

MassHealth Provider Handbook





Welcome

Thank you for joining the MassHealth Provider Network! This MassHealth Provider Handbook is intended for both new and existing providers. The handbook provides a general overview of MassHealth provider requirements to help you serve MassHealth members. While this document touches on many subjects, it is not the sole source of information for these topics. Review the [provider regulations](#) assigned to your provider type, and use this handbook as a reference tool and resource document that will help point you to additional information.





What's in the Provider Handbook?



A section with information for providers joining MassHealth for the first time



A section with information for existing providers



Additional reference tools for MassHealth contracted providers



Sections pointing to other provider resources

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New Providers

Fee-for-Service Providers

MassHealth offers benefits to members on a fee-for-service (FFS) basis or through managed care plans. MassHealth FFS network providers are enrolled in MassHealth and have agreed to furnish medical services and to participate in MassHealth under a provider contract with the MassHealth program. Review the provider types eligible to participate in MassHealth, and the [regulations](#) governing them, before applying.

MassHealth determines provider eligibility in accordance with MassHealth regulations, including but not limited to [130 CMR 450.212](#). If MassHealth determines that the applying provider is eligible to be enrolled, the applying provider is typically enrolled within 30 days after submitting a complete

application. Make sure all the fields on your application are accurate; this way we shouldn't need to contact you for clarification or additional documents, and we may be able to enroll you more quickly. You can learn more online about [applying to MassHealth and requesting an application](#).

Each person, entity, or group practice enrolled as a MassHealth provider has a unique Provider Identification/Service Location (PID/SL). We suggest that you have your PID/SL on hand when logging into the Provider Online Service Center (POSC), contacting MassHealth Customer Service, or accessing Provider Self-Service. You'll still need to use your national provider identifier (NPI) to conduct billing and Health Insurance Portability and Accountability Act (HIPAA) transactions.



**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



Under the FFS model, MassHealth pays providers directly for each covered service received by an eligible member. FFS providers use the POSC to submit claims in MassHealth's Medicaid Management Information System and perform other functions described in this handbook.

All MassHealth providers are required to maintain adequate documentation and records, such as their MassHealth PID/SL, in accordance with MassHealth regulation [130 CMR 450.205](#).

Ordering, Referring, and Prescribing

Section 6401(b) of the Patient Protection and Affordable Care Act of 2010 (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 NPI on the claim and the ORP provider be enrolled with MassHealth in order for the claim to be payable. For a list of eligible ORP provider types; the services that require ORP; and provider types authorized to order, refer, or prescribe, please refer to our web page on [Section 6401 of the ACA](#).



Qualified Medicare Beneficiary Providers

A Qualified Medicare Beneficiary (QMB)-only provider provides medical services only to the following.

- MassHealth Medicare Savings Program members described in [130 CMR 519.010](#) and in [130 CMR 505.007](#)
- 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 otherwise specified in [130 CMR 450.000: Administrative and Billing Regulations](#). QMB-only providers should review MassHealth regulations before providing any services to QMB members.

Office of Long Term Services and Supports

MassHealth's [Office of Long Term Services and Supports](#) provides a system of care for members of all ages who need services to help them live independently, participate in their communities, and increase their overall quality of life. Members receive this care through home- and community-based long-term services and supports (LTSS) and facility-based LTSS. They also receive other covered services through integrated care plans and managed care organizations. You can apply to be an LTSS provider through the [LTSS provider portal](#).

MassHealth Dental Program

MassHealth pays for dental care for 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: Dental Services](#) and [450.105](#) describe dental benefits, service limitations, and member eligibility.

To view MassHealth covered dental services, please see [Subchapter 6 \(Dental Service Codes\)](#) of the Dental Manual.

Providers interested in participating as dental providers should visit the web page for the [MassHealth Dental Program](#) for more information, including how to apply.



MassHealth Managed Care Plans

Primary Care Clinician Plan and Primary Care Accountable Care Organization Plans

Primary Care Clinician Plan

In the Primary Care Clinician (PCC) Plan, primary care providers (PCPs) are called PCCs. The MassHealth network of PCCs, specialists, and hospitals delivers services. PCC Plan members have access to the entire MassHealth fee-for-service (FFS) network for care other than primary care and behavioral health (BH) services. PCC Plan members receive BH services through enrollment with the MassHealth BH vendor (currently the Massachusetts Behavioral Health Partnership, or MBHP).

Upon enrollment in the PCC Plan, members can select a service location and an individual PCC 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. You can find more information for PCC Plan providers in the [PCC Provider Handbook](#).

Primary Care Accountable Care Organizations

An accountable care organization (ACO) is a provider-led health plan that holds participating providers financially accountable for both cost and quality of care for members. Primary care ACOs (PCACOs) are a type of ACO in which a network of PCPs has joined together to provide integrated and coordinated care for members.



Members receive all their primary care from primary care sites (called participating PCPs) that are part of their particular PCACO. Each member of a PCACO is enrolled at a specific primary care site within that PCACO. The PCACO and its participating PCPs contract directly with MassHealth, and members use the MassHealth FFS provider network of specialists and hospitals. Members who enroll in a PCACO receive BH services through MBHP. No matter which PCACO a member is enrolled in, they have access to the whole MassHealth FFS network of providers for care other than primary care and BH services. Because participating PCPs are also contracted MassHealth FFS network providers, they can be eligible to provide specialist care to other MassHealth members who are not part of the PCACO.

PCACO members who need additional care coordination and management can receive those services from staff members of their primary care site or staff members employed directly by the PCACO.

Primary Care Exclusivity and Exceptions

Practices enrolled in a PCACO as a participating PCP location may only be paid to provide primary care services and to see managed care eligible members who are enrolled in that PCACO *for primary care services*. This restriction does not apply to members who are not eligible for PCACOs (members of Senior Care Options [SCO], Program of All-inclusive Care for the Elderly, One Care, etc.). This restriction also does not apply to those

practices when they are providing specialist care (like obstetric and gynecological services) to members.

BH Care for Certain Managed Care Members

MBHP manages BH care for members of MassHealth PCACOs and the PCC Plan.

Managed Care Entities

Managed care entities (MCEs) and Accountable Care Partnership Plans (ACPPs) are MassHealth-contracted health plans that manage separate provider contracts and networks from the MassHealth billing and non-billing programs.

MCOs

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

ACCPs

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

Integrated Care Programs

MassHealth's Integrated Care Programs are voluntary MassHealth-contracted programs for individuals who are dually eligible for both Medicare and MassHealth.

One Care

One Care is a managed care program that integrates Medicare and Medicaid benefits into one plan for dually eligible members who are between the ages of 21 and 64 at the time they enroll. Services are developed and delivered based on an enrollee's assessment and care plan. Care coordinators and care managers are employed by the One Care plans.

SCO

SCO is a managed care program that integrates Medicare and Medicaid benefits for dually eligible members ages 65 and older. Services are developed and delivered based on an enrollee's assessment and care plan. Care coordinators and care managers are employed by the SCO plans.

PACE

PACE is administered by MassHealth and Medicare to provide a wide range of medical, social, recreational, and wellness services to eligible participants. PACE organizations offer services to eligible individuals ages 55 and above who are clinically assessed to require a nursing-home-certifiable level of care. PACE is not a managed care program but includes several features of managed care, including integrated MassHealth and Medicare benefits. You can learn more about the PACE program on our [PACE](#) web page.

One Care

MassHealth+Medicare
Bringing your care together





Provider Manuals and 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 4 outlines program-specific requirements and conditions. Subchapter 6 outlines the covered services and codes for each program. The other subchapters are the same for all providers: Subchapters 1 through 3 are the MassHealth administrative and billing regulations ([130 CMR 450.000](#), often referred to as the “All Provider Regulations”), and Subchapter 5 contains administrative and billing instructions. You can find MassHealth manuals and regulations on our [Provider Publications](#) web page.

The screenshot shows the Mass.gov website with the URL mass.gov/resource/masshealth-provider-publications. The page features a green header with the Mass.gov logo and a search bar. Below the header, there is a blue banner with the title "MassHealth Provider Publications" and a description: "Providers can find regulations, bulletins, manuals, forms, and other information they might need as MassHealth-participating providers." The page also includes a table of contents with the following items:

TABLE OF CONTENTS	
Bulletins	+
Forms	+



Existing Providers

MassHealth Provider ID/Service Location

Each provider's national provider identifier is stored in MassHealth's Medicaid Management Information System with a corresponding MassHealth provider identification/service location (PID/SL). A PID/SL has 10 characters: a nine-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. Providers should maintain proof of their PID/SL, which will be part of the welcome letters they receive upon enrollment.

All MassHealth providers are required to maintain adequate documentation and records, such as their MassHealth PID/SL, in accordance with [130 CMR 450.205](#). You'll also need your PID/SL to access the Provider Online Service Center, and you're required to provide it if MassHealth requests it.

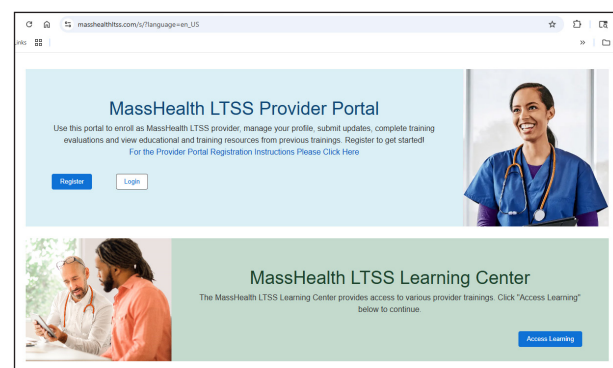
Provider File Maintenance

All MassHealth providers must notify MassHealth of any changes to information that was listed in their provider applications. Examples of changes include corporate/practice structure, changes in licensure, closure or opening of locations, and change of address.

MassHealth providers must notify MassHealth in writing within 14 days of any change in any information submitted in their provider applications. Failure to do so is a breach of their contract. See [130 CMR 450.222](#) and [130 CMR 450.223\(B\)](#).

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

- Long-term services and supports (LTSS) providers must notify MassHealth of provider file changes through the [LTSS provider portal](#).



- Dental providers must email providerrelations@massdhp.com about any changes to their provider files. Additional documentation or paperwork may be required.

Providers who are currently enrolled in MassHealth as fee-for-service (FFS) or ordering, referring, and prescribing (ORP) providers may submit a request to update their provider files using MassHealth Provider Self-Service at our [Existing MassHealth Providers](#) web page.

Fee-for-service provider file information is available in a public-facing provider directory.

MassHealth Provider Directory

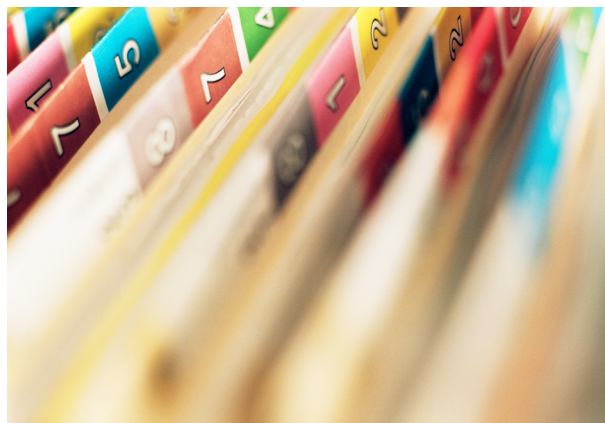
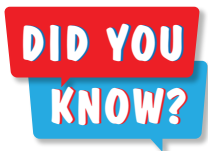
MassHealth has an online [Network Provider Directory](#) that lists demographic information about medical and behavioral health (BH) providers, primary care providers, and specialists who are in the MassHealth FFS network. BH providers who are contracted with the Massachusetts Behavioral Health Partnership are also in this directory. The information in the directory is based on MassHealth provider file information. Therefore, providers need to make sure they keep their information up to date. Providers who are currently enrolled in MassHealth as FFS or ORP providers may submit a request to update their provider files using MassHealth Provider Self-Service at the [Existing MassHealth Providers](#) web page.

MassHealth Provider Revalidation

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

As part of the required revalidation process, MassHealth must revalidate the enrollment information of all enrolled providers and site locations. Other information may also need to be collected using additional forms, such as a Federally Required Disclosure Form (FDRF).

MassHealth will select providers each month for revalidation based on their date of enrollment and will notify them 30 days before the start of their revalidation process.



Providers have 45 days after this notification to complete the revalidation process. Providers who fail to complete revalidation will be subject to termination and removal from the MassHealth program in accordance with federal and state guidelines. Terminated providers will also receive a letter from MassHealth at their primary doing-business-as (DBA) address. Learn more about revalidation at the [Existing MassHealth Providers](#) web page.

Policy Updates

MassHealth, like other insurance plans, may have changes in policies, procedure codes, and other requirements. Providers must stay aware of these changes by reviewing MassHealth bulletins, transmittal letters, and banner messages. [Sign up to get an email](#) whenever a new MassHealth provider bulletin or transmittal letter is published.



Provider Integrity: Compliance, Auditing, and Monitoring

MassHealth may request records from a provider in order to conduct a compliance audit. See [130 CMR 450.205](#). A compliance audit is a comprehensive review of a provider's adherence to regulatory guidelines. Its aim is to eliminate fraud, waste, and abuse from government programs. The audit may include 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. An audit may also include an examination of the medical necessity of services provided to MassHealth members. Additionally, providers' claims are subject to regular monitoring by MassHealth that may result in periodic audits.

Under MassHealth regulation [130 CMR 450.204](#), MassHealth does not pay for services that are not medically necessary, and we may impose sanctions on providers for providing or prescribing a service, or for admitting a member to an inpatient facility, if it is not medically necessary.

Under [130 CMR 450.205](#), 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 or if the provision of services does not meet MassHealth requirements. All providers must keep all records, including medical records, that are necessary to disclose fully the extent and medical necessity of services provided to, or prescribed for, members. Providers must provide to MassHealth, the Attorney General's Medicaid Fraud Division, the Office of the State Auditor, and the United States Department of Health and Human Services on request any information about payments claimed by the provider for providing services or performing related work described in



[130 CMR 450.205](#). See 42 U.S.C. 1396a(a)(27). All providers must also disclose 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 [federal Office of Inspector General \(OIG\)](#) website.

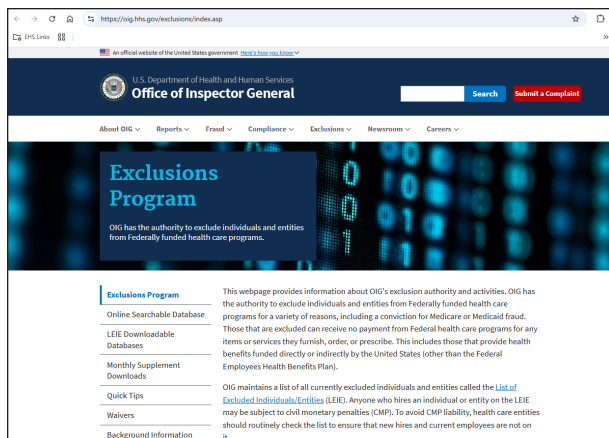
Provider Self-Disclosures

The Patient Protection and Affordable Care Act of 2010 requires MassHealth providers to report and return overpayments received from MassHealth. Providers must report in writing, and return, any overpayments within 60 days after the date they identify the overpayment or, for payments subject to reconciliation based on a cost report, by the date any corresponding cost report is due, whichever is later. Providers who fail to disclose and return overpayments in a timely manner may be subject to sanctions, including administrative fines and suspension or termination from the MassHealth program.

You can find more information on overpayments at [130 CMR 450.235](#).

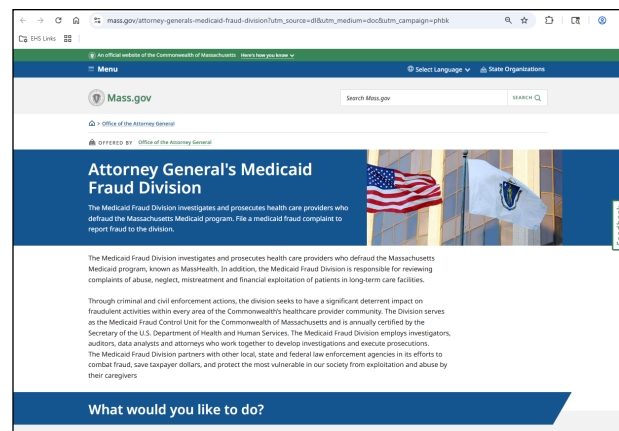
Provider Exclusions/Suspensions

The OIG, as well as MassHealth, has the authority to exclude individuals and entities from federally funded health care programs for a variety of reasons, including, but not limited to, a conviction for Medicare or Medicaid fraud. Those that are excluded will not receive payment from federal or state health care 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 Individuals/Entities](#)” (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties. To avoid civil monetary penalties, health care entities should routinely check the list to ensure that new hires and current employees are not on it.



MassHealth maintains the [List of Suspended and Excluded MassHealth Providers](#), which comprises providers that have been suspended or excluded from participating in MassHealth. It reflects for-cause terminations effective on or after March 23, 2010. MassHealth may exclude a provider for reasons such as sanctions from the provider’s licensing board, the results of a provider audit, criminal proceedings, or other justifications.

Attorney General’s Medicaid Fraud Division



The Attorney General's Medicaid Fraud Division investigates and prosecutes health care providers who defraud MassHealth. It is also responsible for reviewing complaints of abuse, neglect, mistreatment, and financial exploitation of patients in long-term care facilities. Learn more from the [Medicaid Fraud Division](#).



Providers and Members

A MassHealth member is a person MassHealth has deemed eligible and has enrolled in health coverage.

Member Coverage Types

A coverage type is a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria. A member is eligible for services and benefits according to their coverage type.

**DID YOU
KNOW?**

Each coverage type has a list of services that its MassHealth members can receive. Payment for the covered services listed in [130 CMR 450.105](#) is subject to all MassHealth conditions and restrictions, including all applicable prerequisites for payment. Providers should refer to their [program manual](#) for a full list of services, restrictions, and conditions, as well as reviewing the online [chart of MassHealth covered services](#).

Checking a Member's Eligibility

Regulations require providers to check eligibility **before** providing services to a member. Fee-for-service providers can use the [Provider Online Service Center](#) to check the Eligibility Verification System (EVS) via direct data entry single-check or batch (multiple member checks simultaneously). EVS messages tell providers the type of health plan in which a member is enrolled, if any, and whom to contact with billing questions.

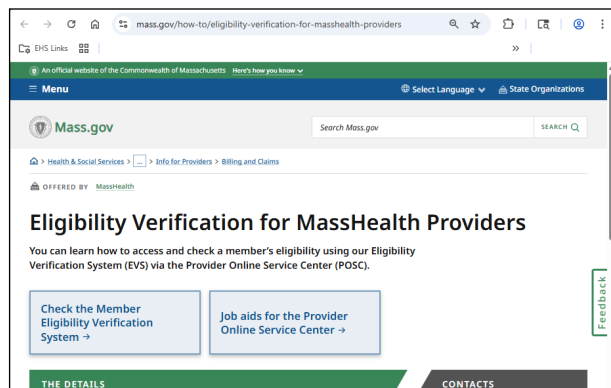
EVS

The MassHealth EVS is designed to display the status of a member's health care coverage for any dates of service requested (though it does not display eligibility for future dates). This includes the identification of the health plan and the type of plan a member has, if applicable, and is based on the information MassHealth has processed as of the date of the EVS access. For members who have other health care coverage in addition to MassHealth, EVS will display information about existing third-party payers, including the following:

- the third-party carrier's 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](#)



The EVS tool is for fee-for-service providers; other providers (such as ordering, referring, and prescribing providers and managed care entity providers) cannot access it. Learn more about EVS codes and messages in [Appendix Y](#) of MassHealth's All Provider Manual.

Provider Requirements to Verify Eligibility and Obtain Payment from Primary Payer

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. Conduct the following steps before providing care.

1. Determine the existence of health insurance by asking the member if they have other insurance and by using insurance databases available to the provider.
2. Verify the member's other health insurance coverage currently known to MassHealth through EVS on each date of service and at the time of billing.



Members With More Than One Insurance

Some members may have more than one insurance coverage type (including Medicare) in addition to MassHealth. MassHealth considers any additional insurance the primary insurance. This means providers must bill the primary and secondary insurers before MassHealth. All payers must submit adjudication details to MassHealth as reported on the other payers' explanation of benefits.

Third-Party Liability

MassHealth is the payer of last resort and is therefore secondary or tertiary coverage for members with third-party liability (TPL).

Note: Casualty payers are not considered health insurance; however, casualty payers (accident and/or workers' compensation) must be billed before 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. The non-MassHealth insurance is 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 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 integrated care plans such as One Care and Senior Care Options



Updating a Member's Third-Party Insurance Information

When a provider has evidence that a MassHealth member's TPL health insurance information differs from what appears in the Eligibility Verification System record, the provider must tell the MassHealth TPL Unit about the changes. To ensure that the member's file is updated to reflect current information, providers should submit the [TPL Indicator Form](#) with acceptable documentation to the TPL Unit.



Authorizations and Referrals

Referrals

Referrals are required for certain specialty services in both the Primary Care Clinician Plan and primary care accountable care organizations [under MassHealth regulations [130 CMR 450.118\(j\)](#) and [130 CMR 450.119 \(l\)](#)]. The requirements for referrals for all other plans are subject to the requirements of the member's coverage type. For specific instructions on how to submit, update, or ask about a referral, please see the MassHealth [Provider Online Service Center \(POSC\)](#) [job aids](#).

Dental providers should refer to the [MassHealth Dental Program](#) website for more information.

Prior Authorization

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, lists of service codes and service descriptions, provider bulletins, MassHealth Drug List, and other documents from MassHealth. Relevant documents, including the MassHealth Drug List, are available on the [Prior Authorization for MassHealth Providers](#) web page, and providers can get copies on request. The provider must submit all PA requests in accordance with MassHealth's instructions. PA 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. See [130 CMR 450.303](#).



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

Certain dental providers may use the POSC for a prior authorization related to CPT codes and may contact the [MassHealth Dental Program](#) for more information regarding these differences.

LTSS providers can learn more at the [LTSS provider portal](#).

Pharmacy Authorization

Providers should use the MassHealth Prior Authorization Forms for Pharmacy Services when a drug or non-drug product requires PA under the MassHealth Drug List. You can find information on how to request PA for a drug, as well as other related forms, at our web page on [drug PA requests](#).

PA for Durable Medical Equipment and Oxygen/Respiratory Equipment

You can find PA requirements for durable medical equipment and oxygen/respiratory equipment in our [MassHealth Durable Medical Equipment and Oxygen Payment and Coverage Guideline Tool](#).

PA for Orthotics and Prosthetics

You can find PA requirements for orthotics and prosthetics in the [MassHealth Payment and Coverage Guideline Tool](#).



View the [MassHealth Guidelines for Medical Necessity Determination](#) here.

All non-LTSS providers submit PA requests through the POSC. Please view the corresponding [job aid](#).

All LTSS providers submit PA requests through the [LTSS provider portal](#). Please view the PA training and resources under Provider Resources in the portal.

Preadmission Screening, Prepayment Reviews, and Post-Payment Reviews

MassHealth conducts utilization management processes, including preadmission screening (PAS) for elective hospital admissions, prepayment reviews for medical necessity and compliance with other regulatory and billing requirements, and post-payment reviews.



MassHealth requires PAS for acute inpatient and chronic disease and rehabilitation hospitals. 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 ask about a PAS, please review our [POSC job aids](#).

MassHealth also conducts reviews after discharge from inpatient settings but before payment (prepayment review).

Finally, MassHealth conducts post-payment utilization reviews of inpatient admissions and outpatient services and may pursue overpayment collection based on findings in accordance with [130 CMR 450.237](#).

Non-Emergency Medical Transportation

MassHealth provides non-emergency medical transportation for eligible members. For non-emergency sedan and wheelchair van transportation, providers must submit transportation requests using the PT-1 Form online via the MassHealth Customer Web Portal. See [MassHealth Transportation Information for Providers](#) for current instructions.





Billing and Claims

Electronic Data Interchange and Payment Rates

Electronic Data Interchange

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
- MassHealth [Standard HIPAA Companion Guides](#)
- MassHealth billing instructions (as applicable)

MassHealth supports the following types of Health Insurance Portability and Accountability Act (HIPAA) EDI transaction:

- 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

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

For more information on the 999 acknowledgment, including how to resolve issues and whom to contact for assistance, please go to the [EDI FAQ](#).

Any MassHealth provider who intends to submit HIPAA EDI transactions to MassHealth must test each transaction with MassHealth before submitting any transactions. Find out about HIPAA testing requirements at our [MassHealth HIPAA EDI Testing Process](#) web page.

MassHealth maintains the [EDI 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. If you need help submitting claims, you can hire a third party from the list of approved vendors.

If you have questions about policies and procedures for testing or submitting HIPAA EDI transactions, or need technical support, contact MassHealth Customer Service at (800) 841-2900, TDD/TTY: 711 and follow the menu prompts for EDI transactions, 8:00 a.m. through 5:00 p.m.

Monday through Friday, excluding holidays, or email edi@mahealth.net.

Payment Rates

Provider rates are established in Executive Office of Health and Human Services (EOHHS) regulations under Title 101 of the Code of Massachusetts Regulations, which reflect MassHealth rates. Review them before providing any services to MassHealth members.

You should also check the [provider manual](#) for your provider type to confirm that a service is covered, since the rate regulations are a repository of codes that do not necessarily reflect covered services. To check rate information, please review the [EOHHS regulations](#).



Eligibility Verification Reminder

Providers must verify eligibility before providing services to members. 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 because of eligibility issues. Eligibility Verification System messages indicate health plan information providers need in order to submit claims accurately.

Claim Submission

- If you are a fee-for-service provider, submit electronic-only claims directly to MassHealth. Paper claims will not be accepted unless providers meet the criteria and have an approved electronic claims waiver.
- For Primary Care Clinician (PCC) Plan and primary care accountable care organization (PCACO) members, submit electronic-only claims directly to MassHealth, except for behavioral health (BH).
- For members whose coverage includes the Massachusetts Behavioral Health Partnership (MBHP)—including members of the PCC Plan and PCACOs—submit BH claims directly to MBHP.
- For managed care organization (MCO) members, submit claims directly to the MCO.
- For Accountable Care Partnership Plan (ACPP) members, refer directly to the applicable ACPP for claim submission instructions.
- For integrated care plans (meaning One Care, Program of All-inclusive Care for the Elderly, and Senior Care Options plans), refer directly to the applicable integrated care plan for claim submission instructions.
- Do not submit dental and pharmacy claims through the Provider Online Service Center (POSC). The process for submitting dental claims is described below. Pharmacy claims must be submitted through the Pharmacy Online Processing System.



Dental Claims

All dental claims must be submitted electronically (unless you have a paper claim waiver on file) directly through the [Dental Program Portal](#).

Timely Submissions

MassHealth must receive initial claims **within 90 days of the service date** unless it has issued other guidance. 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

primary insurer's explanation of benefits (EOB). For claims that are not submitted within the 90-day period but that meet one of the exceptions in [130 CMR 450.309\(B\)](#), a provider must request a waiver of the billing deadline (a 90-day waiver)

under the billing instructions provided by MassHealth. Refer to MassHealth [All Provider Bulletin 233](#) for more information.

Electronic claim submission options available to providers:

- direct billing—direct upload of electronic data interchange batch claim files through the POSC
- vendor (billing intermediary or clearinghouse) that submits claims on your behalf
- direct data entry (DDE) of claims through the POSC

The final deadline for 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 before MassHealth. For more information on final deadline appeals, please see [All Provider Bulletin 232](#) and [All Provider Bulletin 300](#).

Learn more on our web page 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; others may require the documentation to remain on file in the member's medical record. See the applicable program regulations in the MassHealth provider manuals for specific reporting requirements. Attachments that must be submitted with a 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 manual for the applicable provider type and [130 CMR 450.000](#).

Medicare Crossover Claims

After Medicare has made a payment or applied the charge to the deductible, the Medicare Benefits Coordination and Recovery Center will automatically transmit claims for dual-eligible members (members with both Medicare and MassHealth) to MassHealth for adjudication. A claim must contain at least one Medicare-approved service line in order to be crossed over automatically in its entirety 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 the 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 (RA) and/or the claim cannot be located in the POSC during a claim status inquiry.
- Medicare has denied all services.

Providers must follow the instructions in the CMS Health Insurance Portability and Accountability Act (HIPAA) [Implementation Guides](#) and MassHealth [Standard HIPAA Companion Guides](#).



Claim Status

The claim status inquiry function in the POSC 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 POSC or through DDE claim status panels.

The status is also available on the MassHealth issued RA.

Claim Denials and Suspensions

Denials

Denied claims (both batch and DDE) contain edit codes that describe the denial reason. These claims must be reviewed, corrected (if applicable), and resubmitted to MassHealth within the appropriate timeframe.



Suspensions

A suspended claim is a claim that requires review before final adjudication. When a claim appears as suspended on an 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 suspended. The suspended claim will appear on a subsequent RA as paid or denied.

RA (Claim Status Reporting)

An RA is a report that provides claim processing status to providers, indicating whether the claim is paid, denied, or suspended (please see additional information above regarding denied and suspended claims). The RA is a helpful tool for 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 for six months after it is posted. The 835 (HIPAA transaction) RA can be downloaded from the POSC by a provider who has a signed trading partner agreement on file with MassHealth. The PDF RA 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 in the POSC. Please refer to the [POSC job aids](#). Dental providers should consult the [Dental Program portal](#).

An applicable RA is given a six-digit run number each Tuesday, e.g., 100139 one week and 100140 the next week. Each week, the RA is posted on the POSC for providers.

[MassHealth Provider RA Message Text Web Page](#)
MassHealth has a list of message texts that have appeared on [provider RAs](#).

The screenshot shows the MassHealth Provider Online Service Center (POSC) interface. The top navigation bar includes 'HOME', 'MEMBERS', 'PROVIDERS', 'INITIATIVES', and 'REGULATIONS'. The main header reads 'Health and Human Services' and 'Mass.gov'. The left sidebar contains a menu with options like 'Home Services', 'Provider Search', 'Manage Batch Files', 'Upload Batch File', 'Download Batch File', 'Manage Service Authorizations', 'Manage Correspondence and Reporting', 'Manage Members', 'Manage Claims and Payments', 'Manage Provider Information', 'Administer Account', 'Reference Publications', 'News & Updates', and 'Related Links'. The main content area is titled 'MassHealth Provider Online Service Center (POSC)' and features a 'Download Batch File' section. This section includes a 'Search Criteria' form with fields for 'Provider ID', 'Tracking #', and 'Transaction Type' (set to '835 Payment / Advice'). It also has date range filters for 'From Date' (01/01/2020) and 'To Date' (03/01/2020), along with 'Clear' and 'Search Results' buttons.



Overpayments

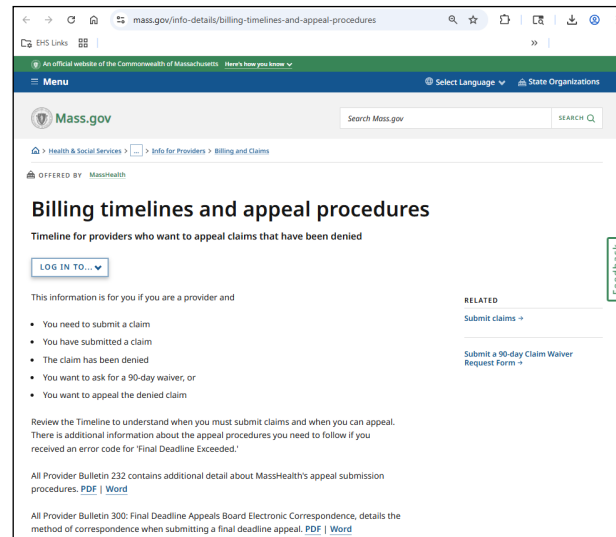
If providers identify overpayments based on a cost report, they must report it to MassHealth in writing and return any overpayments within 60 days after identifying them.

Voids

You can [void a claim](#) if you have already submitted it to MassHealth but no longer want it to be paid. You may need to do this if the claim includes erroneous information or was a duplicate request.

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.



Adjustments

If a provider is paid incorrectly, either underpaid (for which the provider would request more money) or overpaid (for which the provider would return a partial payment), the provider should adjust (replace) the claim.

An adjustment should only be processed within one year after the date of service. If the claim is more than 12 months old, refer to MassHealth's [billing timelines and appeal procedures](#) for help.

You can also learn more at our [MassHealth Claims Information for Direct Data Entry](#) page.



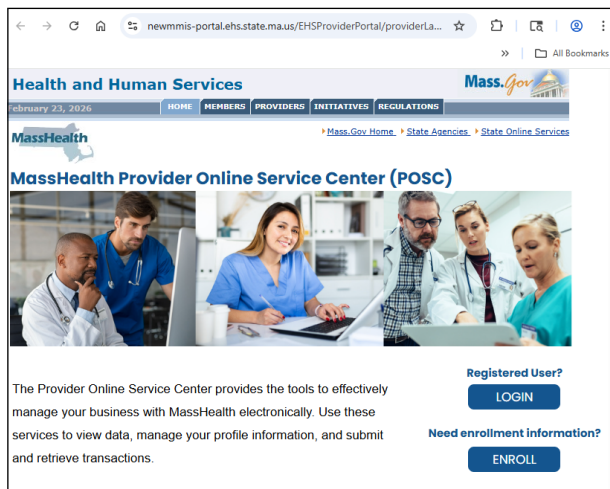
Provider Portals

Provider Online Service Center

The Provider Online Service Center (POSC) is a web-based portal that is available to non-dental and non-long-term services and supports (non-LTSS) provider types, 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 registered to use the POSC.

The POSC includes, but is not limited to, the following functions.

- real-time, interactive claim processing
- status and payment information
- direct data entry and modification of individual transactions such as prior authorization (PA) (for non-LTSS providers), preadmission screening, and eligibility verification
- viewing of notifications, contracts, reports, metrics, and financial data
- provider security—creating and managing subordinate accounts

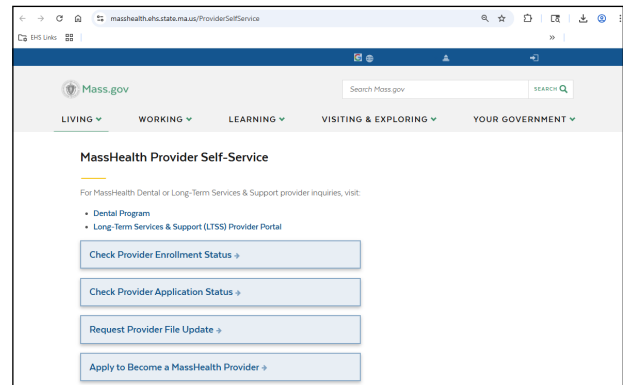


POSC Job Aids

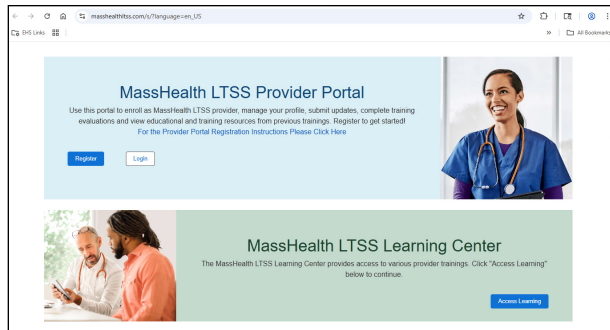
MassHealth has prepared a variety of [job aids](#) as part of the POSC e-Learning courses. The job aids are organized into several functional areas, such as Claims Submission, Preadmission Screening, and Prior Authorizations.

Provider Self-Service

MassHealth also has a [MassHealth Provider Self-Service](#) page for tasks related to enrollment and credentialing:



- [Request an application to enroll as a MassHealth provider.](#)
- Check your enrollment status after you've applied.
- See what step of the credentialing process your application has reached.
- Confirm that you're connected with a group practice or facility and request changes as needed.
- Update your file to keep your information accurate.



LTSS Provider Portal

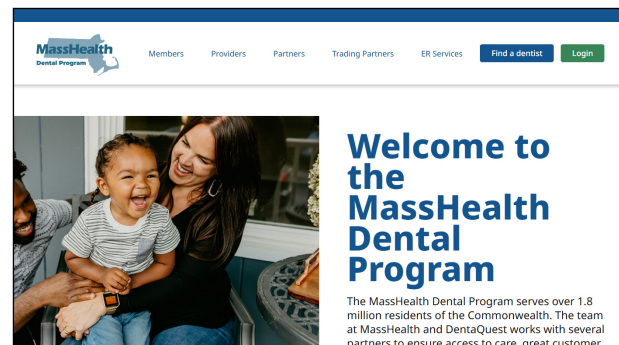
The [LTSS provider portal](#) is a web-based portal that is available to MassHealth LTSS providers. All users must be registered to use the LTSS provider portal so they can perform the following functions.

- Enrollment as a MassHealth provider
- Management of provider file information
- Provider revalidation
- Viewing of MassHealth notifications and updates
- Submission of PA
- Portal security—creating and managing subordinate accounts
- Training presentations and resources
- Links to key resources and information on mass.gov

Dental Program Portal

MassHealth also has a [portal for dental providers](#). All users must be registered to securely access the following functions.

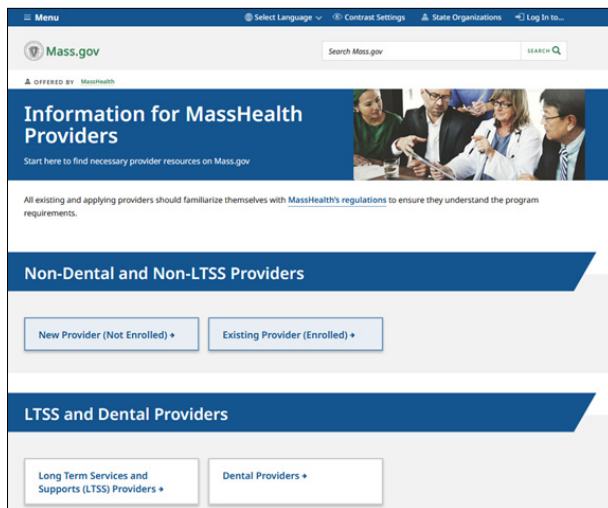
- Verify eligibility
- Upload PAs
- Verify PA status
- View patient treatment history





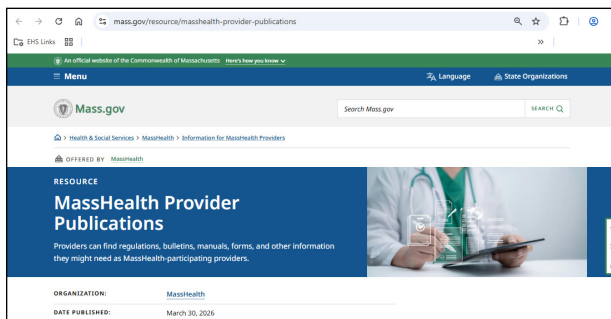
Mass.gov for Providers

MassHealth's [Information for MassHealth Providers](#) page is dedicated to the provider community; it enables users to directly access the resources they need, whether they are applicants or currently enrolled providers. Both groups of providers can get notices, information, and self-service options by choosing either "New Provider (Not Enrolled)" or "Existing Provider (Enrolled)."



Provider Publications

Our [Provider Publications](#) web page offers access to important provider documents such as regulations, bulletins, manuals, forms, appendices, and transmittal letters, as well as other information that MassHealth-participating providers may need.



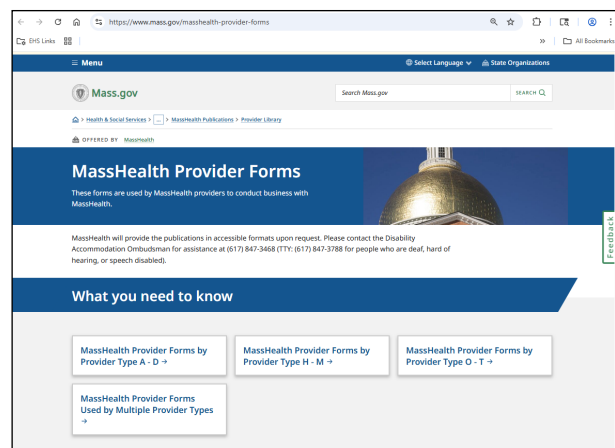
Get Email Alerts When Provider Publications are Posted on the Web

[Sign up if you'd like to get email alerts](#) when MassHealth issues provider bulletins and transmittal letters.

If you have questions, please contact MassHealth Customer Service at (800) 841-2900, TDD/TTY: 711, or email provider@masshealthquestions.com. Long-Term Services and Supports (LTSS) providers should contact the MassHealth LTSS Provider Service Center at (844) 368-5184 or email support@masshealthltss.com.

Provider Forms

Our [Provider Forms](#) web page lists provider forms alphabetically by provider type; it also has a section for forms used by multiple providers.





Provider Education/ Communications

Provider Communications

MassHealth communicates to providers in various ways, primarily through provider bulletins and transmittal letters. MassHealth uses [provider bulletins](#) to communicate procedures, reminders, policy clarifications, and other information to MassHealth providers.

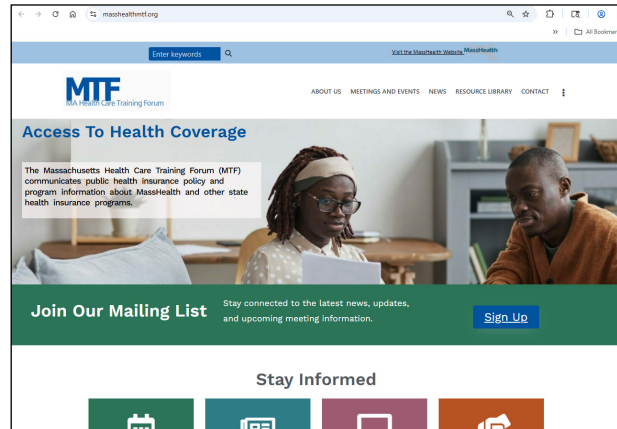
MassHealth uses [transmittal letters](#) to communicate changes to provider regulations (Subchapter 4 of each provider manual) and changes to subregulatory materials, such as the updated list of Healthcare Common Procedure Coding System (HCPCS) codes (Subchapter 6) or the provider manual appendices.

MassHealth uses remittance advice (RA) [message texts](#) to communicate important updates about billing, regulations, and reimbursement.

Providers using the Provider Online Service Center ([POSC](#)) may also review these communications on the POSC home page.

Provider Associations

MassHealth has periodic meetings to share updates with various provider associations and their representatives. Provider associations can then use their websites, emails, and newsletters to convey MassHealth updates to their constituents.



Massachusetts Health Care Training Forum

Massachusetts Health Care Training Forum (MTF) is a program sponsored by MassHealth in partnership with ForHealth Consulting, a division of UMass Chan Medical School. The MTF uses various communication methods to disseminate information about state public health insurance programs and policies.

MTF programs can help provider staff members broaden their knowledge about MassHealth and other state public health insurance programs, policies, and procedures.

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

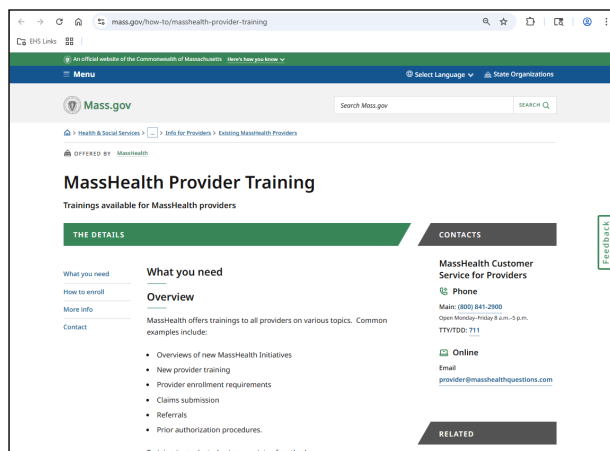
Training and Refreshers

Dental/Long-Term Services and Supports Providers

Please see the “New Providers” section of this document to locate the appropriate vendor for dental/long-term services and supports (LTSS) providers.

All Other Providers

MassHealth has a provider Learning Management System (LMS) for non-LTSS/non-dental providers. It provides on-demand learning modules related to navigating the MassHealth system, finding additional resources, and registering for upcoming in-person trainings. Surveys are available after each learning module/training to ensure that MassHealth is meeting the needs of the provider community.



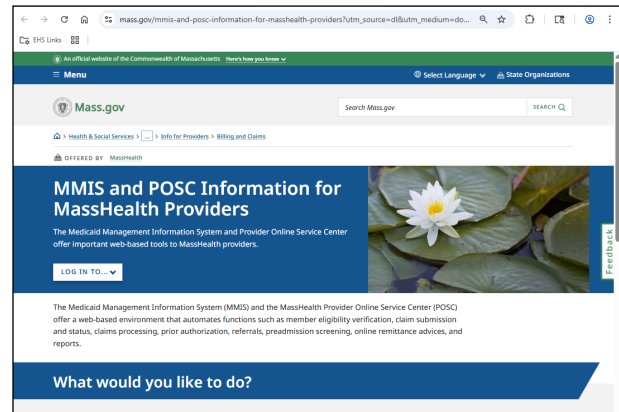
Visit [MassHealth Provider Training](#) to learn more about the LMS and other educational resources.

To Request Training—MassHealth Customer Service

To request provider training on a specific topic, or for training for a provider organization, please contact MassHealth Customer Service at (800) 841-2900, TDD/TTY: 711, or email provider@masshealthquestions.com.

Additional Resources

- [MassHealth Website](#)
 - MassHealth information (for members and providers)
- [Medicaid Management Information System and POSC Information Website](#)
- Web-based tools for tasks like claim submission, referrals, and reports



- [POSC](#)
 - Online MassHealth provider portal for electronic submissions and inquiries
- [Provider Self-Service Homepage](#)
 - Provider enrollment and credentialing
- [Provider Application Request](#)
 - Application to become a fee-for-service provider
- [Provider Payment Rates: Community Health Care Providers \(Ambulatory Care\)](#)
- [Provider Payment Rates: Hospitals/Nursing Facilities and Rest Homes](#)
- [Provider Payment Rates: Purchase of Service: Rates for Social Services](#)

Get Email Alerts When Provider Publications are Posted on the Web

Sign up if you'd like to get an email alert when MassHealth issues a provider message.



Important Information

Below is information for MassHealth network providers. Please note that some is specific to certain provider types.

Massachusetts Behavioral Health Partnership
masspartnership.com
Phone: (800) 495-0086

MassHealth Long-Term Services and Supports (LTSS) Provider Service Center (LTSS providers)
MassHealth's LTSS Program
MassHealth LTSS provider portal:
masshealthltss.com
Phone: (844) 368-5184
Email: support@masshealthltss.com
Mail: MassHealth LTSS, PO Box 159108,
Boston, MA 02215
Fax: (888) 832-3006

Dental Customer Service and Dental Provider Portal
Web: masshealth-dental.org
Phone: (866) 616-2699, TTY: 711
Mail: MassHealth, PO Box 2906,
Milwaukee, WI 53201-2906

MassHealth Customer Service (non-dental, non-LTSS)
Mail: MassHealth Customer Service,
PO Box 278, Quincy, MA 02171-0278
Phone: (800) 841-2900, TDD/TTY: 711
Email: provider@masshealthquestions.com
Fax: (617) 988-8974

Electronic Data Interchange Unit
Web: mass.gov/electronic-data-interchange-edi-and-hipaa-information
Phone: (800) 841-2900, TDD/TTY: 711
Email: EDI@mahealth.net

Health Safety Net (HSN)
Phone: (800) 609-7232
Email: hsnhelpdesk@state.ma.us

Pharmacy (non-HSN)
Phone: (866) 246-8503
Web: mass.gov/lists/masshealth-pharmacy-facts

Pharmacy Prior Authorization (PA)
UMass Chan Medical School
Phone: (800) 745-7318
Fax: (877) 208-7428
Drug Utilization Review Program
ForHealth Consulting
UMass Chan Medical School
Phone: (800) 745-7318
Fax: (877) 208-7428
Mail: PO Box 2586, Worcester, MA 01613-2586

Non-Pharmacy PA (non-LTSS)
PA requests for non-pharmacy services
Phone: (800) 862-8341

MassHealth PA
Mail: Attn: Prior Authorization
1 Enterprise Drive, 4th Floor,
Quincy, MA 02171

Additional Information
Massachusetts Attorney General's Medicaid fraud
[tip line](#)
Phone: (617) 963-2360
Fax: (617) 573-5369

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

Helpful Links
[Provider Online Service Center \(POSC\)](#)
[Provider Directory](#)

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