HSN Migration to MMIS Job Aid

This job aid reviews some specific topics of interest concerning the HSN Migration to MMIS.

For further information, please refer to:

- The updated HSN Billing Guides for HSN-specific billing information @ http://www.mass.gov/eohhs/provider/client-eligibility/health-safety-net/providers/chcs/hsn-claims-information-for-chcs-.html
- The 5010 Billing Guides for general MassHealth rules @ http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/mmis-posc/hipaa-version-5010.html
- The PowerPoint presentation and this job aid which supplements it on the CST KC

Always refer to the Billing Guides for information: if something is NOT mentioned in the HSN Billing Guides then please refer to the 5010 Billing Guides.

HSN Claims - General

Per the HSN Billing Guide, there is a 90 day period for claims submission, or they can be done at once, but most providers wouldn't submit them all at once.

Providers will receive interim payments during rolling transition (September – December, 2012 payment periods) – see the Billing Guides for more details.

CST - EDI Process- 837I and 837P claims will be processed separately as they are for MassHealth since they are different transactions.

Providers can transition to MMIS claim submissions between July 1 – October 1, 2012 with transition occurring on the first of the month and no later than October 1, 2012.

There will be no change to existing HSN payment schedule. (There is a 2 month lag between HSN claims submission and claims payment. Current HSN Providers are used to this).

As of 7/1/12 HSN will be the payor of last resort for HSN claims.

HSN Providers will receive new Provider IDs. HSN will be issuing IDs to all providers mid-May and will share with CST at that time as well as having them on the provider file. If Providers don't get their new HSN PID/SL and it is after implementation it would be CST that issues the new PID/SLs.

Providers will be billing with their NPIs and this will be processed at the PID/SL level just like it does for MassHealth.

MMIS 835 & Remittance Advices (RA) will not reflect actual HSN payment.

Providers not wishing to receive an HSN 835 for HSN claims should notify HSN. After implementation, providers contact CST as CST is managing the transactions. - DHCFP will generate RAs (same format & download via INET [HSN's POSC]) that will outline HSN payments.

Currently, the MMIS ID will not be on the HSN remit. The plan is to report ICN.

Carrier codes can be submitted on workers' compensation / auto insurance claims.

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There are going to be changes in how the CN 1 segment will be used.

For the Service Facility ID use the HSN Site Organization ID (in loop segment 2310C; also see the Billing Guide for more detailed information).

The functionality to track deductibles is being looked at to be rolled out in the future.

<u>HSN claims will be priced based on existing MMIS rules</u>. Claims passing adjudication will be identified by DHCFP and repriced / paid based on DHCFP's payment rules. So providers should not post payments from their MMIS 835 as this is not the actual payment that will be received from DHCFP.

HSN/MassHealth indicated that recurring claims (outpatient claims with span dates > 1 day) could not be submitted to MMIS.

- Span dates are allowed only for outpatient claims where Medicare is reflected in the Coordination of Benefits (COB) segment.

Processing of a 114 bill type as an Outlier claim can be revisited in the future but will not be allowed for the July 1, 2012 migration. This is for Inpatient claims only.

Converted claims will not include an ICN; new claims will have ICNs.

During conversion, an ICN will be assigned to the HSN claims by the conversion process as opposed to by an individual. Additionally, a cross-reference will be established between the HSN claim identifier/PIDSL and the MMIS ICN to facilitate future adjustments.

In terms of providers submitting adjustments, they will not know the MMIS ICN, but are encouraged to submit the HSN claim identifier so we can cross-walk to the original claim. Additionally, the adjustment will be assigned an MMIS ICN as part of the normal claim adjudication process.

Since there is no HSN claims indicator in the MMIS base system. Users will see HSN claims by searching for the HSN provider number or seeing these numbers in the search results.

HSN Claims Adjustments/Voids

MassHealth rules require that claims must be coded with MassHealth assigned ICNs in order for adjustments or voids to be processed. HSN claims originally submitted to and processed by the Division will not contain ICNs. Providers seeking to submit adjustments or voids for these claims to MMIS must report in Loop 2300 within the REF segment an F8 qualifier in REF01 and the claim key assigned by the Division in REF02. Providers can identify the claim key for an HSN claim by reviewing their remit and looking under the column header of "K_CLM_02_130." MassHealth will utilize this information to assign an ICN that will be reported back to providers. Once an ICN is assigned, providers will be required to submit all adjustments / voids in accordance with MMIS requirements.

> **Note**: *Submission of the HSN claim key only applies to HSN paid claims originally processed by the Division and converted as part of migration. All other claims must be submitted in accordance with MMIS requirements.*

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HSN Appeals

Final deadline appeal requests must be submitted with delay reason code 9 in Loop 2300 CLM20 of the 837 transaction. Using an incorrect delay reason code will cause claims to suspend for the incorrect edit and may subsequently cause the claims to deny.

Providers must submit the claim portion of their appeals first. Final deadline appeal requests will initially appear in a suspended status on your remittance advice with Edit 828 (Claim/appeal is under review) and an ICN. The ICN must then be added to the supporting documentation sent to EHSHSN@state.ma.us.

Failure to submit the required documentation with an appeal request may result in the denial of the appeal.

The decision resulting from the review will be reflected on a subsequent RA. If the final appeal is denied, one of the following edit codes will appear with the claim:

9086 – Denied after review
9087 – Insufficient information
9088 – Duplicate appeal request
9089 – The request does not meet the criteria at 130 CMR 450.323(A)

Written notification of the approval or denial decision will be sent to the provider and constitutes the final agency action.

COB Claims

For HSN Phase 1, MassHealth will be processing only batch claims not DDE nor paper so there will not be attachments. Of course, providers can populate COB data on the 837 submission.

Medical Hardship

The Division's Special Circumstances Application will continue to be utilized by providers for submission of applications for Medical Hardship (MH) and Confidential (CA) claims. MH & CA claims submitted without an application on file will not be processed for payment. Application ID's must be coded on MH & CA claims in accordance with current HSN requirements.

MassHealth claims cannot be processed unless submitted with a valid MMIS ID. To process MH & CA claims, the Division and MassHealth are working on a referred eligibility process where HSN will report back to providers, via INET, an MMIS ID assigned to an individual that must be coded on a claim. The Division will provide further information regarding this process in the future. Eligibility for MH & CA individuals will not be reported via the Eligibility Verification System (EVS).

Split Eligibility

When providers are aware that an HSN Eligibility gap is present on a claim, billing must occur in accordance with the Health Safety Net's billing update of May 4, 2009. Billing updates are located on HSN's web page http://www.mass.gov/HSN.html

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276s/277s (batch requests/notifications)

Refer to the Billing Guides for detailed information.

Reconciliation Process

Interim Payments questions should be sent to HCF. The HSN payment schedule will not change as a result of this migration.