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Pharmacy Facts

MassHealth Pharmacy Program

www.mass.gov/masshealth/pharmacy

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POPS Billing Guide

An updated POPS Billing Guide has been published. To view it, go to www.mass.gov/masshealth/pharmacy and click on the link for MassHealth Pharmacy Publications and Notices for Pharmacy Providers, then select the POPS Billing Guide.

MassHealth has updated Section 9.0 of the POPS Billing Guide with several points of emphasis. MassHealth has targeted these fields due to the volume of claims submitted without the fields populated, or with the fields populated with non-supported values. MassHealth recommends that pharmacies and their software vendors review this information to ensure more successful claims processing. Some topics include:

Cardholder First Name (field # 312-CC):

Claims must contain the member's first name. When a claim for a member is received in POPS without the cardholder first name field populated, the pharmacy system will reject that claim and send a message back to the pharmacy.

Cardholder Last Name (field # 313-CD):

Claims must contain the member's last name. When a claim for a member is received in POPS without the cardholder last name field populated, the pharmacy system will reject that claim and send a message back to the pharmacy.

Date of Birth (field # 304-C4):

Claims must contain the member's date of birth. When a claim for a member is received in POPS with a non-matching date of birth, the pharmacy system will reject that claim and send a message back to the pharmacy.

Patient Gender Code (field # 305-C5):

Claims must contain the member's gender code. When a claim for a member is received in POPS without the gender code field populated, the pharmacy system will reject the claim and send a message back to the pharmacy.

Pharmacies may use the MassHealth Eligibility Verification System (EVS) or contact the Xerox Technical Help Desk at 1-866-246-8503 to determine the on-file demographics (e.g., date of birth) for the MassHealth or Health Safety Net (HSN) patient. Please note that Xerox cannot change a member's demographic information. Instead, if the member feels that this information is incorrect the ***MassHealth member*** *must contact MassHealth Customer Service at 1-800-841-2900 for assistance (Hours: Monday through Friday, excluding holidays, 8:00 A.M. to 5:00 P.M.). The* ***Health Safety Net patient*** *must contact 1-877-910-2100 for assistance (Hours: Monday through Friday, excluding holidays, 8:00 A.M. to 5:00 P.M.). Pharmacies with questions involving HSN patients should contact the HSN Help Desk at 1-800-609-7232 for assistance (Hours: Monday through Friday, excluding holidays, 8:00 A.M. to 5:00 P.M).*

Group ID (field # 301-C1):

Claims must contain a Group ID of either MassHealth or HSN: Health Safety Net Pharmacies must submit claims with a Group ID value (field #301-C1) of HSN for a Health Safety Net patient. When a claim for an HSN patient is received in POPS with a Group ID value (field # 301-C1) of MassHealth, POPS will return a reject code of 65 – Patient Not Covered, with a response message similar to "RESUBMIT CLAIM WITH HSN AS THE GROUP ID."

Please note that HSN patients are limited to obtaining prescriptions from eligible in-network pharmacies affiliated with participating hospitals and community health centers.

Other Payer-Patient Responsibility Amount Qualifier (field # 351-NP):

MassHealth supports these values:

01 – Deductible
04 – Benefit Maximum
05 – Copay
06 – Patient Pay Amount
07 – Coinsurance
09 – Health Plan Assistance Amount

MassHealth will deny a claim submitted with any other value, even if the corresponding other payer-patient responsibility amount (field 352-NQ) is $0.00.

POPS Billing Guide *(cont'd)*

If the primary payer returns Patient Responsibility Amounts utilizing component fields, then submit a separate occurrence for any non-zero component, with the applicable qualifier (351-NP) and corresponding $$ amount (352-NQ). MassHealth recognizes the use of qualifier 06-Patient Pay Amount only when the upstream payer does not return Patient Responsibility Amounts at a component level.

When value 09 is submitted, the corresponding other payer-patient responsibility amount (352-NQ) must be a negative amount.

Submission Clarification Code (field # 420-DK):

MassHealth requires this field be populated on each claim. Submitters must use value 00–not specified if no other MassHealth supported values apply.

MassHealth strongly suggests that pharmacists familiarize themselves with these topics and share this information with their IT colleagues and software vendors.

Copay

Pharmacies are reminded that, pursuant to 130 CMR 450.130(G), a pharmacy may not refuse to fill a prescription, or to provide any service, to any MassHealth member who states that he or she is unable to pay any copayment assessed by MassHealth at the time the service is provided. Likewise, the pharmacy may not refuse to provide service to a member based on any outstanding debt that is a result of previously uncollected copayments. This is also true for MassHealth members enrolled in a MassHealth managed care organizations (MCO).

In addition, a pharmacy may not routinely waive the collection of a copayment for MassHealth members or HSN patients. A pharmacy may do so only after determining in good faith that the individual is unable to pay the copayment. Routine waiver of copayments as a business practice may effectively misrepresent the pharmacy's usual and customary charge and constitute an improper discount under 42 USC 1320a-7b(b).

Nondiscrimination

Pharmacies are also reminded that they must offer any product or service to a MassHealth member that they offer to any other customer of their pharmacy. Massachusetts state law prohibits discrimination against any individual because they are recipients of any form of public assistance, including MassHealth. This policy is set forth in detail in Chapter 2 of the MassHealth Pharmacy Provider Manual at 130 CMR 450.202. In essence, a pharmacy, or any provider, may not treat a MassHealth member differently than a privately paying or commercially insured patient. If a pharmacy provides a given product or service to the general public and it is a product or service for which MassHealth reimbursement is available, the provider MUST make that product or service available to MassHealth members. Discrimination against a MassHealth member may result in a provider's prosecution under state and/or federal law.

Payment in Full

As part of the agreement entered into at the time a provider enrolls in MassHealth, providers agree to accept the amount specified by MassHealth regulations for a given product or service as payment in full. Providers are prohibited from soliciting, charging, or receiving any additional monies or other consideration from a MassHealth member or any other person beyond the payment amount authorized by MassHealth. This policy is explained in detail in Chapter 2 of the MassHealth Pharmacy Provider Manual at 130 CMR 450.203.

Moreover, a provider may not refuse a covered service or product to a MassHealth member on the basis of the amount of the reimbursement available from MassHealth. Such refusal is a violation of both the Nondiscrimination and Payment in Full sections of MassHealth regulations and may result in sanction or prosecution of a provider under MassHealth regulations and state and/or federal law.