

# SENDPro Frequently Asked Questions

Question ID	Category	Question	MassHealth Response
1	837	In PACDR 837, when a claim has a mix of paid and denied lines, will State submit at the header level or individual line?	It will depend on the level in which the reject occurred. When a claim line is rejected for an error, the claim at the header level and all its associated lines get rejected as well. The error codes returned will depend on the level in which the reject occurred.
2	999	Will the 999 provided by MassHealth be either positive or negative, with no partial acceptance? In other words, will the AK901 value be either A (Accepted) or R (Rejected)?  Or will MassHealth provide partially accepted 999s (AK901 = P) or 999s accepted with errors (AK901 = E)?	MassHealth will provide accepted 999s (AK901 = A), rejected 999s (AK901 = R), partially accepted 999s (AK901 = P), or 999s accepted with errors (AK901 = E).
3	277DRA	Will files be partially accepted on a 277DRA, or is it all or none?	A 277DRA response provides an accept/reject status on each claim level unless a failure is found in a higher level such as in the Information Receiver or Billing/Service Provider level. Note that if a claim line was failed because of a line level issue, then the whole claim will be rejected.
4	277DRA	Will 277DRAs be shared per file? Or will they be batched?	277DRA files are produced at the file level aligned with the inbound PACDR and NCPDP transaction file submitted. MassHealth will not batch multiple files into one 277DRA.
5	837I	Diagnosis codes are limited to a maximum of 12 for the 837P and 25 for the 837I. What is MassHealth's process to support a supplemental diagnosis codes submission on the PACDR?	At this time, MassHealth will not support supplemental diagnosis codes. We may consider this in the future, but it would be post-SENDPro implementation.
6	837P	Are trading partners going to submit vision claims as professional claims in the PACDR 837P?	It depends on where the service was provided. Typically, vision claims would be submitted in the PACDR 837P if services were performed in a professional setting. However, this should not preclude submission on the PACDR 837I when optical services/surgeries are performed in an institutional setting.
7	Adjustment on Rejections	If an encounter is submitted to MassHealth and rejected, how does MassHealth expect an adjustment to be submitted?	If an encounter is submitted and rejected, the encounter must be corrected before an adjustment for that encounter is submitted. If an adjustment is submitted and rejected, the adjustment must be corrected before a subsequent adjustment is submitted.

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8	Border State Indicator	The definition of the border state indicator is not clear. Since this is a provider-only file, how do we know if the provider has offered services within the state or outside the state?	The definition comes from CMS. If there are providers out of state that have been paid the same Massachusetts in-state rates, CMS wants those providers to be identified. For example, if a Massachusetts provider renders a service to a MassHealth member (and the MCE pays \$20 per unit) and another provider in another state gets \$20 per unit for the same service, then that out-of-state provider should have a border state indicator = Y.
9	Bundled Claims	When mother and baby claims are assigned their own ID, is there only one bill or two separate bills?	If the claim is for the baby, the mother's ID will not be billed.
10	CAS Segments	Can you please confirm if MassHealth is expecting the CAS segments to be populated at both the header and detail level? In looking at the examples in the 837P, there was only one example of the CAS segment in both sections.	Yes, CAS segments are populated at both the header and detail level when applicable.
11	CG Example	MCE followed the example for denied encounter on companion guide and ran into issues with compliance checker when we used the values shown in companion guide.  a) NM1*PR*2*EDS*****PI*EDS~ 2330 segment >>>> NM1*PR*2*EDS*****PI*EDS - Is this payer ID value correct? We are getting an error value of element NM108. The expected value is 'XV' when the National Plan ID is mandated for use.	There is no "XV" National Plan ID mandate; therefore, it should not be used. The only other qualifier that would be valid is "PI." Review with a compliance checker application or vendor.
12	Claim Lines	Is there a limit on how many detailed claim lines can be submitted on a single claim?	MassHealth is conforming to the IG/TR3 standard of a maximum of 50 detail lines per claim on the 837P; 999 detail lines per claim on the 837I; and 50 detail lines per claim on the 837D.
13	Claim Lines	When an MCO submits an encounter with multiple service lines to MassHealth, will MassHealth only respond with the ICN at the header level?	Responses will align with standards. If the file fails at the envelope level, then a TA1 will be produced. If the file passes TA1 validation, then a +999 will reflect total file level acceptance. If the file fails at the ST-SE billing provider level, then the -999 will reflect at the billing provider level. If it fails at the claim level, -999 will reflect at the claim level. If a line item has issues, then the -999 will provide details at the line level.
14	Claim Lines	For PACDR 837, in new format, should claim lines still be split as is done with proprietary?	The encounter will be kept whole and should not split lines.
15	Claim Sequencing	Regarding claim sequencing, if a claim is paid and then adjusted within the 2-week timeframe, does MassHealth want to see only the adjustment or both the paid original claim and the adjustment?	MassHealth expects to see both the paid original claim and the adjustment, along with the adjudication dates in the same file and in the right sequencing. If there is an original claim with two adjustments in the same file, the first adjustment will be tied to the original, and the second adjustment will be tied to first adjustment.
16	Claim Sequencing	Consider the scenario of an original claim with two adjustments in the same file. What happens if the original claim is rejected?	If an original claim is rejected, all its corresponding adjustment files will also be rejected. In this case, if the original is rejected, both the adjustments will be rejected. All the files need to be resubmitted.
17	Claim Sequencing	From the SENDPro perspective, how will each of these claims be evaluated? Will the files in the above scenario be handled independently?	If the original is rejected and the adjustment comes through before the original is resubmitted, the adjustment will be rejected. MCEs will be notified of the rejection in the 277DRA.

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18	COB	Please confirm how many payers details an MCO can send in an encounter file in the COB loops: two payers, three payers, etc.? Also, what is the expected sequence of ordering to report multiple payers? Example: A claim has a 310 record, a 320 record, and a 330 record with different payers information. One record contains Medicaid payer information, the second contains Medicare information, and the third contains commercial insurances in a given claim. In what order is the information expected to be submitted on an 837 PACDR encounter file?	The IG/TR3 provides guidance on submitting COB, which begins in the 2320 Other Subscriber segment. SBR01 describes payer responsibility and whether the payer is primary, secondary, tertiary, etc. The order in which to apply payer responsibility is based on the order in which the original claim was paid. For example, if the commercial plan/Medicare paid first, then they would be listed as primary. The balance due would pass on to the secondary payer, if applicable. Note that Medicaid should always be the payer of last resort.
19	Data Deidentification	For sample files currently being submitted, we are deidentifying the data, but will this be required for beta testing going forward? Or will this be replaced by the encryption process?	Deidentification of data is to make sure there is no PHI/PII data in lower environments. All files sent to MassHealth need to be encrypted in both lower environments and production environments with the shift to using MOVEit for file submissions.
20	Data Deidentification	Should deidentification of data and encryption be in place during TPT?	Yes, deidentification of data and encryption should be in place during TPT.
21	Denied Claims	Can MassHealth confirm that denied claims, not just paid claims, will be submitted going forward?	Yes, this is correct. Paid, partially paid, and denied claims will all be required to be submitted. For specific instructions, please refer to the latest draft of the companion guide.
22	Denied Claims	In PACDR 837, what should CN104 be for denied claims?	CN104 should be populated with D for denied, R for partial, and P for paid for 837 I/P/D.
23	Denied Claims	In PACDR 837, should encounters be sent even if they are denied due to being incomplete or lacking a legitimate member for the claim?	Yes, if the encounter went through the MCEs' adjudication system and was denied, it should still be sent. There may be issues if MCEs are able to take in original claims without certain required fields (incomplete claims without member ID or provider ID). SENDPro has validations that will reject encounters that do not follow the standard implementation guide and MassHealth companion guide.
24	Denied Claims	Document Reference: MassHealth Standard Companion Guide National Council of Prescription Drug Programs (NCPDP) Post-Adjudication V5.1, p.11  "Denied Claims MassHealth requires denied claims to be submitted in a separate file from paid claims. Denied claims should be populated where Record Status Code (399) = 2 for all claims in that file."  Question: Let's say an MCE's Rx vendor does not currently send denied claims to MCE for generation of encounters for MassHealth. Is the companion guide stating that encounters for denied Rx claims will now be required under SENDPro? Or simply that if the MCE sends encounters for denied Rx claims, they must be sent in a separate file from encounters for paid claims?	The MCE's vendor needs to send denied claims to the MCE to submit to MassHealth.

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25	Discharge Hour	If we don't have the discharge hour value from the provider, is there a default value?	MCEs should communicate to their provider that this information is required for relevant inpatient institutional claims. There cannot be a default value.
26	Duplicate Claims	For PACDR 837 and NCPDP, will SENDPro check for duplicate claims?	MassHealth EDME will be doing a duplicate claim check validation, and feedback will be reported in the 277DRA. EDME defines a duplicate as two claims with the same claim number. EDME separately tracks duplicate services in other reporting and in rate-setting calculations. EDME will provide guidance with respect to existing duplicate encounter logic to identify similar encounters.
27	Duplicate Claims	If two claims are submitted to MassHealth that have a different services but the same provider and same date of service, would they be considered duplicates?	No, these claims may come up in an exception file, but will not automatically be rejected.
28	Duplicate Claims	Regarding avoiding the submission of duplicate services, if a claim is denied internally in an MCE's system as a duplicate, should those denials still be submitted to MassHealth?	Yes, if the claim is denied as a duplicate in the MCE system, that should not cause a problem. Denials should all be submitted with an original ICN.
29	Duplicate Claims	If a line was denied for duplicate service in a partially denied claim, will it get rejected?	No, it will not get rejected.
30	Edits Guidance	Has MassHealth released documentation detailing the edits that will be applied to each file type yet?	The implementation guide and companion guide include the edits. There are no soft edits. MassHealth can review and share fatal errors, processing errors, and a list of situational field guidance.
31	File Naming Convention	For special projects, the file naming convention includes the "xxx" suffix. Is this MassHealth-directed, and do MCEs need to follow it?	For special projects, MassHealth will communicate expectations with MCEs. For instance, if an amendment needs to be submitted in a particular way, MassHealth will communicate it to plans. If MCEs submit special project files without MassHealth's express direction and agreement on the suffix, those files will be rejected.
32	File Naming Convention	What is a special project file submission?	These are not yet defined, but would be submissions outside of standard EDI file submissions. Some examples could be a submission needed to fulfill a CMS internal request, a request the MCE initiated with MassHealth's prior approval, retroactive adjustments by the MCE to reflect rebates, a fee schedule adjustment sent in a separate file, or financial reconciliation projects. Standard EDI file submissions should not include the special project indicator.
33	File Naming Convention	Will MCEs be notified ahead of time for special project requests?	Yes, MCEs will be notified ahead of time for any special project requests.

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34	File Naming Convention	<p>The MassHealth companion guides state the following in the Product File-naming Convention section:</p> <p>"If a file is intended for a specific request, it is essential to include this specificity in the naming convention to facilitate easy identification of the file. In the case of this process, the naming convention is as follows: submitterid_transactionid_transtype_datetime_env_xxx. The three-character alpha suffix xxx defines the exception when needed."</p> <p>Please provide the circumstance(s) under which the xxx suffix will be required and how that suffix will be communicated to the MCE.</p>	This suffix would be used for special submissions with MassHealth mostly related to the correction of previously submitted data outside of regular submissions. The suffix would be agreed upon between MassHealth and the MCEs prior to submission.
35	File Submissions	<p>It is our understanding that we must send a separate file per MCO/ACO based on the below from the Meeting Notes (p. 2) sent after the 4/23/2024 SENDPro Companion Guides Draft 2 Webinar (we believe 'ACP' in the second to last row should read 'ACO').</p> <p>Based on this, we were expecting the submitter ID to be the ENTITY_PROVIDER_ID that corresponds to the particular entity whose encounters are contained in the file. Can you please clarify?</p>	Submit your parent ID in ISA06, Interchange Sender ID on behalf of all MCO/ACO entities and their individual entities in the 1000A Submitter Loop NM109. One file can be submitted by the MCE parent organization on behalf of all their associated ACOS.
36	File Submissions	Do MCEs need to submit a trigger file as is required when submitting encounter files in production?	For the EDI files submitted to SENDPro (837/NCPDP), a trigger file is not required. Note that this response is for the claims file. Supplemental files may have separate guidance.
37	File Transfer	Please let us know the difference between SFTP/MOVEit user accounts and Virtual Gateway access?	Virtual Gateway access allows individual users to navigate to the EDI portal and exchange files using the browser. SFTP batch access is for the service accounts that connect directly to MOVEit. This account can be used to connect directly for automated batch processing using any FTP application or custom code.
38	File Transfer	For the SFTP/MOVEit user account, can we get a system user account rather than specific individual accounts?	Yes, the SFTP user will be a system user account. Individual users are necessary for access via the Virtual Gateway.
39	HCP	When is the HCP02 Repriced Allowed Amount required, and what is the correct qualifier (HCP01)?	HCP01 is the code specifying the pricing methodology used to pay the claim. HCP02 is the amount allowed under that pricing methodology. MassHealth expects this to be populated for all values of HCP01. Note that HCP01 and HCP02 are always required for 837I and 837P. Please refer to the Record Indicator Memo.

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40	HCP	<p>The 837P and 837I companion guides contain the following repriced allowed amount loops/segments in the tables in section 10:</p> <p>2300 HCP02</p> <p>2400 HCP02</p> <p>1. Are these fields intended to report the allowed amounts on all encounters or only if the claim for which the encounter is being submitted was repriced by an external repricer?</p> <p>2. When required to populate HCP02 (dependent upon response to question 1), is the requirement to populate the HPC02 segment at both the 2300 loop level (i.e., summary/claim level repriced amount) as well as at the 2400 loop level (i.e., line level repriced amount)? Or is the population at either 2300 or 2400 loop sufficient?</p>	<p>The HCP segment is used to report pricing and repricing information; it should be populated at the header and also at the line level where applicable. HCP02 should represent the final payment methodology as recorded in your system. If it was repriced by an external repricer, then HCP02 should represent the allowed amount under the repricing. Please follow CMS guidance for the definition of "allowed amount." Note that HCP01 and HCP02 are always required for 837I and 837P.</p>
41	In Network Indicator	<p>Document Reference:</p> <p>MassHealth Standard Companion Guide National Council of Prescription Drug Programs (NCPDP) Post-Adjudication V5.1, p. 18</p> <p>How does MassHealth interpret Field 266, IN NETWORK INDICATOR? Our vendor captures whether a provider is in network for the benefit the claim is adjudicated under, and that indicator is available to be submitted on the encounter. Or is that state referring to whether the prescriber or pharmacy has a Medicaid ID registered with MassHealth?</p>	<p>MassHealth interprets Field 266 "IN NETWORK INDICATOR" as a provider who is in network for the benefit the claim is adjudicated under.</p>
42	MassHealth Edits	<p>Besides the SNIP edits, what other edits will be used for claims processing?</p>	<p>MassHealth-specific edits are noted in the Companion Guides in Section 7 and 10. Most of the edits are up front. MassHealth edits that will result in a rejection are mostly related to processing (encounters are correctly labeled as paid, partially denied, or denied, verifying if the daisy chain is broken, etc.).</p>
43	Medicare Amounts	<p>How should we represent Medicare Amounts vs Medicaid amounts for SCO dual members in the 837?</p>	<p>For dual members, report Loop 2320 SBR06 as 1 and populate all related segments such as 2320 AMT and 2320 MIA or MOA as inpatient/outpatient, and identify Medicare and Medicaid in 2330B. Populate where applicable CAS02 for the adjustment reason code. 1 is Medicare deductible, 2 is Medicare coinsurance, and 3 would be Medicare copayment (for a subscriber with Medicare). SBR09 should have the values MA (Medicare Part A), MB (Medicare Part B) or OF (Medicare Part D) as applicable. MC would be Medicaid.</p>
44	Member/Provider Files	<p>We plan to submit 837 I and P individually for SCO, OneCare, and MCO/ACO, but what about provider and member files? Will they be submitted individually for each product, or can they be submitted together?</p>	<p>One provider file should be sent for each product (SCO, OneCare, and MCO/ACO). If your entity has the same set of providers for all products, then MassHealth can internally discuss and provide further guidance on whether MCEs can submit one provider file with a way to distinguish between products.</p>
45	MOVEit	<p>How is one SSH key generated for multiple users for MOVEit user accounts?</p>	<p>Only service accounts require an SSH key. User accounts do not require keys.</p>

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46	Parallel Processing/Cut-Off	Will MCEs need to submit the proprietary format on a monthly basis?	The proprietary format will be submitted on a monthly basis unless otherwise specified by MassHealth.
47	Partially Denied	Are partially denied and partially paid claims the same?	Yes. Partially denied claims will go in the denial files. Fully paid claims will go in the paid file.
48	Partially Denied	If a claim has two lines, one denied and one paid, which file will it be submitted on?	It will be partially denied and go into the denied files.
49	Prior Authorization Number	<u>Loop 2300 - Prior Authorization Number</u> – Is this Mandatory required to be submitted ONLY for dental claim types, as this is not specified in Prof and INST 837 PACDR guide? Please clarify/confirm.	REF-Prior Authorization is situational in PACDR 837 professional, institutional, and dental. If prior authorization is required, the expectation is that it is populated and submitted to MassHealth.
50	Provider Information	What provider types (rendering, attending, referring, billing, etc.) are required on the PACDR 837s?	All provider information is required when services are performed by provider types, in accordance with instructions specified on the X12 Implementation Guide and in conjunction with MassHealth Companion Guides used for claim submission.
51	Provider Information	Will PIDSLs be provided by MassHealth? If so how often will they be provided?	MCEs should have PIDSLs from MassHealth via the CMS enrollment rule. MCEs are to save PIDSLs in their system and use them when submitting encounters.
52	Provider Information	As providers onboard daily, how often will provider information be shared with MCEs?	MCEs should have PIDSLs from MassHealth via the CMS enrollment rule. MCEs are to save PIDSLs in their system and use them when submitting encounters.
53	Provider Information	If the rendering provider is the same as the billing provider, would <u>the taxonomy only be expected in the billing loop, but not the</u>	Yes, it would only be expected in the billing loop as aligned with the IG.
54	Provider Information	In production, if a PID/SL is not provided on a record, will it be rejected? Is it ever acceptable for a record to be sent to SENDPro without a PIDSL?	Once a PIDSL is submitted, it needs to be a valid PIDSL. If it is not valid, it will be rejected. A list of PIDSLs is shared with the plans by the team enrolling providers. MCEs should check with their internal teams for the list of PIDSLs.
55	Provider Information	Are the internal Provider ID the same as the PIDSL?	Internal Provider Number, Internal Provider Location ID, and PIDSL are three different data elements.
56	Reference Identification	For the 2320 SBR03 data element, which is the reference identification, should we be using our MassHealth-assigned Trading Partner ID?	This field is the group or policy number for the subscriber. MCEs should be submitting MH-assigned TPIDs in the ISA06 and 1000A NM109.
57	Reference Identification	For the 2330B NM109 data element, which is the reference identification, should we be using our MassHealth-assigned Trading Partner ID?	This is the ID that identifies the payer/other payer at the header level. If the payer is the MCE, then NM109 should be populated with the PIDSL. If the payer (payer in this context does not refer to a MCE's vendor; vendors are considered MCEs) is another organization, then use the identifier that you associate with the payer. MassHealth is considering requesting a submission of the IDs for other COB payers for a given MCE.
58	Reference Identification	For the 2430 SVD01 data element, which is the reference identification, should we be using our MassHealth-assigned Trading Partner ID?	This is the ID that identifies the payer/other payer at the line level. MassHealth expects that 2430 SVD01 should be populated to be consistent with 2330B NM109, as per the implementation guide. If the payer is the MCE, then NM109 should be populated with the PIDSL. If the payer (payer in this context does not refer to a MCE's vendor; vendors are considered MCEs) is another organization, then use the identifier that you associate with the payer. MassHealth is considering requesting a submission of the IDs for other COB payers for a given MCE.

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59	Rejected Claims	In PACDR 837 and NCPDP, would the ICN in rejected claims match the ICN that was submitted by the TP?	Yes.
60	Rejected Claims	For the bi-weekly submissions currently scheduled to be submitted, there could be a situation that an encounter gets denied and the claim is processed as paid within the two-week reporting period. Does MassHealth want to see the denial even if it is corrected, or should plans suppress the denied file and only send the paid claim?	MassHealth expects to see all iterations related to the claim. Denied claims will be sent in the denied file. If the claim later gets paid, it should come in as an adjustment in the paid file if the paid adjustment claim is linked to the original denied claim in the MCE's system. If it is not linked in the MCE system, it should be sent as an original claim in the paid file. The denied claim should not be voided.
61	Reports	Regarding the SENDPro portal dashboard, will parent organization information be available with children's information?	A summary report shows when parents submit on behalf of a child submitter, and there is a breakdown by each submitter.
62	Response Files	If MCEs have not received response files from MassHealth within two business days, should MCEs reach out?	Yes, MCEs should reach out to the MCE comms team.
63	Sequential File Submissions	Regarding sequential submissions, can claims be submitted on different days, or do they need to be in sequential order?	Claims need to be submitted in sequential order. MassHealth is processing claims on a first in, first out basis. Additionally, if MCEs receive an acknowledgement back, they will know the claim was processed.
64	Submission Frequency	For PACDR 837 and NCPDP, are you expecting the denied/partial claims file on a monthly basis?	Denied/partial claims files should be submitted on the same timeline as paid claims. These will be submitted on a bi-weekly basis for at least six months after go-live. MassHealth will provide further guidance at that time on when submissions will move to a weekly basis.
65	Submission Frequency	How often can encounters be submitted?	Currently, MassHealth expects encounters to be initially submitted on a bi-weekly basis and will later transition to weekly submissions. MassHealth will send a notification about the transition from a bi-weekly to weekly schedule.
66	Submitter ID	Is our submitter ID that we use for SCO and One Care proprietary encounter submissions going to remain the same?	Yes, please use the SCO/One Care PIDSL.
67	Supplemental Files	Can MassHealth clarify what files will continue in the future?	The below files will continue to be submitted.  1) Member (MEM) 2) Member Enrollment (MEMENROLL) Associated zipped Metadata file 3) Provider file and associated provider supplemental files (Please refer to the Provider File Webinar.)
68	Taxonomy	Should the taxonomy code be provided for all providers?	Though it might state as situational in the implementation guide, taxonomy is critical for CMS T-MSIS reporting, especially the billing provider's taxonomy. Therefore, it is imperative that MCEs/vendors encourage and educate providers to submit taxonomies on claims. Note that MassHealth will validate the taxonomy value.
69	Taxonomy	Taxonomy is situational for 837. Will MassHealth add taxonomy code requirements to the companion guide?	Provider taxonomy codes are noted as required in the current companion guide posted on mass.gov, especially the billing provider taxonomy code. MCEs/vendors need to convey the importance of populating taxonomy codes to providers. This information is important for MassHealth to meet CMS T-MSIS reporting mandates.



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70	Taxonomy	For providers with multiple taxonomies, will MassHealth be validating taxonomy based on location of service or verifying that it is a valid code?	The validation is checking that the taxonomy code itself is a valid taxonomy. MassHealth does not check the relationship with the location.
71	Taxonomy	If there are multiple records for the same provider but different taxonomy codes, should MCEs be populating all taxonomy codes?	MCEs must include all taxonomy codes in the provider file submission.
72	Timely Submissions	Is there a timely requirement for submissions?	Yes, timely submissions need to be met as per the MassHealth contract with the plans to avoid penalty issues.
73	Timely Submissions	How frequently will the plans have adjustments (multiple) on a bi-weekly basis?	It depends on the claims, systems, claim adjudicators, and provider group. Generally, some claim systems are very quick in processing and so it is feasible to get encounter denied for error and a new version of the encounter submitted quickly in the same timeframe. During bi-weekly submissions, it is highly possible to have multiple adjustments. Greater volumes are expected as the process is provider driven.
74	Timely Submissions	Will there be any penalties if a paid claim is adjudicated by the MCE and will not be submitted within the timeframe defined? What if the timeframe varies for each plan?	If timely submissions are not adhered to as agreed in the MassHealth contracts, penalties may apply.
75	Transmission Correction	For NCPDP files, is record indicator (398) similar to doing a record amendment in the proprietary layout?	It is not. For amendments, you need to void the claim and submit a new, original claim.
76	Transmission Correction	Is record indicator (398) related to voids and adjustments?	The record indicator should not be confused with voids or adjustments. Voids and adjustments will be in record status (399), not record indicator (398). This will not be part of the regular submission. This will only be needed in certain scenarios. MassHealth will work with MCEs in these scenarios.
77	Vendors	Are vendors allowed to send files directly to SENDPro?	Vendors cannot directly submit files. MCEs can submit separate/break up files depending on how they receive the files from the vendors (multiple P files vs. single P file). Vendors must also include the correct submitter code corresponding to the MCE submitter and follow MassHealth Companion Guides.
78	Vendors	Use of Vendors: An MCE will be outsourcing some or all encounter submissions to a vendor(s). We are currently negotiating SOWs. We would like to confirm that vendors may submit encounter files directly to MassHealth if using our Submitter ID. We've read and/or heard both 'yes' and 'no' to this question.	Per slide 14 of the Companion Guide Draft 2 Webinar, vendors cannot submit files directly to MassHealth, but they can submit files to the MCEs, who will submit the files to MassHealth with the MCE identifier populated in the SENDER ID field.

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79	Vendors	<p>An MCE wants further clarification on Vendors (TPA) submitting files directly to MassHealth due to the reasons listed below.</p> <p>a. CMS supports vendor-direct encounters submissions. We would like to maintain consistency of our encounters submissions with both CMS and MassHealth.</p> <p>b. It is more efficient and cost effective for vendors to submit directly.</p> <p>c. PHI exposure risk is reduced by limiting the number of transmissions enroute to MassHealth.</p>	Currently, vendors do not directly submit to MassHealth, and we plan to continue this process for SENDPro. This decision was made under the advisement of our security and compliance teams.
80	Voids/Adjustments	For PACDR 837 and NCPDP, what will happen if MassHealth receives an adjustment before the original was accepted?	If the original encounter gets rejected and an MCE sends its corresponding adjustment, then the adjustment will also get rejected. The original encounter should be fixed before the adjustment is sent; otherwise, the adjustment will be rejected. If the adjustment is sent as an original, it will not get rejected by SENDPro, but MassHealth will not know the full history of the claim. For an audit trail of encounter data, both the original encounter and adjustment must be submitted.
81	Voids/Adjustments	Can MCEs hold the submission of an adjustment until the response of the original is received? It is not mandatory to send in an adjustment at the same time as the original, correct?	Yes, adjustments can be submitted in a separate file.
82	Voids/Adjustments	If an original claim is rejected and an adjustment in CSV format is submitted as original, will MassHealth reject the adjustment (scenario where original claim cannot be corrected and must be adjusted)?	Technically, it will not be rejected. Edits and validations are in place for all plans. MassHealth follows X12 standards and expects plans to also follow these standards. Adjustments cannot be submitted as originals.
83	Voids/Adjustments	What's the thinking behind the original/adjustment process MassHealth adopted?	Plans cannot submit an adjustment until the original is accepted.
84	Voids/Adjustments	In denied claims, MCEs typically send only certain denied claims to avoid failure of certain edits. What is MassHealth's guidance for this?	MassHealth's intent is to allow the MCEs to have more flexibility in submissions while maintaining a proper submission sequence. MCEs should not submit adjustment/voids until acceptance is received on the original. For denied encounters (CN104 ="D"), MassHealth will apply less strict edits.
85	Voids/Adjustments	Can MCEs replace a denied paid claim with an adjustment claim sent with encounter frequency 7, and can these claims have different claim numbers?	MassHealth expects to see all iterations related to the claim. Denied claims will be sent in the denied file. If the claim later gets paid, it should come in as an adjustment in the paid file if the paid adjustment claim is linked to the original denied claim in the MCE's system. If it is not linked in the MCE system, it should be sent as an original claim in the paid file. The denied claim should not be voided.
86	Voids/Adjustments	When an original claim is paid in the MCE's system and the same claim is later denied in the MCE's system, how should this claim be submitted to MassHealth?	MassHealth expects that an original claim (accepted in the MassHealth system) will subsequently be submitted as a voided claim. In addition, if an adjustment was denied, it should also be sent in the denied claims file.

Question ID	Category	Question	MassHealth Response
87	Voids/Adjustments	How would the following scenario be handled? An original encounter is submitted and then rejected by State. Then an adjustment to the rejected original claim is received. How would this be sent to MassHealth? Would it be sent as an original with encounter frequency 1?	MassHealth would like to maintain the daisy chain as much as possible. MCEs will have to resubmit the initial rejected original claim to MassHealth. After MassHealth's acceptance of this claim, MCEs can then submit an adjusted claim.
88	Voids/Adjustments	In the 837 memo, will 1K (payer claim number) be incremented with each adjusted claim?	No, 1K is the REF01 qualifier value in the 277DRA that ties back to the Payer's claim number submitted in the encounter. REF02 is the payer claim number.
89	Voids/Adjustments	Can a paid replacement be submitted on top of a denied original?	MassHealth expects to see all the iterations related to the claim. Denied claims will be sent in the denied file. If the claim later gets paid, it should come in as an adjustment in the paid file if the paid adjustment claim is linked to the original denied claim in the MCE's system. If it is not linked in the MCE system, it should be sent as an original claim in the paid file. The denied claim should not be voided.
90	Voids/Adjustments	Everything is currently at line level with former claim number and sequence. Now that everything is at header, is submitting just the former claim number enough to replace or void all lines (sequences)? Please confirm.	Per X12 standard, a claim is submitted with a header and detailed line records, and the claim frequency is at the header level and corresponds to all claim lines. All information submitted at the header and line level should be in compliance with the implementation guide.
91		In the recent State webinar, it was communicated that duplicate claim IDs for the same claim number will cause rejection in the State system. If a claim C1/E1 encounter was submitted to State but got rejected and was later resubmitted, would it be considered as a duplicate?	No, this would not be considered a duplicate, as the first submission was not accepted into the MassHealth system.
92		LogID 1000A, CG Ref PER03: Will MassHealth only accept an email address?	Loop 1000A PER03 should be the EM qualifier, and PER04 should be the email address. Any additional communication information can be supplied in PER05-08.