMMONWEALTH of MASSACHUSETTS | Executive Office of Health and Human Services

Welcome

Thank you for joining the MassHealth Provider Network! This MassHealth Provider Handbook, or "handbook," is intended for both new and existing providers. The handbook provides a general overview of MassHealth provider requirements and expectations and includes resources to aid in serving MassHealth members. While this document touches on many subjects, it is not the sole source of information for these topics. It should be used as a reference tool and resource document that will help point you to additional, more detailed information.

What is the Provider Handbook?

An overview of MassHealth for new and existing providers

An additional reference tool for MassHealth contracted providers

A guide that covers many areas for providers and points to available provider resources

Important: The Provider Handbook is not a replacement for any regulation or provider guidance.

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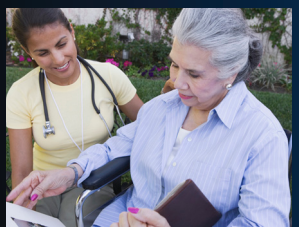


Fee-For-Service (FFS) and MassHealth Provider Network

MassHealth offers benefits on a Fee-for-Service (FFS) basis or through managed care plans.* Under the FFS model, MassHealth pays providers directly for each covered service received by an eligible MassHealth member. MassHealth also pays network providers directly for services provided to Primary Care Clinician (PCC) Plan and Primary Care Accountable Care Organization (ACO) members. Providers would bill MassHealth directly for services provided to such members. Each provider in the FFS network is issued a Provider Identification/Service Location number (PID/SL). These providers use the Provider Online Service Center (POSC) to submit claims into MassHealth's Medicaid Management Information System (MMIS) system in addition to other functions described in this handbook.

MassHealth Network providers are enrolled in MassHealth as contracted providers via a provider agreement and are required to furnish medical services and participate in MassHealth under a provider contract with the MassHealth agency. For purposes of applying, in regulations 130 CMR 450.235 through 450.240, the term "provider" includes formerly participating providers.

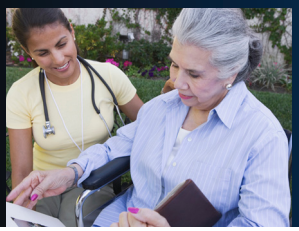
**Please note that other Managed Care Plans such as Managed Care Organizations (MCO), Senior Care Options (SCO), Program of All-inclusive Care for the Elderly (PACE), One Care, and Accountable Care Partnership Plans (ACPP) have separate provider networks and contracts. Providers must have contracts with these plans to service their members and receive payment for services rendered.*

MassHealth

MassHealth Provider Network of Specialists and Hospitals

FFS providers

- Have a MassHealth provider contract and are issued a PID/SL
- Can be part of the PCC/Primary Care ACO
- Bill MassHealth directly through POSC
- Are part of the MassHealth provider network



MassHealth Health Plans for Managed Care Eligible Members

Primary Care Clinician Plan and Primary Care Accountable Care Organizations – MassHealth Managed Care (MassHealth Provider Network)

Primary Care Clinician (PCC) Plan

In the PCC Plan, primary care providers (PCPs) are called primary care clinicians (PCCs). The MassHealth network of PCCs, specialists, and hospitals delivers services. PCC Plan members have access to the entirety of the MassHealth Fee-for-Service network for non-primary care.

Upon enrollment into the PCC Plan, members may select a service location and an individual health care provider from among MassHealth-participating PCC Plan network providers. The member's PCC is responsible for providing and/or coordinating most of the member's medical care and, as necessary, referring the member to other MassHealth providers for non-primary care services. More information for PCC plan providers can be found in the Primary Care Clinician (PCC) Provider Handbook.

Primary Care Accountable Care Organizations (PCACOs)

An ACO is a provider-led health plan that holds participating providers financially accountable for both cost and quality of care for members. In this type of ACO, a network of PCPs has joined together into an ACO to provide integrated and coordinated care for members.

Members will receive all of their primary care from primary care sites that are part of their particular Primary Care ACO, unless they receive a referral to go elsewhere. All members in a Primary Care ACO are enrolled at a single primary care site within that ACO. The ACO contracts directly with MassHealth and uses the MassHealth FFS provider network of specialists and hospitals. Members who enroll in a Primary Care ACO receive behavioral health services through the Massachusetts Behavioral Health Partnership. No matter which Primary Care ACO a member is enrolled in, they have access to the entirety of the MassHealth Fee-for-Service network of providers for non-primary care. It is important to note that primary care sites are also contracted MassHealth FFS network providers and can provide specialist care to other MassHealth members who are not part of the Primary Care ACO.

Primary Care Exclusivity and Exceptions

Practices enrolled in a Primary Care ACO as a participating primary care practice location may only see managed care eligible members who are enrolled in that Primary Care ACO *for primary care,* unless they receive a referral. This restriction does not apply to members who are not managed care eligible (SCO, PACE, One Care, etc.) or who are involved in the Special Kids Special Care program of the Department of Children, Youth and Families. This restriction also does not apply to practices if they are providing specialist care to those members (OB/GYN services for example).

The Massachusetts Behavioral Health Partnership (MBHP)

MBHP manages behavioral health care for more than 500,000 MassHealth members statewide. Working with its network of providers, MBHP offers high quality, accessible, culturally sensitive health care to members of the MassHealth Primary Care Clinician (PCC) Plan, Community Care Cooperative (C3), Partners HealthCare Choice, Steward Health Choice, and the BeHealthy Partnership plan. The MBHP also serves children in state custody and others. For more information, please visit the MBHP website.

Managed Care Organizations and Accountable Care Partnership Plans — (separate provider contract and network)

Managed Care Organizations (MCOs)

MCOs are health plans run by health insurance companies that provide care through their own provider network that includes PCPs, specialists, behavioral health providers, and hospitals. Care coordinators are employed by the MCO.

Accountable Care Partnership Plans (ACPPs)

An Accountable Care Partnership is a provider-led health plan that holds participating providers financially accountable for both cost and quality of care for members. In this type of ACO, a network of PCPs works with just one MCO to create a full network that includes PCPs, specialists, behavioral health providers, and hospitals. PCPs plan and coordinate care to meet the needs of the member.

For more information about ACOs and the Payment & Care Delivery Innovation initiative, please visit the PCDI for Providers web page.

Integrated Care Plans (separate provider contract and network)

One Care

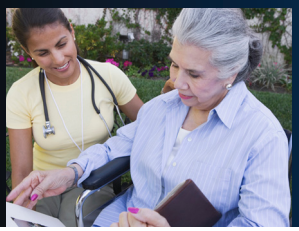
One Care is an integrated care option for dual-eligible individuals (those who have Medicare and MassHealth) ages 21-64 (at the time of enrollment) who are living with disabilities. One Care covers all of a member's Medicare, MassHealth, and prescription drug benefits, including Medicare Part D, under the same plan. You can find more information about One Care, including eligibility and enrollment information and information about which One Care plans are available in each county, on the One Care home page.

Program of All-inclusive Care for the Elderly (PACE)

PACE is an integrated care option for individuals living in the community (not in a facility) ages 55 and older who are at a nursing home level of care and live in an area served by a PACE organization. PACE covers all of the services covered by Medicare and MassHealth and any other service deemed necessary. The goal of PACE is to allow participants to live safely in their homes instead of in nursing homes. You can find more information on the PACE home page.

Senior Care Options (SCO)

SCO is an integrated care program for individuals age 65 and older. SCO covers all of the services covered by Medicare and MassHealth and the Frail Elder Waiver. The program provides services to members through a senior care organization and its network of providers. It combines health services with social support services by coordinating care and specialized geriatric support services, along with respite care for families and caregivers. You can learn more about SCO here. You can learn more about the Frail Elder Waiver here.



Types of MassHealth Network Providers

MassHealth provides assistance paying for benefits for qualified children, families, seniors, and people with disabilities living in Massachusetts. This is done through our agreements with contracted providers. MassHealth network providers are grouped together by the services that they provide to our members. These providers are managed under specific areas of MassHealth that are responsible for program regulations, operating policies and procedures, monitoring of services, providers access, and financial management. You can find a full list of providers and their corresponding manuals online.

Office of Long Term Services and Supports (OLTSS) — Fee-for-Service

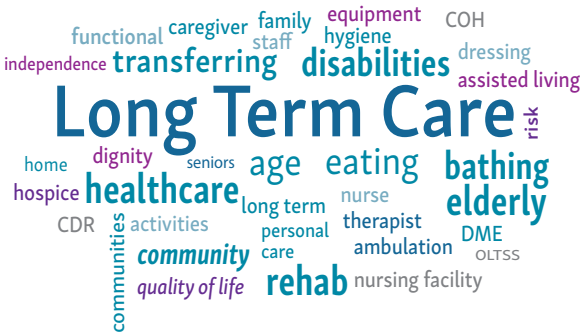
Programs and services managed by the Office of Long-Term Services and Supports (OLTSS) enable hundreds of thousands of people with disabilities and chronic conditions in Massachusetts to:

- live with independence and dignity in their daily lives;
- participate in their communities to the fullest extent possible; and
- improve their overall quality of life.

Most people receive these services in their home or at community programs. Some people get these services in a facility where they live, such as a nursing facility.

Provider types managed by OLTSS and links to the provider manuals for each:

- Adult Day Health
- Adult Foster Care
- Chronic Disease and Rehabilitation (CDR) Inpatient Hospital
- Chronic Disease and Rehabilitation (COH) Outpatient Hospital
- Continuous Skilled Nursing (CSN) Agency
- Day Habilitation
- Durable Medical Equipment (DME) Competitive Bid



- Durable Medical Equipment (this includes a pharmacy that provides DME)
- Fiscal Intermediary (Personal Care)
- Group Adult Foster Care
- Group Practice Therapists (PT/OT/ST)
- Home Health Agency
- Hospice
- Independent Nurse
- Independent Living Centers (Personal Care)
- Individual Therapists (PT/OT/ST)
- Nursing Facilities
- Orthotics
- Oxygen and Respiratory Therapy Equipment
- Personal Care Attendant
- Prosthetics
- Rehabilitation Centers
- Speech and Hearing Centers

Office of Behavioral Health — Fee-for-Service

MassHealth's behavioral health program offers its members a diverse set of resources to manage their behavioral health needs. There are a variety of behavioral health services (mental health and substance use disorder) to address each member's individual need. Behavioral health services range from acute psychiatric inpatient care to outpatient counseling services, such as individual, group, couple or family therapy, and substance use disorder treatment. Psychological and neuropsychological assessments are also available.

Behavioral health services are offered in a variety of settings, such as an inpatient or outpatient hospital, mental health or substance use disorder outpatient clinic, member's home, private office, and/or nursing facilities.

Provider types managed by the Office of Behavioral Health:

- Early Intervention Program
- Psychiatric Inpatient Hospital
- Psychiatric Outpatient Hospital
- Psychiatric Day Treatment Program
- Mental Health Center Services
- Psychologists and Neuropsychologists
- Substance Use Inpatient Hospital
- Substance Use Outpatient Hospital
- Substance Use Treatment Services

Dental — Fee-for-Service

The mission of the MassHealth Dental Program is to expand access to high-quality and compassionate oral health services. Dental care is one of many benefits available to children and adults who are eligible for MassHealth, the Health Safety Net, and the Children's Medical Security Plan. The MassHealth dental program regulations at 130 CMR 420.000 and 450.105 describe the dental benefit, service limitations, and member eligibility.

There are two categories of care under MassHealth's Dental Benefit:

1. Dental services utilizing ADA/CDT codes which are submitted to the dental portal hosted by DentaQuest, where all (prior authorization (PA) requests and claims adjudications are processed.
2. Medical Services/Oral Surgery utilizing CPT/HCPCS codes which are submitted to the MassHealth Provider Online Service Center (POSC/Portal)

MassHealth has contracted with Dental Service of Massachusetts, Inc. (DSM) to manage the MassHealth dental program. DSM and its subcontractor, DentaQuest, LLC (DentaQuest) work with MassHealth to help improve the MassHealth dental program. Dental services covered by MassHealth are:

- Exams and radiographs
- Teeth cleaning and fluoride treatment
- Tooth fillings
- Crowns for children younger than 21
- Partial and complete dentures
- Tooth extraction
- Oral surgery

Dental providers must complete an application to enroll with MassHealth to bill for dental services utilizing App Central at App Central. Additionally, dental providers must create an account on the MassHealth dental provider web portal to check member eligibility, service history, submit claims and perform other essential administrative tasks.

For assistance, please contact DentaQuest customer service at (800) 207-5019 between the hours of 8 a.m. to 6 p.m., Monday through Friday.

To view MassHealth covered dental services, please see Subchapter 6 Dental Service Codes of the Dental Manual.

Oral Surgeons

Oral surgeons who are enrolled as a MassHealth dental provider must also enroll to bill oral surgery CPT/medical codes via MassHealth's Provider Online Service Center (POSC) by filling out a Data Collection Form.

For Oral surgery CPT medical Covered Services please see Subchapter 6 Dental Service Codes of the Dental Manual.

SPECIAL NOTICE

All Integrated Care Organization (ICO), Senior Care Organization (SCO), and Program of All-Inclusive Care for the Elderly (PACE) plans listed below may have a different dental policy than MassHealth. Please review the dental policy for each plan.

- BMCHP
- Common Care Alliance
- Fallon/Navicare
- Senior Whole Health
- Tufts Health Unify
- United Health Care
- One Care

Pharmacy — Fee-for-Service

The MassHealth Pharmacy Program provides pharmacy coverage for more than one million members of the Commonwealth for acute and chronic prescription medications as well as certain over-the-counter products and professional services such as vaccines. The program manages a robust formulary known as the MassHealth Drug List (MHDL) for its members while maintaining clinical appropriateness and cost savings. Included in the MHDL are initiatives that the pharmacy program has put in place to better serve the member's course of therapy, such as the Pediatric Behavioral Health Initiative (PBHMI) and the Concomitant Opioid Benzodiazepine Initiative (COBI). The Pharmacy Program uses the Pharmacy Online Processing System (POPS) for claim submission for MassHealth ACOB and Fee-for-Service plans as well as the Health Safety Net (HSN) and Children's Medical Security Plan (CMSP). Providers can find information about POPS, including helpful billing tips, in the POPS Billing Guide.

More information on the MassHealth Pharmacy Program, including links to the MassHealth Drug List, Pharmacy Regulations, Pharmacy Facts, Publications and Notices can be found at MassHealth Pharmacy Program.

MassHealth Pharmacy Regulations: 130 CMR 406.000: *Pharmacy Services*

MassHealth Pharmacy Facts: MassHealth Pharmacy Facts

MassHealth Drug List: MassHealth Drug List - Health and Human Services

Specialists and Hospitals — Fee-for-Service

The MassHealth Fee-for-service program within the Office of Provider and Pharmacy Programs includes ambulatory services that are paid per service rendered. These services are rendered by the following providers:

- Acute Inpatient Hospitals
- Acute Outpatient Hospitals and Hospital Licensed Health Centers (HLHCs)
- Acupuncture Services
- Audiologists
- Community Health Centers
- Family Planning Agencies
- Freestanding Abortion and Sterilization Clinics
- Freestanding Ambulatory Surgery Centers (FASCs)
- Freestanding Renal Dialysis Clinics
- Hearing Instrument Specialists

- Independent Clinical Laboratories
- Independent Diagnostic Testing Facilities (IDTFs)
- Optometrists
- Opticians
- Podiatrists
- Chiropractor
- Physicians
  - o Nurse Practitioners
  - o Nurse Midwives
  - o Physician Assistants
  - o Certified Nurse Specialists
  - o Psychiatric Certified Nurse Specialists
  - o Certified Registered Nurse Anesthetist
- Urgent Care Clinics

Acute Outpatient Hospital Program

MassHealth pays for outpatient hospital visits and ancillary services (such as radiographic views, laboratory tests, medical supplies, and drugs) that are medically necessary and appropriately provided, as defined at 130 CMR 450.204: *Medical Necessity*. The quality of such services must meet professionally recognized standards of care.

As defined in 130 CMR 410.000: *Outpatient Hospital Services*, "hospital outpatient department" may also refer to hospital-licensed health centers and other hospital satellite clinics.

Acute Inpatient Hospital Program

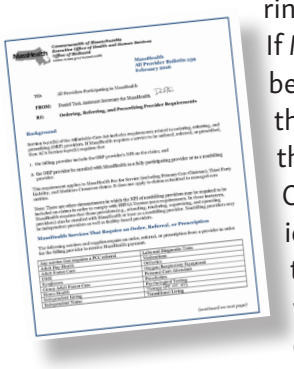
MassHealth pays for inpatient hospital services that are medically necessary and appropriately provided as defined by 130 CMR 450.204: *Medical Necessity*. The quality of such services must meet professionally recognized standards of care.

As defined in 130 CMR 415.000: *Acute Inpatient Hospital Services*, "hospital" refers specifically to an acute inpatient hospital or unit only, unless the context clearly indicates otherwise.

For more information about acute hospital programs, including eligibility, regulations and specific information for patients and providers, visit the following web pages:

- Acute Outpatient Hospital Manual for MassHealth Providers
- Acute Inpatient Hospital Manual for MassHealth Providers

Ordering, Referring, and Prescribing (ORP)



Section 6401(b) of the Affordable Care Act (ACA) includes requirements related to ordering, referring, and prescribing (ORP) providers. If MassHealth requires a service to be ordered, referred, or prescribed, then ACA Section 6401(b) requires that the billing provider include the ORP provider's national provider identifier (NPI) on the claim and the ORP provider must be enrolled with MassHealth in order for the claim to be payable. An ORP provider can be enrolled with MassHealth as a fully participating provider or as a non-billing provider. For the claim to be payable, only certain types of providers may be listed on a claim as the ordering, referring, or prescribing provider, referred to as authorized ORP providers. For more information about ORP requirements, including the services that require ORP and provider types authorized to Order, Refer, or Prescribe, please refer to the following provider bulletins:

All Provider Bulletin 259

All Provider Bulletin 274

You can also learn more on the ACA ORP Requirement for MassHealth Providers web page.

Qualified Medicare Beneficiaries (QMB) Provider

A Qualified Medicare Beneficiaries (QMB)-only provider is a provider who provides medical services only to MassHealth Senior Buy-In members described in 130 CMR 519.010: *MassHealth Senior Buy-In* and in 130 CMR 505.007: *MassHealth Senior Buy-In and Buy-In* and certain MassHealth Standard members who are eligible for QMB benefits described in 130 CMR 519.002(A)(4)(c) and 130 CMR 505.002(O). QMB-only providers are subject to all regulations pertaining to providers participating in MassHealth, except as provided below or as otherwise specified in 130 CMR 450.000: *Administrative and Billing Regulations*. QMB-only providers may bill only for medical services for QMB members and Standard members eligible for QMB benefits, whether or not the associated medical services are specified in 130 CMR 400.000 through 499.000.

Health Safety Net (HSN)

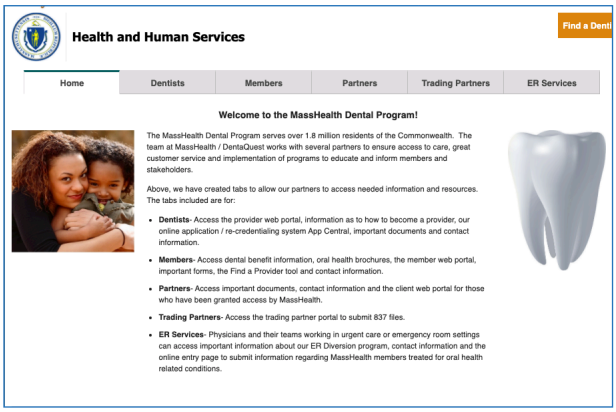
Health Safety Net (HSN) pays only acute care hospitals and community health centers for certain essential health care services provided to qualified uninsured and underinsured Massachusetts residents. HSN is available to uninsured and underinsured Massachusetts residents whose family income is less than a certain percentage of the Federal Poverty Level (FPL). Learn more about HSN, including eligibility, regulations, and specific information for patients and providers, on the Health Safety Net web page.

HSN Dental Providers

The Health Safety Net pays for the same set of dental services that are covered by MassHealth Standard, plus certain services currently not covered by MassHealth.

Patients may be determined eligible only for the HSN or may be determined eligible for MassHealth with HSN as a secondary payer for certain services. The Health Safety Net prices dental services using MassHealth's dental fee schedule.

As of January 1, 2017, DentaQuest administers the Health Safety Net Dental program. HSN dental providers submit dental claims directly to DentaQuest for processing and pricing. The Health Safety Net makes a monthly payment to providers, which includes payment for both medical and dental services. This Office Reference Manual provides important information for HSN providers about eligible dental services, claims, clinical criteria, and other processes.



DentaQuest Customer Service

For assistance, please contact DentaQuest customer service at (800) 207–5019 between 8 a.m. and 6 p.m., Monday through Friday.

Additionally, you can reach DentaQuest through the MassHealth Dental Program home page and the MassHealth/HSN Dental Provider Web Portal.

Children's Medical Security Plan (CMSP)

The Children's Medical Security Plan (CMSP) provides primary and preventive medical, behavioral health, and dental coverage to uninsured children younger than 19 years of age who do not qualify for any MassHealth coverage types (other than MassHealth Limited). CMSP program regulations are found at 130 CMR 522.004.

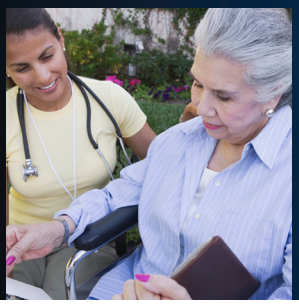
For more information about CMSP, please visit the Children's Medical Security Plan web page for current eligible providers and services, covered codes, and prior authorizations.

Community Partners

The MassHealth Community Partners Program coordinates person-centered, community-based supports that promote continuity of care and independence for MassHealth members with behavioral health (BH) or long-term services and supports (LTSS) needs. While the majority of eligible members are identified by ACOs/MCOs or MassHealth, healthcare providers may also refer a member to the Community Partners Program by contacting the member's health plan (i.e., ACO or MCO).

Across the Commonwealth, BH and LTSS Community Partners bring together community resources, health plans and primary care providers (PCPs) to ensure that eligible members receive the right scope and intensity of care in the community. Community Partners can help coordinate services and supports such as health and wellness coaching, assistive hearing and vision devices, durable medical equipment, medication reconciliation, personal care assistance, and home health aide services. Community Partners can also help connect members with behavioral health services, day programs (such as adult day health and adult foster care), and other programs such as food stamps, fuel assistance, and Meals on Wheels. Community Partners can also help the pediatric population access community-based services and supports.

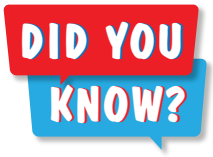
Learn more about the Community Partners Program.



MassHealth Provider Directory, Provider File Maintenance, and Revalidation

MassHealth Provider Directory

MassHealth has an online directory that lists demographic information for Behavioral Health providers, specialists, and providers in the Primary Care Clinician Plan and Primary Care Accountable Care Organizations. The information listed in the MassHealth Network Provider Directory is based on MassHealth Provider file information. Therefore, providers need to make sure that they keep their information up to date.



MassHealth Provider ID and Service Location (PID/SL)

Each provider's NPI is stored in MassHealth's Medicaid Management Information System (MMIS) with a corresponding MassHealth provider ID and service location (PID/SL). This PID/SL is 10 characters, made up of a 9-digit base number and an alpha service location letter (e.g., 123456789A). The provider's PID/SL will be displayed on MassHealth reports as well as correspondence and remittance advices.

Provider File Maintenance

Providers must notify MassHealth of any changes in their information. Examples of changes include corporate/practice structure, change(s) in licensure, closure or opening of new location, change of address, etc.

Each MassHealth provider must notify the MassHealth agency prior to or no later than the date of the change. Failure to do so constitutes a breach of the provider contract which may be subject to fines or termination. See the regulations at 130 CMR 450.222 and 130 CMR 450.223(B):

Some of the ways that providers can report their changes to MassHealth:

Pharmacy/LTSS providers:
- Contact the appropriate vendor for Pharmacy/LTSS (please see the important Information section for contact information)

Dental providers:
- Dental providers must notify the DentaQuest credentialing department of all changes in writing via email at MassHealthEnrollment&Credentialing@dentaquest.com. Additional documentation or paperwork may be required.

Other providers:
Submit an update request on the Provider Online Service Center (POSC). Changes made via the POSC may still require additional documentation or paperwork.

For more information regarding provider enrollment and credentialing, including change of provider address information, please go to the MassHealth Provider Enrollment and Credentialing (PEC) web page.

Provider File Integrity (MMIS)

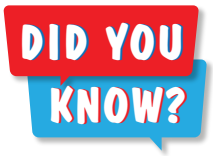
Per 130 CMS 450.223(B), all providers are required to notify MassHealth of any of any change in any of the information submitted in the application. Failure to do so constitutes a breach of the provider contract.

Providers can notify MassHealth and submit a request to update their provider file through the POSC (non-LTSS providers) and though the LTSS Provider Portal (LTSS providers). Some changes are significant (i.e., change of business address or change of ownership) and may require a new application to be submitted.

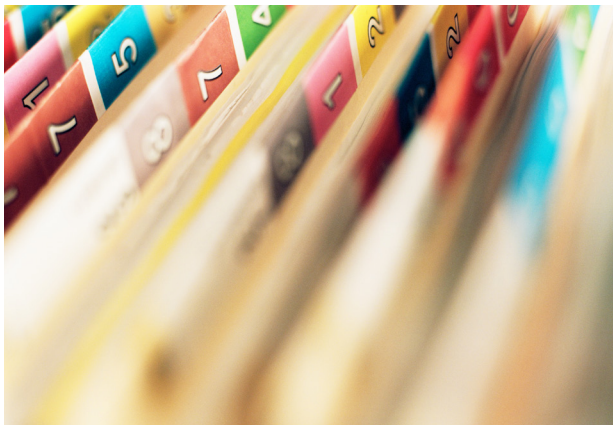
MassHealth Provider Revalidation

MassHealth providers need to revalidate their information at least every five years.

Section 6401 of the Affordable Care Act established a requirement for Medicare and Medicaid to revalidate enrollment information for all enrolled providers, regardless of provider type, under new enrollment screening criteria at least every five years. MassHealth will select providers each month for revalidation based on their date of enrollment.



As part of the required revalidation process, MassHealth must revalidate the enrollment information of all enrolled providers and site locations. Other information such as Federally Required Disclosures Form (FDRF) may be required. Providers are notified by MassHealth when it is time to complete their revalidations. Revalidation is completed on the POSC (non-LTSS providers) and the LTSS Provider Portal (LTSS providers). See Section 6401 of the Affordable Care Act, 42 CFR 455.414 and 42 CFR 455.104(c) (l) (iii).



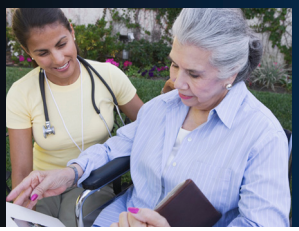
Providers have 45 days from the date of the revalidation letter to complete the revalidation process. Failure to complete revalidation in a timely fashion will result in sanctions. Sanctions may include, but are not limited to, administrative fines and suspension or termination from participation in MassHealth.

Learn more about Revalidation here.

Dental Providers

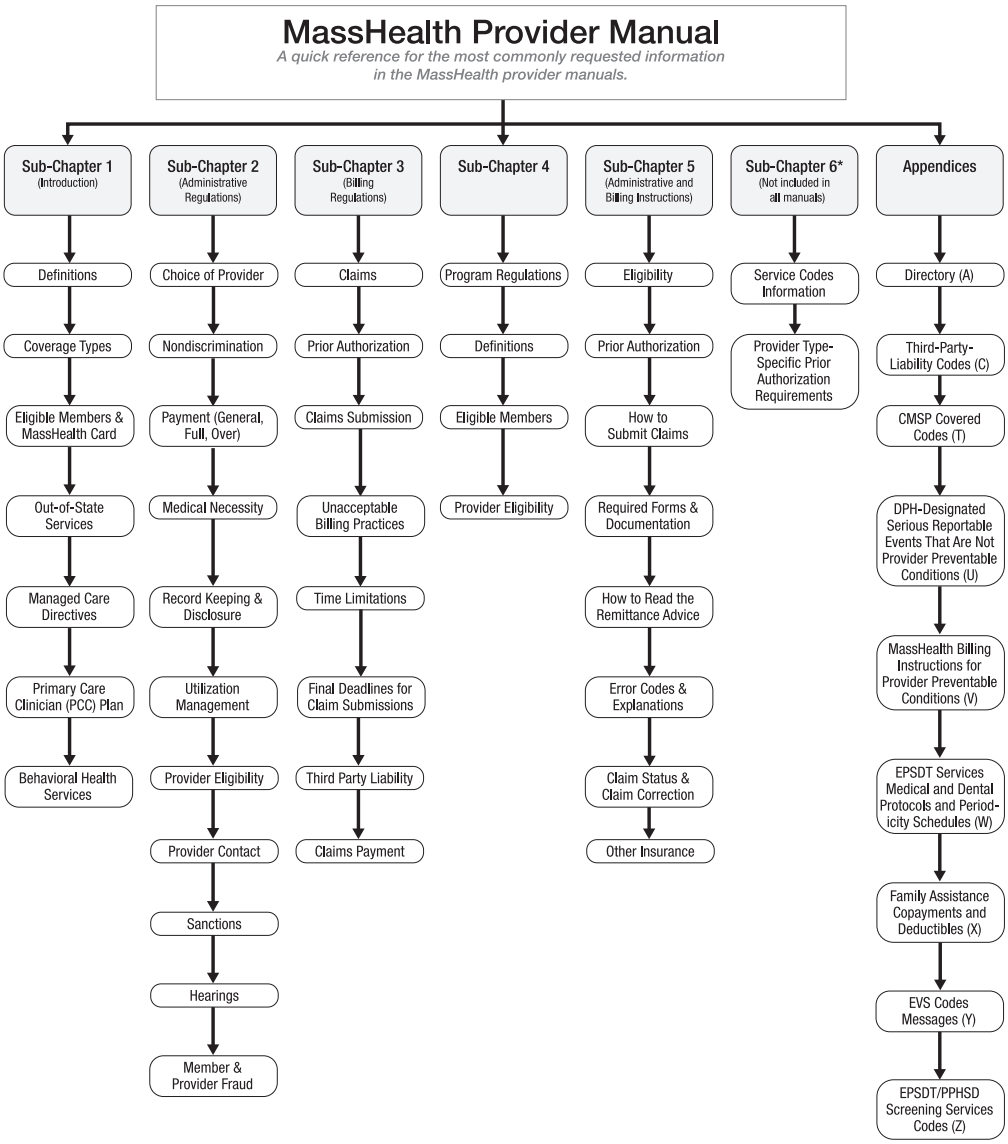
Network providers are re-credentialed every five years.

Dental providers and businesses will be notified by DentaQuest when it is time to recredential. Dental providers and businesses will be required to complete a recredentialing application utilizing App Central. Questions related to recredentialing can be directed to the DentaQuest Provider Enrollment and Credentialing team at MassHealthEnrollment&Credentialing@dentaquest.com or (800) 233-1468.



Provider Manuals & Regulations

All MassHealth providers are required to understand and comply with applicable regulations. Each provider type/program has a Provider Manual that includes subchapters that are specific to the provider type/program. Subchapter 5 (Administrative and Billing Instructions) is often referred to as the All Provider Regulations. While all of the subchapters are important providers should pay attention to Subchapter 4, which outlines the requirement and conditions of the program that providers are required to be in compliance with at all times. Providers will also need to review the Subchapter 6 that outlines the covered services (services and codes) for each program. Below is high level chart of the Provider Manual subchapters.



Rates

Fees are published in the 101 CMR series of rate regulations*. Please reference your provider manual to confirm that a service is covered, as the rate regulations house a repository of codes that are not necessarily reflective of covered services. To view rate information, please refer to the Provider Payment Rates web page.

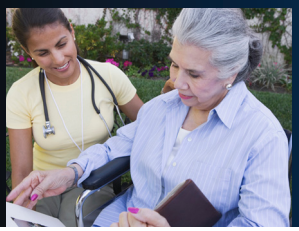
**Hospital providers should refer to their RFA to research and find answers related to payment methodologies.*

DID YOU KNOW?

MassHealth regulations are periodically updated. Current versions can be found at https://www.mass.gov/service-details/masshealth-provider-regulations.

If you'd like to see proposed changes to the regulations, as well as information about public hearings, you'll find that at www.mass.gov/service-details/masshealth-proposed-regulations.

Everything you need to know about provider manuals is at www.mass.gov/lists/masshealth-provider-manuals.



Provider Integrity

Compliance Auditing and Monitoring

A compliance audit is a comprehensive review of a provider's adherence to regulatory guidelines whose aim is to eliminate fraud, waste and abuse from government programs. See 42 U.S.C. 1396a(a)(27). The audit may include, but not be limited to, a review of paid claims, third party liability, staffing levels, employee requirements, a review of a provider's financial records, and other records such, as prior authorizations, invoices, and cost reports. The audit may also include an examination of the medical necessity of services provided to MassHealth members. Additionally, provider's claims are subject to regular monitoring by MassHealth that may result in periodic audits.

Pursuant to MassHealth regulations 130 CMR 450.204: *Medical Necessity,* MassHealth does not pay for services that are not medically necessary and may impose sanctions on providers for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

Photo: Carlos Muza, Unsplash

Pursuant to 130 CMR 450.205: *Recordkeeping and Disclosure,* MassHealth will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. All providers must keep such records, including medical records as are necessary to disclose fully the extent and medical necessity of services provided to, or prescribed for, members and must provide to MassHealth and the Attorney General's Medicaid Fraud Division, the state Auditor and the United States Department of Health and Human Services on request such information and any other information about payments claimed by the provider for providing services or otherwise described in 130 CMR 450.205. See 42 U.S.C. 1396a(a)(27). All providers must also disclose such records and information to any other state and federal agency to which disclosure is required by law.

Providers can review recommendations for implementing effective compliance programs via the Office of the Inspector General's website.

Provider Self-Disclosures

The Affordable Care Act of 2010 (ACA) imposes federal requirements on MassHealth providers to timely report and return overpayments received from MassHealth. Providers must report in writing and return any overpayments within 60 days of (1) the provider identifying such overpayment, or (2) for payments subject to reconciliation based on a cost report, the date any corresponding cost report is due. Providers who fail to disclose, explain, and return overpayments in a timely manner may be subject to sanctions, including administrative fines and suspension or termination from the MassHealth program.

Providers can find more information defining overpayments at 130 CMR 450.235.

Predictive Modeling

In 2013, MassHealth implemented a pre-payment screening process using the Predictive Modeling System. This system detects potential improper payments through predictive modeling, comprehensive data analytics, and other statistical methods. The Predictive Modeling System is fully integrated into the Medicaid Management Information System (MMIS) and employs sophisticated algorithms and models to identify improper billing of claims and detect emerging trends and behavioral patterns of improper billing activity. This system enables MassHealth to review claims for regulatory noncompliance on a pre-payment basis. For more information, please refer to All Provider Bulletin 234.

Photo: Carlos Muza, Unsplash

MassHealth routinely performs reviews of providers who participate in MassHealth. These reviews assure compliance with the regulations governing MassHealth, and help to determine whether the services provided were medically necessary, appropriate, and of a quality that meets professionally recognized standards of care. These reviews are required by federal law at 42 U.S.C. 1396a(a)(27), (30), and by Massachusetts General Laws at Chapter 118E, as well as by Code of Massachusetts Regulations at 130 CMR 450.204, 205, and 206.

Provider Exclusions/ Suspensions

The Office of Inspector General (OIG) has the authority, as well as MassHealth, to exclude individuals and entities from federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded can receive no payment from federal or state healthcare programs for any items or services they furnish, order, or prescribe. The OIG maintains a list of all currently excluded individuals and entities called the "List of Excluded Individual/Entities" (LEIE) Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties. To avoid civil monetary penalties, healthcare entities should routinely check the list to ensure that new hires and current employees are not on it.

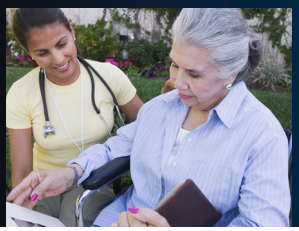
MassHealth maintains a list of providers who have been suspended or excluded from participating in the MassHealth program. This list is updated monthly and reflects suspensions or exclusions effective on or after March 23, 2010.

Attorney General's Medicaid Fraud Division

The Medicaid Fraud Division investigates and prosecutes health care providers who defraud MassHealth. In addition, the Medicaid Fraud Division is responsible for reviewing complaints of abuse, neglect, mistreatment, and financial exploitation of patients in long-term care facilities. Learn more on the Medicaid Fraud Division web page.

Attorney General's Medicaid Fraud tip line — (617) 963-2360; (617) 573-5369 (fax).

Learn how to file a complaint.



MassHealth Members and Benefits

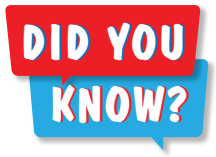
What is a MassHealth Member?
A MassHealth member is a person determined by MassHealth to be eligible for MassHealth.

What are the member coverage types?
A member is eligible for services and benefits according to the member's coverage type. A coverage type is a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria. The following MassHealth coverage types are offered to eligible individuals, families, and people with disabilities: Standard, CommonHealth, CarePlus, Family Assistance, and Limited.

What provider services are covered for each coverage type?
Each coverage type has a list of services that MassHealth members in that coverage type can receive. Payment for the covered services listed in 130 CMR 450.105 is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment. See individual program regulations for information on covered services and specific service limitations, including age restrictions applicable to certain services. Providers should refer to their program manual for a full list of services, restrictions, and conditions. View the online chart of MassHealth covered services.

How do I check a member's eligibility?
Regulations require providers to check eligibility ***before*** providing services to the member. Providers can use Provider Online Service Center (POSC) portal to check the Eligibility Verification System (EVS) via DDE (single check) or batch (multiple member checks simultaneously). EVS messages let providers know the type of health plan, including ACOs, in which a member is enrolled and whom to contact with billing questions.

Eligibility Verification (EVS)
The MassHealth Eligibility Verification System (EVS) is designed to display the status of a member's health care coverage for the date(s) of service requested (please note EVS does not display eligibility for future dates). This includes the identification of the health plan and the type of plan that the member is enrolled, if applicable. For members who have health care coverage in addition to MassHealth, EVS will display information about existing third-party payers including but not limited to the following:



- the third-party carrier name(s) and plan details
- 7-digit MassHealth proprietary Carrier Code

For more information about checking member eligibility, please refer to the following web pages:

- Eligibility Verification System Overview
- Check Member Eligibility

Learn more about EVS codes and messages. For information regarding Provider Online Service Center (POSC), please refer to the POSC section of this handbook.

Dental — Member Benefits
Dental care is one of many benefits available to children and adults who are eligible for MassHealth. In general, members are eligible for the dental benefit if they are enrolled in one of the following coverage types:

- MassHealth Standard
- MassHealth CommonHealth
- MassHealth Family Assistance
- CarePlus
- MassHealth Limited (emergency services only)
- Children's Medical Security Plan

The MassHealth dental program regulations at 130 CMR 420.000 and 450.105 describe the dental benefit, service limitations, and member eligibility.

MassHealth Member Dental Customer Service (DentaQuest)

(800) 207-5019
TTY: (800) 466-7566

Hours: 8 a.m. to 6 p.m. (Monday through Friday)

Dental — Eligibility Verification
For dental, eligibility must be verified on the date of service prior to providing care and documentation (fax from IVR, screen shot or print out) should be kept on file.

Participating MassHealth dental providers may access member eligibility information 24 hours a day, 7 days a week through the MassHealth Dental Program's Interactive Voice Response (IVR) system at (800) 207-5019 or through the provider web portal.

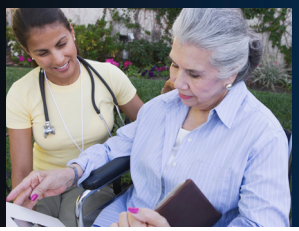
MassHealth covered services					
Services	**Standard**	**CommonHealth**	**Buy-In****	**Family Assistance*****	**CarePlus**
Abortion	✔	✔		✔	✔
Acute inpatient hospital †	✔	✔		✔	✔
Adult day health	✔	✔			
Adult foster care	✔	✔			
Ambulatory prenatal care	✔	✔		✔	✔
Ambulatory surgery center services	✔	✔			✔
Audiologist/hearing services	✔	✔		✔	✔
Behavioral health (mental health and substance use disorder) services	✔	✔		✔	✔
Chiropractor †	✔	✔		✔	✔
Chronic disease and rehabilitation inpatient hospital	✔	✔		✔	✔
Community health center	✔	✔		✔	✔
Continuous skilled nursing	✔	✔			
Day habilitation	✔	✔			
Dental services †	✔	✔		✔	✔
Dialysis services	✔	✔		✔	✔
Durable medical equipment (includes oxygen and respiratory therapy equipment)	✔	✔		✔	✔
Early intervention	✔	✔		✔	
Early and periodic screening, diagnostic and treatment (EPSDT) services	✔	✔			
Emergency Inpatient and outpatient hospital services	✔	✔		✔	✔
Family planning	✔	✔		✔	✔

MassHealth covered services					
Services	**Standard**	**CommonHealth**	**Buy-In****	**Family Assistance*****	**CarePlus**
Group adult foster care services	✔	✔		✔	✔
Hearing aid and dispensing services	✔	✔		✔	✔
Home health	✔	✔		✔	✔
Hospice	✔	✔		✔	✔
Intensive early intervention	✔	✔		✔	
Laboratory	✔	✔		✔	✔
Medicare Part B premium			✔		
Medical/surgical supplies	✔	✔		✔	✔
Nursing facility services	✔	✔			✔
Nurse midwife	✔	✔		✔	✔
Nurse practitioner	✔	✔		✔	✔
Orthotic†	✔	✔		✔	✔
Outpatient hospital	✔	✔		✔	✔
Personal care	✔	✔			
Pharmacy	✔	✔		✔	✔
Physician	✔	✔		✔	✔
Podiatrist	✔	✔		✔	✔
Preventive pediatric health-care screening and diagnostic (PPHSD) services				✔	
Prosthetic†	✔	✔		✔	✔
Radiology and diagnostic services	✔	✔		✔	✔
Therapy (physical, occupational, and speech/language)	✔	✔		✔	✔
Transportation (emergency)	✔	✔		✔	✔
Transportation (non-emergency)	✔	✔			✔
Vision care (exams/treatment)†	✔	✔		✔	✔
Vision care (ophthalmic materials)	✔	✔		✔	✔

†This symbol indicates increased service coverage for members 21 years of age and older. The increased coverage was the result of health-care reform legislation effective July 1, 2006.

**MassHealth Senior Buy-In also covers Medicare Part A Premium and Medicare Parts A and B coinsurance and deductibles, where applicable.

***Persons in Family Assistance with HIV will receive coverage for all medically necessary services, including the expansion of chiropractor, dental, vision, orthotic, prosthetic, and tobacco-cessation services.



Third Party Liability (TPL)

MassHealth members can have health insurance, either Medicare and/or commercial, in addition to MassHealth. All third- party payers in effect for the date services are provided, including health and casualty insurance, must be billed before submitting a claim to MassHealth. MassHealth is considered the payer of last resort and is therefore considered secondary or tertiary coverage for members with TPL. **Note:** Casualty payers are not considered to be health insurance; however, casualty payers (accident and/or workers' compensation) must be billed prior to MassHealth when applicable.

Commercial Insurance

MassHealth members can have both MassHealth and private health insurance at the same time. Private health insurance could be from employment, a family member, or a parent with or without custody. MassHealth considers other insurances to be the primary insurance. This is sometimes referred to as commercial insurance or employer-sponsored insurance.

Medicare as Primary Insurance

Some MassHealth members have MassHealth and Medicare at the same time. MassHealth considers Medicare to be the primary insurance. This means Medicare is billed as the primary insurer and MassHealth is the secondary coverage. **Note:** This does not apply to members who have Medicare/MassHealth and participate in managed care plans such as SCO, PACE, or One Care.

Members Who Have More Than One Insurance in Addition to MassHealth

There are some members who could have more than one insurance in addition to MassHealth (including Medicare). MassHealth considers any additional insurance to be the primary to MassHealth. This means these insurances must be billed as the primary and secondary insurers prior to MassHealth. Adjudication details from all payers must be submitted to MassHealth as reported on the other payer's Explanation of Benefits (EOB).

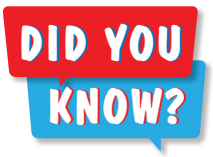
Provider Requirements to Verify Eligibility and Obtain Payment

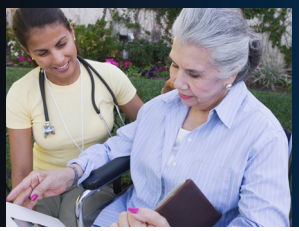
MassHealth regulations at 130 CMR 450.316 require providers to make diligent efforts to identify and obtain payment first from other resources, including casualty payer payments, to ensure that MassHealth is always the payer of last resort. Diligent efforts include, but are not limited to the following:

1. determining the existence of health insurance by asking the member if they have other insurance and by using insurance databases available to the provider.
2. verifying the member's other health insurance coverage, currently known to the MassHealth agency through the **Eligibility Verification System (EVS) on each date of service and at the time of billing.**

Updating a Member's Third Party Insurance Information

When a provider has evidence that a MassHealth member's Third Party Liability (TPL) health insurance information differs from what appears in the Eligibility Verification System (EVS) record, the provider should inform the TPL Unit of the changes. To ensure the member's file is updated to reflect current information, providers should submit the Third Party Liability Indicator form with acceptable documentation to the TPL Unit.





Authorizations and Referrals

Referrals

Referrals are required for certain specialty services in both the PCC plan and Primary Care ACOs [see 130 CMR 450.118(J) and 130 CMR 450.119 (I)]. The requirements for referrals for all other plans are subject to the requirements of the health plan in which the member is enrolled. For specific instructions on how to submit, update, or inquire about a referral, please see the MassHealth POSC Job Aids.

Referral Circles

Primary Care ACOs use the MassHealth Fee-for-Service (FFS) provider network for specialty services and have the option of defining a Referral Circle, a subset of the MassHealth FFS network for whom referral requirements are waived for members in the Primary Care ACO. If a member's hospital or specialist is part of the Referral Circle of the member's Primary Care ACO, the member does not need a referral to receive services from that hospital or specialist. Accountable Care Partnership Plans and MCOs may have preferred networks within their overall networks that have modified authorization requirements. For more information on these potential arrangements, please contact the plans directly.

Prior Authorization (PA)

In certain instances, MassHealth requires providers to obtain prior authorization (PA) 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 MassHealth. Such information, including but not limited to the MassHealth Drug List, is available on the Prior Authorization for MassHealth Providers web page, and copies may be obtained upon request. The provider must submit all prior authorization requests in accordance with MassHealth'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.

There are two types of PA requests: prior authorization for a drug or nonpharmacy services.

Learn more about Prior Authorization (non-LTSS providers); Or refer to our Job Aids.

LTSS providers can learn more at the LTSS Provider Portal.

Preadmission Screening (PAS)

MassHealth requires screening of inpatient admissions for Acute Inpatient and Chronic Disease and Rehabilitation Hospitals. MassHealth conducts reviews before elective admissions (admission screening) and after discharge but before payment (prepayment review). MassHealth also conducts utilization reviews of inpatient admissions and outpatient services on a post-payment basis pursuant to 130 CMR 450.237. Providers can submit PAS requests through the POSC. PAS 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. For specific instructions on how to submit, update, or inquire about a PAS, please see the MassHealth POSC Job Aids.

Non-Emergency Medical Transportation (PT-1)

MassHealth provides non-emergency medical transportation for both ambulatory and non-ambulatory MassHealth members living in the community who are going to MassHealth-covered services.

Chair van/chair car transportation is provided through a PT-1 form. This form must be completed for authorization to transport a member to a specific location. MassHealth members will need a separate form for each location or service that they need to go to. Please submit a PT-1 form online through the Customer Web Portal (CWP) to obtain transportation services for your patient. We no longer accept PT-1 forms by fax or mail.

It is the responsibility of the provider to verify eligibility, and coverage of the individual needing transportation, before a PT-1 request is submitted, and/or before coordinating Ambulance (non-emergency) transportation with an ambulance provider directly.

Learn more information about the PT-1 form and the Customer Web Portal.

Prior Authorizations for Durable Medical Equipment (DME) and Oxygen/Respiratory

Prior authorization requirements for DME/OXY can be found on our MassHealth Durable Medical Equipment and Oxygen Payment and Coverage Guideline Tool.

Prior Authorizations for Orthotics and Prosthetics (ORT/PRT)

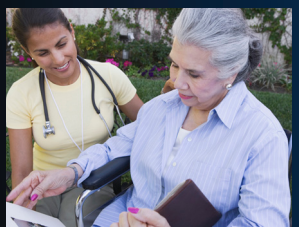
Prior authorization requirements for ORT/PRT can be found in the MassHealth Orthotics and Prosthetics Payment and Coverage Guideline Tool.

Learn more about prior authorization and view the MassHealth Guidelines for Medical Necessity Determination.

All non-LTSS providers submit PA requests through the POSC. Please view the Job Aid.

All LTSS providers submit PA requests through the LTSS Provider Portal. Please view the PA training and resources under Provider Resource in the LTSS Provider Portal.

Photo: Thisisengineering, Unsplash



Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) is a process that facilitates the exchange of data in a standardized message format between two computer systems. EDI is the industry standard terminology for electronic transactions.

EDI specifications and instructions to submit electronic transactions to MassHealth are based on the following documents:

- ASC X12 Standards for Electronic Data Interchange Implementation Guide (IG)
- MassHealth Companion Guide
- MassHealth Billing Instructions (as applicable)

MassHealth supports the following Health Insurance Portability and Accountability Act (HIPAA) EDI transactions:

- 270/271: Health Care Eligibility/ Benefit Inquiry and Information Response
- 276/277: Health Care Claim Status Request and Response
- 820: Health Care Premium Payment
- 834: Health Care Benefit Enrollment and Maintenance Outbound
- 835: Health Care Payment/Remittance Advice
- 837I: Health Care Claim: Institutional
- 837P: Health Care Claim: Professional

To access the MassHealth Companion guides, please go to the MassHealth Technical Refresh web page.

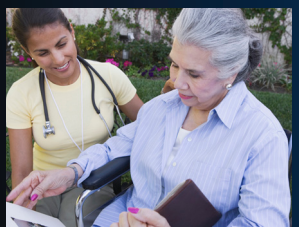
MassHealth will generate a 999 acknowledgement upon receipt of an electronic file. The 999 is a HIPAA transaction that acknowledges the receipt of a standard transaction and identifies whether the transaction will be accepted or rejected for downstream systems processing.

For more information regarding the 999 acknowledgement, including how to resolve issues and who to contact for assistance, please go to the Electronic Data Interchange web page.

Any MassHealth provider who intends to submit HIPAA EDI transactions to MassHealth must test each transaction with MassHealth prior to submitting any transactions in the production environment. Learn more about the HIPAA Testing process.

MassHealth maintains a MassHealth-Approved Vendor List, which provides the names, phone numbers, transaction types, and services of vendors that are approved to submit electronic HIPAA-compliant transactions to MassHealth. Learn more about the MassHealth-Approved Vendor list.

If you have questions about policies and procedures for testing or submitting HIPAA EDI transactions, or need technical support, contact MassHealth at (800) 841-2900 and follow the menu prompts for EDI Transactions, Monday through Friday from 8 a.m.–5 p.m., excluding holidays, or by email to edi@mahealth.net.



Billing and Claims

Eligibility Verification Reminder

Eligibility must be verified prior to providing service. By verifying a member's eligibility on the day or date range of service, providers may be able to reduce the risk of their claims being denied due to eligibility. EVS messages indicate health plan information for accurate submission. Dental providers need to follow additional requirements as outlined in the MassHealth Members and Benefits section of the handbook.

Claims Submission

- For PCC plan and Primary Care ACO members, please submit electronic only claims* directly to MassHealth except for behavioral health (BH).
- BH claims should be submitted directly to MBHP.
- For Managed Care Organization (MCO) members, please submit claims directly to the MCO.
- For Accountable Care Partnership Plan members, please refer directly to the applicable Accountable Care Partnership Plan for claims submission instructions.
- Dental and Pharmacy claims should not be submitted through POSC.

*Per MassHealth All Provider Bulletin 225 (April 2012), effective January 1, 2012, all claims must be submitted electronically. Only providers who have received an approved electronic waiver may submit paper claims. Please reference the EDI section of this handbook for more information regarding electronic transmissions.

Dental Claims

All dental claims must be submitted electronically (unless you have a claims paper waiver on file) directly to DentaQuest via the following methods:

- Electronic claims via direct data entry at www.masshealth-dental.net. This is a secure, HIPAA-compliant, direct data-entry option. Please contact the EDI team at EDIteam@dentaquest.com to ensure your practice has the necessary software to generate a HIPPA compliant 837D file, requirements for set-up are reviewed, necessary configuration takes place and testing of transaction involved is completed.
- Electronic claims in the HIPAA-compliant 837D format via upload to our secure trading partner portal is available at www.masshealth-dental.net.
- Electronic submission via a clearinghouse partner using payer ID CKMA1.
- Electronic submission MassHealth Provider Web Portal.
- Paper claims on the ADA 2012 or newer claim form only for those providers who have an approved electronic claim submission waiver on file with MassHealth/DentaQuest.

Please refer to the MassHealth Dental Office Reference Manual located in the documents section of the provider web portal.

For dental general billing, claims, member eligibility questions or training requests reach out to the MassHealth/DentaQuest customer service center at (800) 207–5019 or email customer service at inquiries@masshealth-dental.net.

Oral Surgeons — Billing Medical

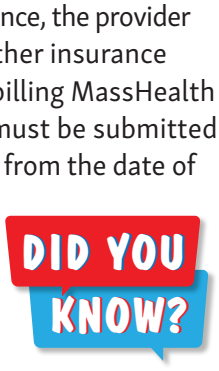
All participating oral surgery providers are obligated to bill MassHealth for dental and medical covered services.

Oral surgeons must complete the enrollment process to bill for covered oral surgery CPT/medical codes via MassHealth's Provider Online Service Center (POSC) by filling out the *Data Collection Form and Registration Instruction* and e-mailing it to PINregistrationsupport@mahealth.net in order to gain access.

For medical general billing or claims questions reach out to the MassHealth/Maximus customer service center at (800) 841-2900 or email questions to providersupport@mahealth.net.

Timely Submissions

Initial claims must be received by MassHealth **within 90 days of the service date**. If the member has other insurance, the provider must bill the other insurance carrier before billing MassHealth and the claim must be submitted within 90 days from the date of the explanation of benefits (EOB) of the primary insurer. For claims that are not submitted within the 90-day period but that meet one of the exceptions specified in section 450.309 B of the Administrative and Billing Regulations, a provider must request a waiver of the billing deadline (a 90-day waiver) pursuant to the billing instructions provided by MassHealth, refer to MassHealth All Provider Bulletin 233 dated February 2013.



Electronic claim submission options available to providers:

- Direct billing — direct upload of EDI batch claims files through POSC;
- Vendor (billing intermediary or clearinghouse) that submits claims on your behalf, and
- Direct Data Entry (DDE) of claims though the Provider Online Service Center.

Final submission of a claim is 12 months from the date of service or 18 months from the date of service if the member has another insurance carrier billed prior to MassHealth. For more information on Final Deadline Appeals, please see All Provider Bulletin 232 dated February 2013 and All Provider Bulletin 300 dated September 2020.

Learn more about billing timelines and appeal procedures.

Claim Attachments

For certain services, MassHealth requires other forms and documentation. Some services require submission of an attachment with the claim, while others may require such documentation to remain on file in the member's medical record. See the applicable program regulations in the MassHealth provider manual for specific report

requirements. Attachments that must be submitted with the claim must be submitted using DDE only. Some services that require a submission of an attachment must be submitted with a Delay Reason Code. Please refer to the applicable provider type Administrative and Billing Regulations 130 CMR 450.000.

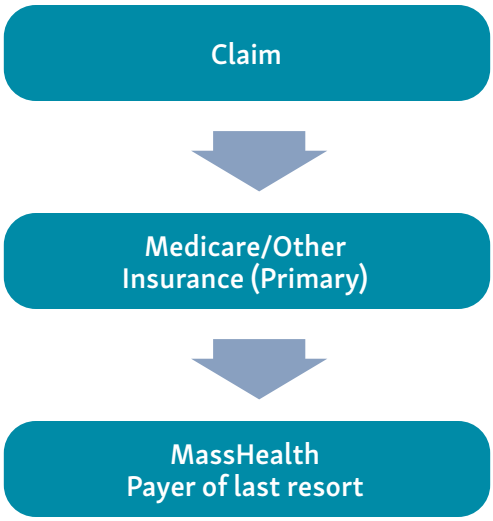
Coordination of Benefits (COB) — Member has Other Insurance

If the member has other insurance (Medicare and/or commercial), submit the claim to the other insurance carrier, following the other insurer's billing instructions. If the claim is denied for reasons other than a correctable error, or is partially paid by the other insurance carrier, the claim may be submitted to MassHealth. The claim should not be submitted to MassHealth if denied for noncompliance with any one of the insurer's billing and authorization requirements.

Medicare Crossover Claims

After Medicare has made a payment or applied the charge to the deductible, the Benefits Coordination and Recovery Center (BCRC) will automatically transmit claims for dual-eligible members (Medicare and MassHealth) to MassHealth for adjudication. A claim must contain at least one Medicare-approved service line in order for the entire claim to be crossed over automatically to MassHealth. For Medicare crossover payment methodology, please refer to 130 CMR 450.318. Providers may directly submit electronic claims for dual-eligible members to MassHealth using the 837 Transaction or POSC if one of the following statements is true:

- The member has other insurance in addition to Medicare and MassHealth;
- The member's Medicare claim has not appeared on a MassHealth crossover remittance advice and/or the claim cannot be located in POSC during a claim status inquiry; or
- Medicare has denied all services.



Providers must follow instructions described in the HIPAA 837 implementation guides and MassHealth companion guides when submitting COB claims for dual eligible members for the reasons listed above. Providers must include all the COB information on their claim submission to MassHealth as it is reported on the other payer's Explanation of Benefits (EOB).

Enhanced COB Claim Editing

When submitting a Coordination of Benefits claim, providers must report all valid Claim Adjustment Group Codes (CAGCs) and Claim Adjustment Reason Codes (CARCs) as they appear on the other payer's Explanation of Benefits (EOB) or 835 to MassHealth when the other payer has denied the claim/claim detail line. Both pieces of information are critical for MassHealth to determine its financial responsibility for the claim/claim detail line and must be reported accurately on the MassHealth claim.

Enhanced COB claims editing (implemented in December 2017) enforces MassHealth TPL regulations to ensure that MassHealth pays for claim/claim detail lines only when there is a member liability and does not pay when the provider is financially obligated for the claim/claim detail line.

Learn more about COB.

Learn more more about Third Party Liability.

Claims Status

The claim status inquiry functionality in the Provider Online Service Center allows you to verify the status of a claim submitted to MassHealth. After MassHealth processes a claim, the claim is given a 13-digit Internal Control Number (ICN). Providers can upload a 276 batch file and download the 277 response (HIPAA transaction sets) for the status of the claim through the Provider Online Service Center or through direct data entry (DDE) claims status panels.

The status is also available on the MassHealth issued remittance advice (RA).

Claim Denials and Suspensions

Denials

Claims (both batch and DDE) that deny contain edit code(s) that describe the denial reason. These claims must be reviewed, corrected (if applicable), and resubmitted to MassHealth within the appropriate time frame. To visit the list of edits that can appear on the RA, please see the List of Explanation of Benefit Codes Appearing on the Remittance Advice and other additional aids listed in the Additional Claims Resources section below.

Suspensions

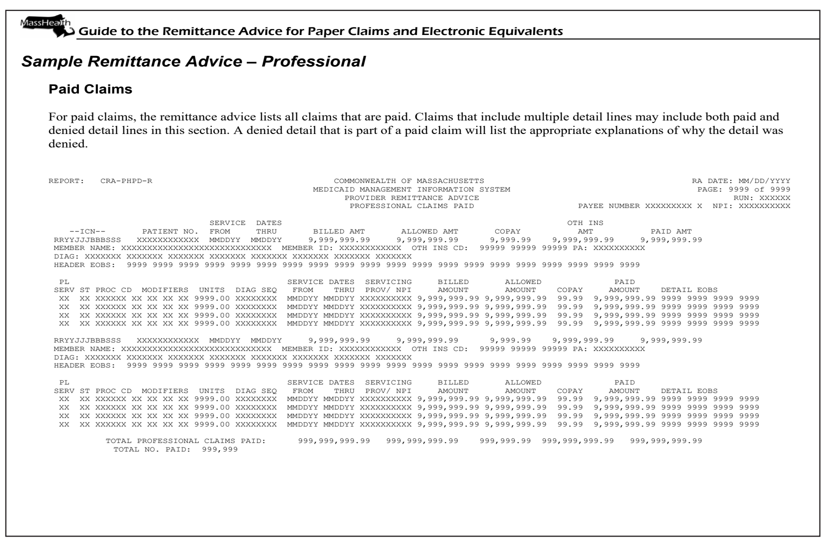
A suspended claim is a claim that requires review before final adjudication. When a claim appears as suspended on a remittance advice (RA), the ICN assigned to the claim will remain the same throughout the processing cycle. You should post the claim as received by MassHealth. Do not rebill the claim while it is in suspense. The suspended claim will appear on a subsequent RA as paid or denied.

Remittance Advice (Claim Status Reporting)

A Remittance Advice (RA) is a report that provides claims processing status to providers indicating if the claim is paid, denied, or suspended (please see additional information below regarding denied and suspended claims). The RA is a helpful tool when reconciling accounts, as it reports the status of a claim submitted to MassHealth.

The RA is available in two forms: the 835 electronic RA, and the downloadable PDF RA, which is available online. The 835 (HIPAA transaction) RA can be downloaded from the POSC by a provider who has a signed Trading Partner Agreement (TPA) on file with MassHealth. The RA in PDF format also displays information about claim status, although it appears in a format that is unique to MassHealth. Providers can review, download, or print the PDF RA on the Provider Online Service Center.

Each Tuesday, the applicable RA is given a 6-digit run number, e.g., 100139, one week and 100140 the next week. On a weekly basis, the Remittance Advice is posted on POSC for providers.



MassHealth Guide to the Remittance Advice for Paper Claims and Electronic Equivalents

Sample Remittance Advice – Professional

Paid Claims

For paid claims, the remittance advice lists all claims that are paid. Claims that include multiple detail lines may include both paid and denied detail lines in this section. A denied detail that is part of a paid claim will list the appropriate explanations of why the detail was denied.

```
REPORT:   CRA-PHPD-R                                COMMONWEALTH OF MASSACHUSETTS                                    RA DATE: MM/DD/YYYY
                                                  MEDICAID MANAGEMENT INFORMATION SYSTEM                                  PAGE: 9999 of 9999
                                                        PROVIDER REMITTANCE ADVICE                                           RUN: XXXXXX
                                                         PROFESSIONAL CLAIMS PAID                  PAYEE NUMBER XXXXXXXXX X  NPI: XXXXXXXXXX

                              SERVICE  DATES                                                     OTH INS
   --ICN--        PATIENT NO.  FROM     THRU       BILLED AMT       ALLOWED AMT       COPAY         AMT          PAID AMT
 RRYYJJJBBBSSS   XXXXXXXXXXXX  MMDDYY  MMDDYY     9,999,999.99     9,999,999.99      9,999.99    9,999,999.99    9,999,999.99
 MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MEMBER ID: XXXXXXXXXXXX  OTH INS CD:  99999 99999 99999 PA: XXXXXXXXXX
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  PL                                          SERVICE DATES  SERVICING     BILLED        ALLOWED              PAID
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  XX  XX XXXXXX XX XX XX XX 9999.00 XXXXXXXX  MMDDYY MMDDYY XXXXXXXXXX 9,999,999.99 9,999,999.99  99.99  9,999,999.99 9999 9999 9999 9999
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 RRYYJJJBBBSSS   XXXXXXXXXXXX  MMDDYY  MMDDYY     9,999,999.99     9,999,999.99      9,999.99    9,999,999.99    9,999,999.99
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  PL                                          SERVICE DATES  SERVICING     BILLED        ALLOWED              PAID
 SERV ST PROC CD  MODIFIERS  UNITS  DIAG SEQ   FROM    THRU  PROV/ NPI     AMOUNT        AMOUNT     COPAY     AMOUNT     DETAIL EOBS
  XX  XX XXXXXX XX XX XX XX 9999.00 XXXXXXXX  MMDDYY MMDDYY XXXXXXXXXX 9,999,999.99 9,999,999.99  99.99  9,999,999.99 9999 9999 9999 9999
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           TOTAL PROFESSIONAL CLAIMS PAID:      999,999,999.99   999,999,999.99    999,999.99  999,999,999.99   999,999,999.99
            TOTAL NO. PAID:  999,999
```

MassHealth Provider Remittance Advice Message Text webpage
MassHealth has a historical listing of message texts that have appeared on provider Remittance Advices available on Mass.gov.

Additional Claims Resources

Many claims are denied due to eligibility. For more information about checking member eligibility, please go to the following web pages.

Eligibility Verification System Overview

Check Member Eligibility

MassHealth Billing and Claims, containing important information about billing and submitting claims

POSC job aids, including denied claims correction and adjustments

Billing Tips is an assortment of informational leaflets that summarize policies and regulations, including using RA to reconcile accounts

Guide to the Remittance Advice for Paper Claims and Electronic Equivalents

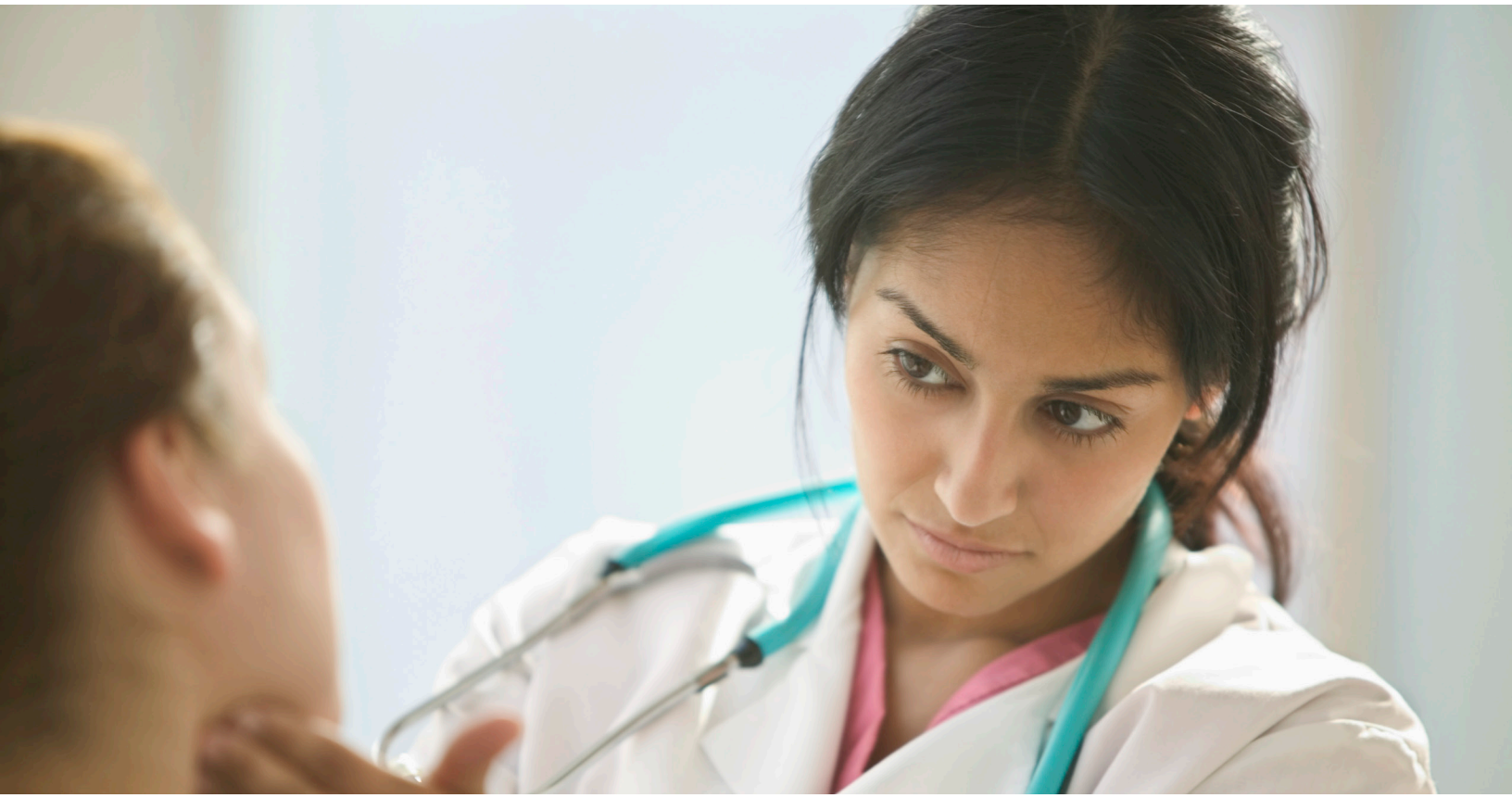
List of Explanation of Benefit Codes Appearing on the Remittance Advice

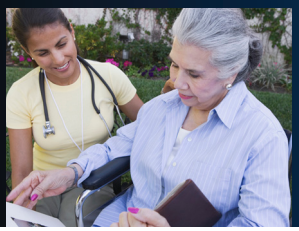
Information regarding 835, including Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)

Timely Filing Bulletins—

- All Provider Bulletin 233: Revisions to the 90-Day Waiver Procedures
- All Provider Bulletin 232: Revisions to the Final Deadline Appeal Procedures
- All Provider Bulletin 300: Final Deadline Appeals Board Electronic Correspondence

Learn more about Adjusting/replacing a paid claim.





Payments

Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT)
Enrollment/Modification Form

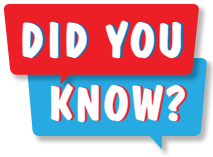
The Office of the Comptroller and the Office of the State Treasurer have mandated that all providers enrolled in MassHealth, including individual practitioners who will receive payments directly, participate in EFT. EFT payments are automatically deposited into a designated bank account. They are less expensive to process, highly dependable in getting deposited into a provider's account, and processed in a secure manner. EFT is helpful in streamlining operations by reducing paperwork, and it functions as a convenient and effective electronic method of reimbursement.

Please note that all payments are issued by the Office of the Comptroller. Account reconciliation is the provider's responsibility. Although MassHealth does not reconcile provider accounts, there is information on the billing tips page that providers can use to help reconcile the accounts with the RA.

Learn more about the EFT form.

VendorWeb

VendorWeb is the online application through which statewide contractors may view their payment transactions with the Commonwealth of Massachusetts. VendorWeb provides information on scheduled payments and payment history. To use VendorWeb, you must know your Vendor Code and the last 4 digits of your Taxpayer Identification Number (TIN). If you are unable to locate your Vendor Code, contact the applicable Customer Service for your provider type. VendorWeb shows Prompt Payment Discounts as well as any intercepted payments.



VendorWeb is managed by the Office of the Comptroller. The website contains a general How to use VendorWeb job aid as well as a job aid specifically for MassHealth providers.

To access VendorWeb and more information regarding the available job aids, please go to massfinance.state.ma.us/VendorWeb/vendor.asp

Overpayments

Voids and Adjustments

If a provider receives an overpayment for one of the reasons below, the provider must return the full amount paid by MassHealth for a particular claim or remittance advice. To do this, the provider must request that the payment be voided. Do not send a company check or return the original check received from the Department of the State Treasurer. Instead, deposit the check and follow the void procedures outlined below.

Please Note: If a provider was notified by letter that MassHealth is performing a retrospective utilization review, a peer review, or any other review of your services, please do not return overpayments for the period under review, as they cannot be accepted.

Reasons to Request a Void (non-dental and non-pharmacy)

- Payment was made to the wrong provider number
- Payment was made for the wrong member
- Payment was made for overstated services
- Payment was made for services for which full reimbursement has been received from other payers

Providers can only void previously paid non-dental and non-pharmacy claims in the following ways:

- Through the Provider Online Service Center using the HIPAA-compliant 837 format
- By submitting a paper Void Request Form

Learn more information about how to void a claim.

Adjustments

If a provider is paid incorrectly, either underpaid (requesting more money) or overpaid (returning a partial payment), the provider should adjust (replace) the claim.

Learn more about how to adjust a claim.

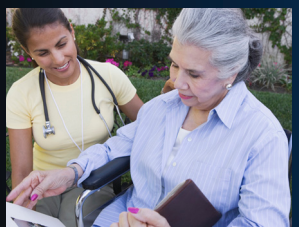
Providers can only adjust previously paid non-dental and non-pharmacy claims through the Provider Online Service Center using the HIPAA-compliant 837 format.

Please Note: An adjustment should only be processed within one year from the date of service. Please do not revert to this process if the claim is beyond 12 months.

Provider Overpayment Disclosure Form

MassHealth has developed a Provider Overpayment Disclosure form for use when disclosure via the Provider Online Service Center (POSC) or direct data entry (DDE) is not appropriate, and the provider is unable to use or follow the standard administrative and billing methods of resolution. This form captures key information that will allow MassHealth to identify the affected claims, such as the Internal Control Number (ICN), the provider's name and number, and the date of service.

For more information regarding the Provider Overpayment Disclosure form, please see All Provider Bulletin 256.



Provider Portals

Provider Online Service Center (POSC)

The POSC is a web-based portal that is available to MassHealth providers, business partners, and relationship entities to view information, submit and receive transactions, and effectively conduct business with MassHealth online. Providers, business partners, and relationship entities must be enrolled in and/or registered to use the POSC.

The Provider Online Service Center includes the following functions:

- Enrollment as a MassHealth provider and management of profile information
- Real-time, interactive claims processing
- Status and payment information
- Direct data entry and modification of individual transactions such as prior authorization (non-LTSS providers), pre-admission screening, and eligibility verification
- Viewing of notifications, contracts, reports, metrics, and financial data
- Provider Security – creating and managing subordinate accounts
- Links to MassHealth provider and Mass.gov

To access the POSC: newmmis-portal.ehs.state.ma.us/EHSProviderPortal/providerLanding/providerLanding.jsf

Learn more about POSC and Job aids.

Provider Online Service Center (POSC) Job Aids

MassHealth has prepared a variety of job aids as part of the POSC e-Learning courses. The job aids are organized by functional area. The jobs aids can be found on the Job aids for the Provider Online Service Center (POSC) webpage. Beneath the name of each functional area listed below are links to the job aids associated with processes within those functional areas.

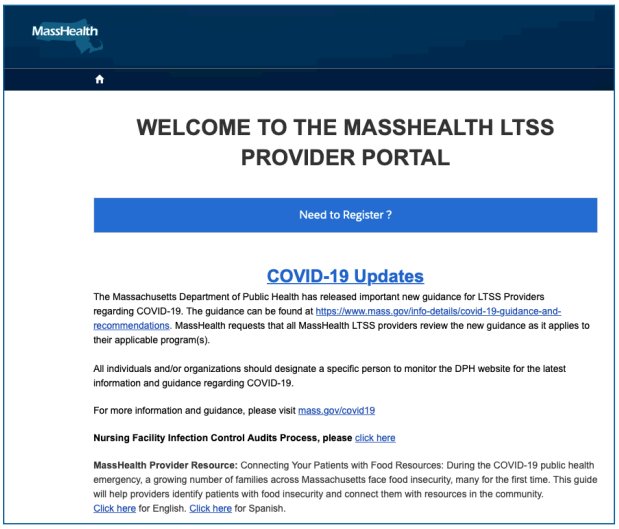
List of job aids functional areas:

- Provider Information & Navigation
- Batch Claims Processing
- Editing Claims Post Submission
- Eligibility Verification
- Health Safety Net (HSN)
- HIPAA Pharmacy Claims
- Managed Care
- Preadmission Screening
- Prior Authorization
- Provider Profile Maintenance
- Provider Security
- Referrals
- SCO/PACE
- Submitting a Management Minutes Questionnaire
- Submitting Institutional Claims
- Submitting Professional Claims
- Submitting Residential Care Home/Rest Home Claims
- Third Party Liability (TPL) (Note: The Professional and Institutional TPL job aid instructions supplement the instructions found in the Professional and Institutional Claim Submission with MassHealth job aids. Providers should follow the instructions described in the Professional or Institutional Claim Submission with MassHealth job aids, and then refer to the TPL job aid when reporting COB information on the claim
- View Metrics/Reports

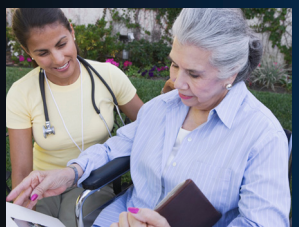
LTSS Provider Portal

The LTSS Provider Portal is a web-based portal that is available to MassHealth LTSS providers. All users must be enrolled in and/or registered to use the LTSS Provider Portal. Below outlines the LTSS Provider Portal functionalities:

- Enrollment as a MassHealth provider
- Management of profile information
- Provider Revalidation
- Viewing of MassHealth notifications and updates
- Submission of prior authorizations
- Portal Security – creating and managing subordinate accounts
- Training presentations and resources
- Links to key resources and information on Mass.gov

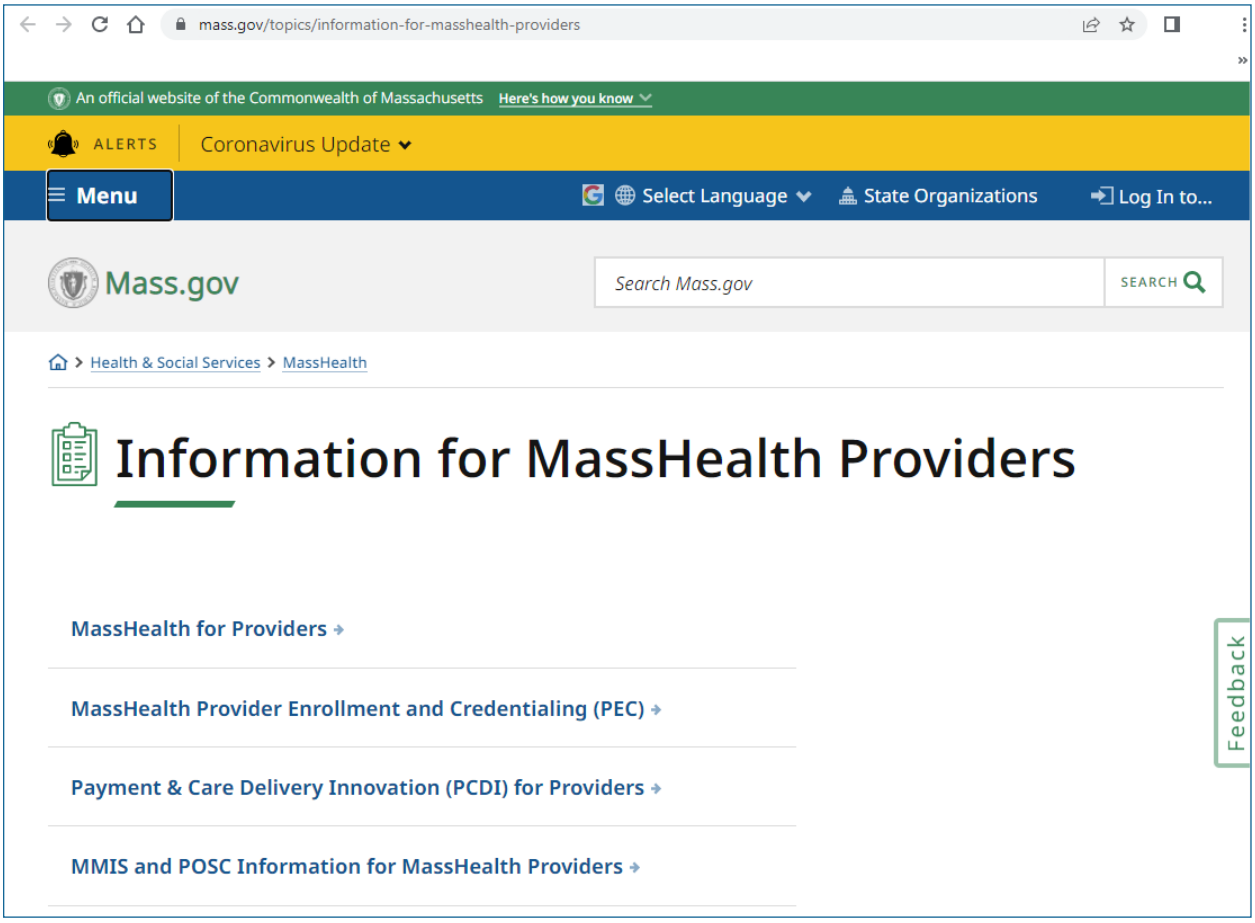


Access the LTSS Provider Portal here.



Mass.gov for Providers

MassHealth has a webpage dedicated to providers on Mass.gov. This website allows providers to access information, notices, and tools relevant to MassHealth Providers.

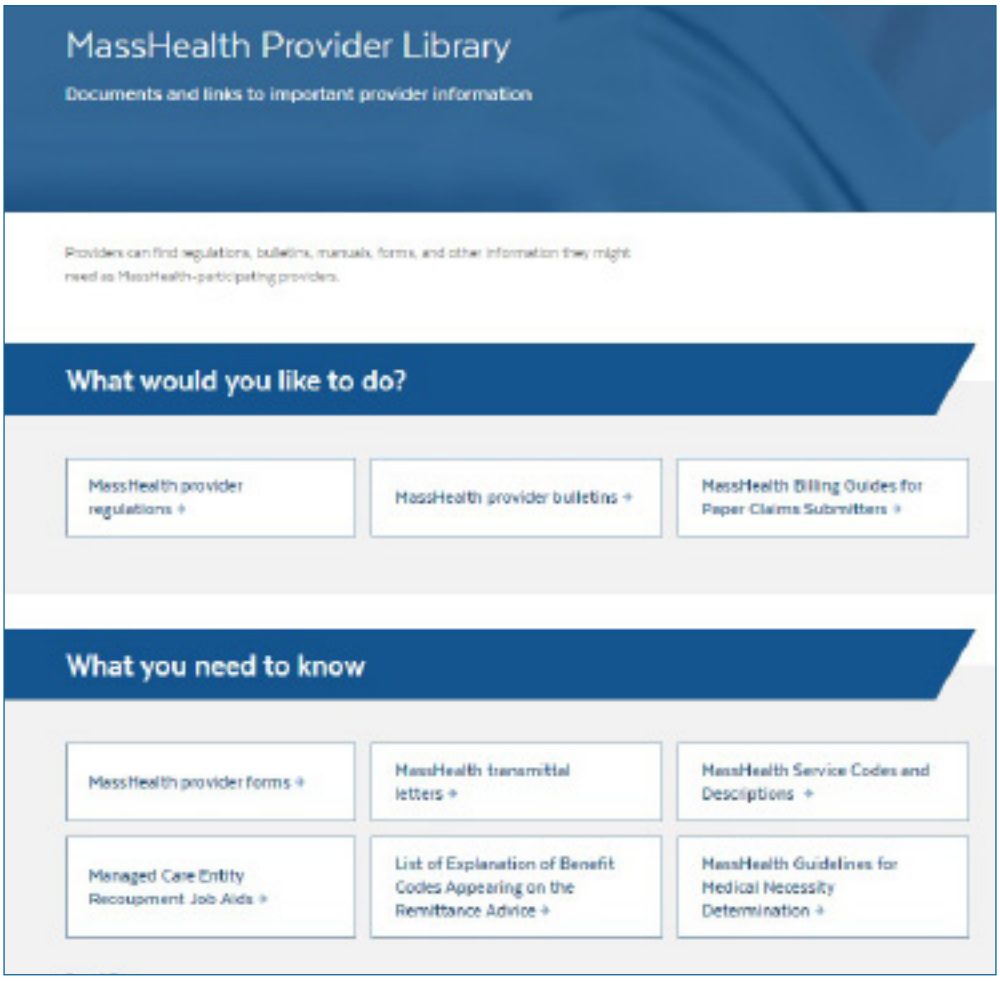


View the MassHealth for Providers web page.

Provider Library

The Provider Library provides access to important provider documents such as regulations, bulletins, manuals, forms, appendices, transmittal letters, and other information that providers may need as MassHealth-participating providers.

Access the Provider Library.



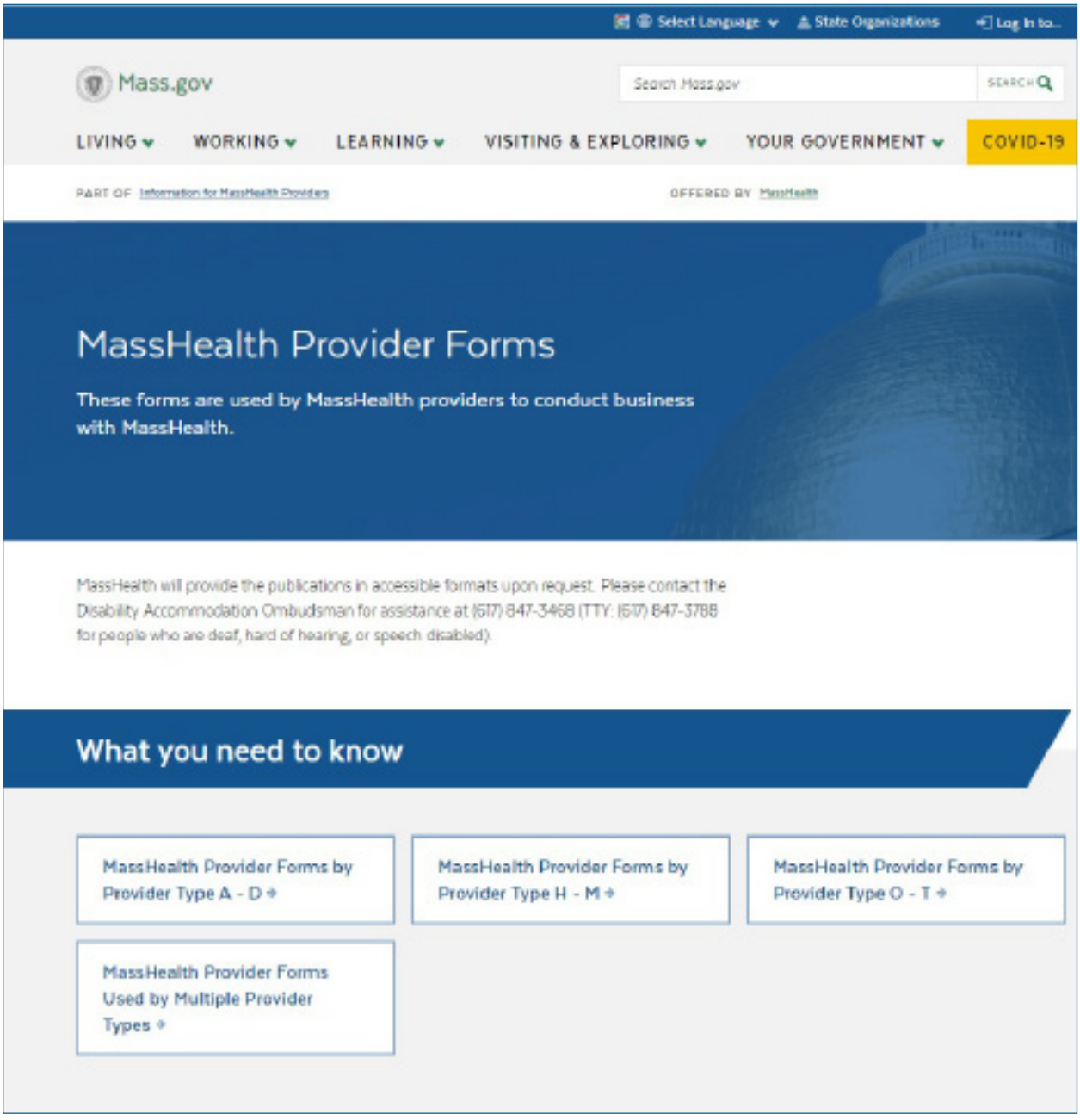
Get Email Alerts When Provider Publications are Posted on the Web

To receive email alerts when MassHealth issues a provider bulletin or transmittal letter, please complete this online form.

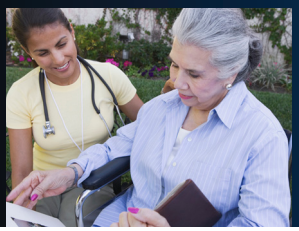
If you have questions, please contact the MassHealth Customer Service Center at (800) 841-2900 or email providersupport@mahealth.net. LTSS providers should contact the MassHealth LTSS Provider Service Center at (844) 368-5184 or email support@masshealthltss.com.

Provider Forms

MassHealth has a webpage that contains a number of forms necessary for conducting business with MassHealth. The page organizes forms alphabetically by provider type and forms used by multiple providers.



Access the provider forms page.



Provider Resources/ Communications

Provider Communications

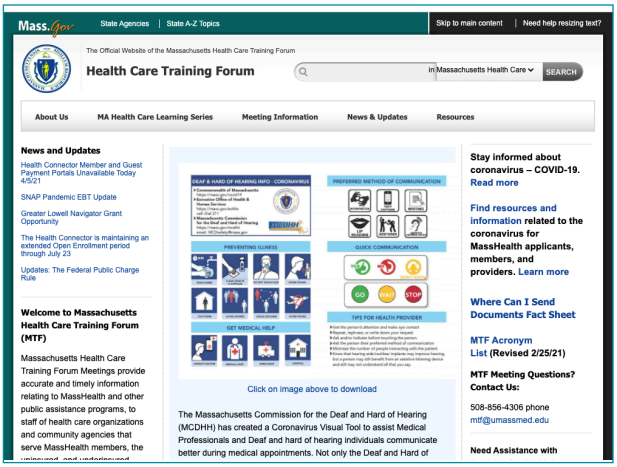
MassHealth communicates to providers in various ways. Primarily, communication occurs through provider bulletins and transmittal letters. MassHealth uses provider bulletins to communicate procedures, reminders, policy clarifications and other information to MassHealth providers. Transmittal letters are used to communicate changes to MassHealth provider regulatory and sub-regulatory information such as updated to the Subchapter 6 list of HCPCS codes.

Additionally, MassHealth uses Remittance Advice Message Text Messages that are found on the first page of the remittance advice that providers receive to communicate important updates. When logging into the POSC, providers should always check the Broadcast Messages under the Manage Correspondence and Reporting link.

To receive email alerts when MassHealth issues a provider bulletin or transmittal letter, please complete this online form.

Provider Associations

MassHealth has partnered with various provider associations and have quarterly meetings with association representatives to share MassHealth updates. This partnership provides another source to communicate MassHealth provider information through these associations' websites, emails, and newsletters.



Massachusetts Health Care Training Forum (MTF)

Massachusetts Health Care Training Forum (MTF) is a program sponsored by MassHealth in partnership with Commonwealth Medicine, UMass Medical School. MTF provides accurate and timely information relating to MassHealth and other state public health insurance programs, to staff of health care organizations and community agencies that serve MassHealth members, the uninsured, and underinsured. The MTF uses a various range of communication methods to disseminate state public health insurance-related programs and policy information. Communication methods include a total of 16 regional meetings held throughout the year in four regions of the state, program updates via email communications, a regularly updated program website, including a growing number of training webinars.

Why Participate in MTF?

- Receive convenient, high-quality training by experts to improve staff's ability to work in accordance with MassHealth and other state public health insurance programs, policies, and procedures.
- Discuss important issues face-to-face with MassHealth and other state agency representatives at one of four regional meetings.
- Have access to continuing education on emerging topics and other EOHHS programs.
- Receive regular MassHealth updates featuring time-sensitive information and resources.
- Access resources, such as MTF meeting handouts, and FAQs.
- Network with colleagues to problem-solve and identify resources to better serve your MassHealth population.
- Access to important updates via MTF email alerts.

For more information, to stay connected and sign up for the MTF newsletter, or register for an upcoming meeting, go to www.masshealthmtf.org/

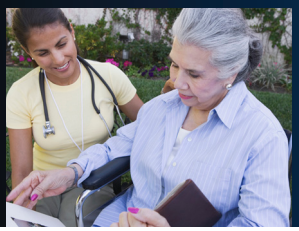
Additional Resources

- MassHealth Website
  - o MassHealth Information (member and provider information)
- MMIS and POSC Information Website
  - o Latest information on the MMIS and any system changes

- Provider Online Service Center (POSC) Website
  - o Online MassHealth provider portal for electronic submissions and inquires
- Provider Payment Rates: Community Health Care Providers (Ambulatory Care)
- Provider Payment Rates: Hospitals/Nursing Facilities and Rest Homes

Get Email Alerts When Provider Publications are Posted on the Web

To receive email alerts when MassHealth issues a provider bulletin or transmittal letter, please complete this online form.



Training and Refreshers

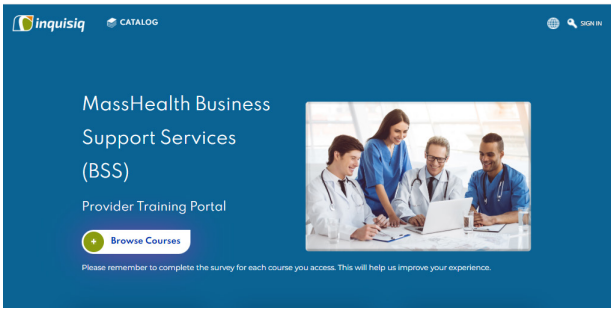
Dental/Pharmacy/LTSS Providers

Please see important information section to contact the appropriate vendor for Dental/ Pharmacy/LTSS.

Other Providers

MassHealth Provider Learning Management System for Non-LTSS Providers

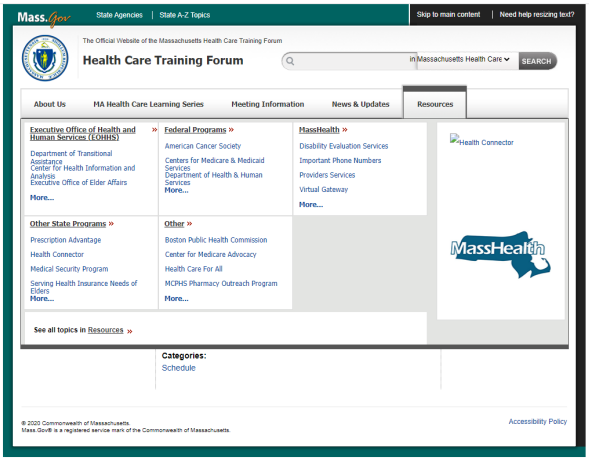
MassHealth has a Provider Learning Management System (LMS) for Non-OLTSS providers. The LMS provides on demand learning modules related to how providers can better navigate the Mass Health system, additional resources, and the ability to register for upcoming in-person trainings. We also encourage providers to evaluate each of our trainings and learning modules so we are able to evaluate the effectiveness of our educational offerings. Surveys are available after each learning module/training to ensure we are meeting the needs of the provider community.



To access the LMS, please visit MassHealth Learning Management System (LMS) and login or complete the registration form to obtain access.

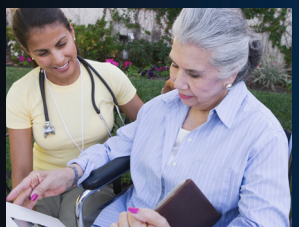
To Request a Training - MassHealth Customer Service

To request a provider training regarding a specific topic or for a provider organization, please contact MassHealth at (800) 841-2900 or email provider-support@mahealth.net



Massachusetts Health Care Training Forum (MTF) — For All Provider Types

The MTF meetings provide accurate and timely information relating to MassHealth and other state public health insurance programs, to staff of health care organizations and community agencies that serve MassHealth members, the uninsured, and underinsured. Click here to learn how to register for an upcoming meeting.



Important Information

Below is a listing of information for MassHealth Network Providers. Please note that some are specific to certain provider types. Please see the Types of MassHealth Providers Section for more information on types of MH providers.

Massachusetts Behavioral Health Partnership (MBHP)

www.masspartnership.com
Phone: (800) 495-0086

MassHealth LTSS Provider Service Center (LTSS providers)

MassHealth's Long-Term Services and Supports (LTSS) program
MassHealth LTSS Provider Portal – www.masshealthltss.com
Call LTSS Provider Service Center at (844) 368-5184
Email: support@masshealthltss.com
Mail: MassHealth LTSS, PO Box 159108, Boston, MA 02215
Fax: (888) 832-3006

DentaQuest Customer Service

For assistance, please contact DentaQuest customer service at (800) 207-5019 between the hours of 8 a.m. to 6 p.m., Monday through Friday.

Additionally, you can reach us via the MassHealth website at www.masshealth-dental.net, the MassHealth Dental Provider Web Portal and via mail at 465 Medford Street, P.O. Box 9708, Boston, MA 02114-9708.

MassHealth Customer Service Center (non-dental, non-LTSS, and non-pharmacy)

Mail: MassHealth Customer Service, PO Box 121205 Boston, MA 02112-1205
Email: providersupport@mahealth.net
Phone: (800) 841-2900
Fax: (617) 988-8974

Electronic Data Interchange Unit (EDI)

Email: EDI@mahealth.net
Phone: (800) 841-2900

Pharmacy (non-HSN)

MassHealth Pharmacy Technical Help Desk:
Phone: (866) 246-8503 (available 24/7)
Pharmacy Facts: www.mass.gov/lists/mass-health-pharmacy-facts

Health Safety Net (HSN)

Pharmacies with questions involving Health Safety Net members should contact the HSN Help Desk: (800) 609-7232 (Hours: Monday–Friday, excluding holidays, 8 a.m.–4 p.m.)

Pharmacies with HSN Payment Remittance Advice inquiries: Phone: (800) 609–7232

Pharmacy Prior Authorization
University of Massachusetts Medical School
Phone: (800) 745-7318
Fax: (877) 208-7428

Drug Utilization Review (DUR) Program

Commonwealth Medicine
University of Massachusetts Medical School
P.O. Box 2586, Worcester, MA 01613-2586

Non-Pharmacy Prior Authorization (non-LTSS)

Prior authorization requests for non-pharmacy services
MassHealth
Attn: Prior Authorization
100 Hancock Street, 6th Floor, Quincy, MA 02171
Phone: (800) 862-8341

Additional Appropriate Phone Numbers

Attorney General's Medicaid Fraud tip line
(617) 963-2360; (617) 573-5369 (fax)

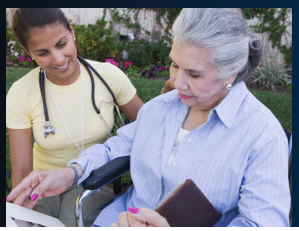
VendorWeb
Phone: (617) 348-5298 Fax: (617) 210-5468

Helpful Links

Provider Online Service Center (POSC)

Provider Directory

Search for providers in one of these plans:		Primary Care	Specialists	Behavioral Health
	MassHealth Network Also for age 65+ and those with secondary insurance	SCROLL DOWN	SCROLL DOWN	**CLICK HERE** links to PDF file
	Primary Care Clinician (PCC) Plan	SCROLL DOWN	SCROLL DOWN	**CLICK HERE**
	Mass General Brigham ACO	**CLICK HERE**	SCROLL DOWN	**CLICK HERE**
	Steward Health Choice*	**CLICK HERE**	SCROLL DOWN	**CLICK HERE**
	Community Care Cooperative*	**CLICK HERE**	SCROLL DOWN	**CLICK HERE**



Tips/Best Practices

General

Make sure that you know all provider MassHealth billing rules, resources, and regulations and how to access them.

- Do you know the link to the MassHealth website?
- Have you accessed the Provider Publications web page and the many resources available?
- Have you reviewed the POSC job aids?
- When was the last time that you fully reviewed the provider manual?

Make sure that you stay updated with the information resources.

- Sign up for Bulletin and Transmittal letter emails.
- Review weekly message texts on RA or via Provider Library on the MassHealth website (if RA access is not available).
- Review POSC broadcast messages.

Attend trainings, forums and related MassHealth association information when available.

- Watch for MassHealth Trainings.
- Attend MassHealth Training Forum (MTF) and Association meetings
- For LTSS providers, attend all LTSS trainings available via the MassHealth LTSS portal.
- For non-LTSS providers, register and take available classes on the MassHealth Provider Learning Management System for Non-LTSS Providers.

  Keep your MassHealth contact information up to date.
- Always make sure that MassHealth has the most updated information including addresses, emails, phone numbers, etc.
- Use the POSC to regularly check and update provider information needed in order to receive any communication from MassHealth (Job aids and training is available to assist providers with using the POSC to update provider information).

Member Eligibility

Make sure you and all responsible staff understand how to check eligibility.

- Many denials, delays and potential lost revenue are due to the lack of **up-front** eligibility checks.
- Review the eligibility job aids available for POSC on Mass.gov.
- Make sure you understand what type of benefit the member has in EVS.
- Make sure you understand what services are covered for each member. Do not assume, check subchapters 1–3 of your provider manual.

Make sure that eligibility is ***checked every time*** prior to providing service to the member.

Make every effort to find out other primary insurer(s) during the eligibility verification process and make diligent efforts to bill all primary insurers first.

Submit any TPL corrections to MassHealth using the TPL indicator form.

Make sure that any vendor who is doing business on your behalf is also following these guidelines, ultimately the provider is responsible.

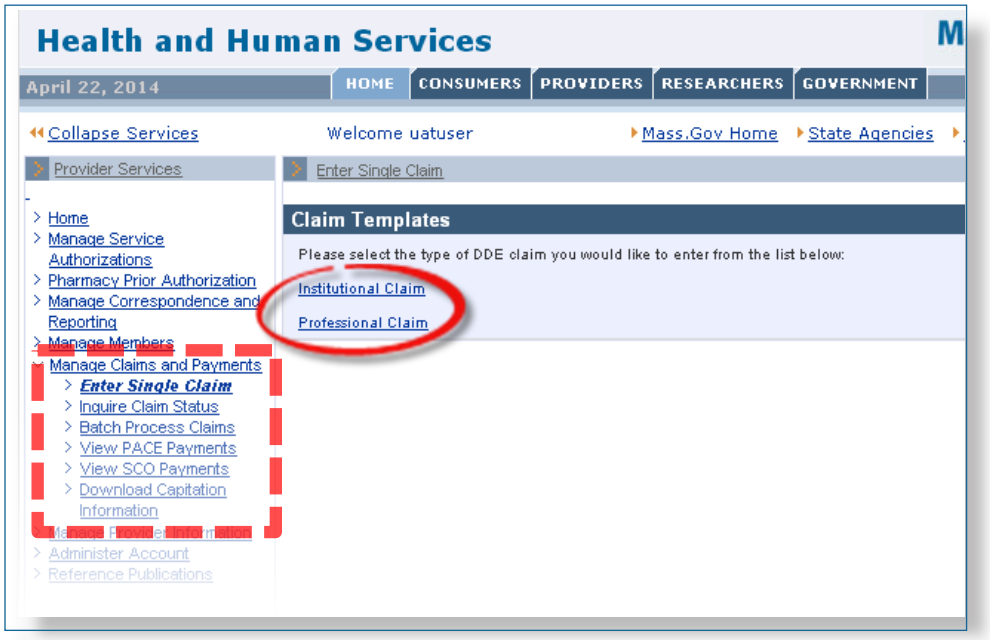
Claims

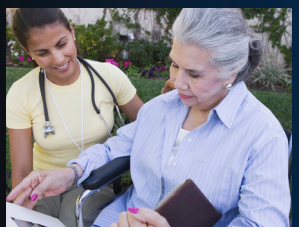
Claims Submissions

- Learn how to submit and manage claims through DDE.
- Understand how your facility is submitting claims to MassHealth.

- Make sure that any software or billing intermediary is set up according to MassHealth billing guidelines (MassHealth billing guide/companion guide) Note: make sure your software or billing intermediary is set up to submit Coordination of Benefit claims.
- Once 837 batch claims are submitted, download the 999 to make sure that the file passed compliance.
- Within 24 hours of submitting a batch of claims, always check claims status on two to three claims in the POSC to make sure that the claims are processing correctly. (For example, the file passed compliance, but the wrong month was submitted).

- Claims Denials
  - o Use the RA for detailed claim information including list of MassHealth EOB codes and adjustment information.
  - o Correct fixable errors immediately using the POSC.
- Claims-Related Reports
  - o **Download and save all RAs** from the POSC (only six months is available and requests for additional copies have a cost).
  - o Download and save monthly metric reports.
  - o Compare monthly reports to check on progress or identify potential issues early.





Appendix A: Acronyms

Acronym	Definition
ACA	Affordable Care Act
ACO	Accountable Care Organization
ACOB	Accountable Care Organization (Model B)
ACPP	Accountable Care Partnership Plans
ADA	American Dental Association
BCRC	Benefits Coordination and Recovery Center
BH	Behavioral Health
BMCHP	Boston Medical Center Healthnet Plan
C3	Community Care Cooperative
CAGC	Claim Adjustment Group Codes
CARC	Claim Adjustment Reason Codes
CDR	Chronic Disease and Rehabilitation (CDR) Inpatient Hospital
CDT	Current Dental Terminology
CMR	Codes Of Massachusetts Regulations
CMSP	Children's Medical Security Plan
COB	Coordination of Benefits
COBI	Concomitant Opioid Benzodiazepine Initiative
COH	Chronic Disease and Rehabilitation (COH) Outpatient Hospital
CPT	Current Procedural Terminology
CWP	Customer Web Portal
DDE	Direct Data Entry
DME	Durable Medical Equipment
DSM	Dental Service of Massachusetts
DUR	Drug Utilization Unit
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EOB	Explanation Of Benefits
EPSDT	Early and Periodic Screening Diagnostic and Treatment

Acronym	Definition
EVS	Eligibility Verification System
FAQ	Frequently Asked Questions
FASC	Freestanding Ambulatory Surgery Center
FFS	Fee-for-Service
FPL	Federal Poverty Level
FRDF	Federally Required Disclosures Form
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountablity Act
HLHC	Hospital Licensed Health Center
HSN	Health Safety Net
ICN	Internal Control Number
ICO	Intergrated Care Organization
IDTF	Independent Diagnostic Testing Facility
IG	Implementation Guide
IVR	Interactive Voice Response
LEIE	List of Excluded Individual and Entities
LMS	Learning Management System
LTSS	Long-Term Services and Supports
PEC	Provider Enrollment Credentialing
MBHP	Massachusetts Behavioral Health Partnership
MCO	Manage Care Organizations
MHDL	MassHealth Drug List
MMIS	Medicaid Management Information System
MTF	Massachusetts Health Care Training Forum
NPI	National Provider Identifier
OB/GYN	Obstetrics and Gynecology

Acronym	Definition
OIG	Office of Inspector General
OLTSS	Office of Long-Term Services and Supports
ORP	Ordering, Referring and Prescribing
ORT	Orthotics
OT	Occupational Therapy
PA	Prior Authorization
PACE	Program of All-inclusive Care for the Elderly
PAS	Preadmission Screening
PBHMI	Pediatric Behavioral Health Medication Initiative
PCACO	Primary Care Accountable Care Organizations
PCC	Primary Care Clinicians
PCCP	MassHealth Primary Care Clinician Plan
PCDI	Payment & Care Delivery Innovation initiative
PCP	Primary Care Providers
PEC	Provider Enrollment Credentialing

Acronym	Definition
PID/SL	Provider Identification/Service Location number
POPS	Pharmacy Online Processing System
POSC	Provider Online Service Center
PPHSD	Prevenative Pediatric Health-care Screening and Diagnostic
PRT	Prosthetics
PT	Physical Therapy
PT-1	Prescription for Transportation
QMB	Qualified Medicare Beneficiaries
RA	Remittance Advice
RARC	Remittance Advice Remark Codes
RFA	Request For Application
SCO	Senior Care Organizations
ST	Speech Therapy
TIN	Taxpayer Identification Number
TPA	Trading Partner Agreement
TPL	Third Party Liability
TPLI	Third Party Liability Indicator

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