Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-169
July 2009

TO: All Providers Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: All MassHealth Provider Manuals (Revised Part 6 of the Administrative and Billing Instructions)

This letter transmits a revised Part 6 (Claim Status and Correction) of the Administrative and Billing Instructions (Subchapter 5) for all provider manuals. Part 6 was previously revised to reflect changes due to the implementation of NewMMIS. The attached revised Part 6 corrects an error in Web navigation on page 5.6-2. The paragraph containing the corrected text appears below. For your convenience, we are reissuing all of Part 6. However, only page 5.6-2 was revised.

> **Denied Claims**
> When a claim is listed on the RA as denied, it has reached its final disposition. To determine the reason for denial, review the explanation of benefit (EOB) codes on the RA. For an explanation of the EOB codes, go to www.mass.gov/masshealth. Click on Information for MassHealth Providers, then on MassHealth Claims Submission, and then on List of Explanation of Benefit Codes Appearing on the Remittance Advice. You may also refer to the list of EOB codes and descriptions that appear on the last page of the RA on which the claim appeared as denied.

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

All Provider Manuals

Pages 5.6-1 through 5.6-10

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 5.6-1 through 5.6-10 – transmitted by Transmittal Letter ALL-165

Part 6. Claim Status and Correction

To verify the status of a claim submitted to MassHealth for services provided to MassHealth members (with the exception of pharmacy and dental), you can use either batch HIPAA transaction sets 276/277 or the direct data entry (DDE) panel on the Provider Online Service Center. Additionally, you can view all claims (including pharmacy and dental) on your MassHealth remittance advice (RA).

For information about status inquiries and correction of retail pharmacy claims, refer to the POPS Billing Guide, the 835 Companion Guide, and the MassHealth remittance advice.

For information about status inquiries and correction of dental claims, please contact Doral Dental USA, Inc. at 1-800-207-5019.

Important Information about Processing Claims in NewMMIS

Claims are processed at the header level in NewMMIS. This means that if you send in a claim with multiple detail lines, all lines stay together as one claim during processing and are assigned an internal control number (ICN) that will be the claim identifier.

Individual lines are adjudicated on their own merit, and therefore, different detail lines submitted on the same claim could be paid, denied, or suspended. If one line on a claim suspends, the whole claim stays in a suspended status until the suspended detail line is reviewed and released for processing. Likewise for a multi-line professional claim, if some detail lines on the claim are paid and some are denied, the overall claim is assigned a paid status as payment is going out to the provider for that claim.

Claim processing varies with claim type. Correcting and rebilling claims is described by claim type in the following paragraphs.

Suspended Claims

MassHealth suspends claims for various reasons, such as medical review, review of required documentation, and pricing.

Note: It is a good idea to make a note in your records that the claim was received by MassHealth, so that it is not rebilled while in suspense.

A suspended claim appears on the RA only for information. You can track suspended claims by the internal control number (ICN), which remains the same throughout the processing cycle. Suspended claims require no action. Do not attempt to correct or rebill a suspended claim.

This suspended claim later appears on the RA as paid, pended, or denied.

Denied Claims

When a claim is listed on the RA as denied, it has reached its final disposition. To determine the reason for denial, review the explanation of benefit (EOB) codes on the RA. For an explanation of the EOB codes, go to www.mass.gov/masshealth. Click on Information for MassHealth Providers, then on MassHealth Claims Submission, and then on List of Explanation of Benefit Codes Appearing on the Remittance Advice. You may also refer to the list of EOB codes and descriptions that appear on the last page of the RA on which the claim appeared as denied.

Correcting Claims

If a claim needs to be corrected, the method of correction depends on the status shown on the Provider Online Service Center or the most current PDF or electronic 835 RA. Review the specific sections by claim type in this document before attempting to correct claims.

For electronic claims, review the applicable MassHealth companion guide for detailed loop/segment information. For direct data entry (DDE), refer to the e-Learning tool available on the Provider Online Service Center. For paper claim submissions, please refer to the CMS-1500 Billing Guide and UB-04 Billing Guide on the MassHealth Web site.

Note: "RA" refers to both the electronic 835 remittance advice and the PDF remittance advice, unless otherwise stated.

Professional Claims

Paid Claims

MassHealth classifies a professional claim as paid in the following two situations:

- all detail lines have paid; or
- some detail lines have paid and some have denied.

If you are correcting the claim within 90 days of the oldest date of service on the denied claim detail lines, you can send in a new claim with only the corrected denied lines. If more than 90 days have passed since the oldest date of service on the denied claim detail lines, the process for correcting the denied lines depends on the data elements being corrected.

- If the member ID, provider ID, or claim type is being changed, you can send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same, you can send in a replacement claim with appropriate lines from the original claim (both paid and denied). Omit lines that have denied correctly and should not be resubmitted, add additional lines if necessary, or correct data elements on existing detail lines as appropriate. Identify the ICN of the originally paid claim as the former ICN for the replacement claim.

Note: If any of the previously paid lines required an attachment, the attachment must be submitted again with the replacement claim. Otherwise a previously paid line may be denied.

Denied Claims

MassHealth classifies a professional claim as denied only if all the detail lines on the claim have denied. If the errors on the claim that caused it to deny can be corrected, the corrected claim can be submitted again to MassHealth.

If you are correcting the claim within 90 days of the oldest date of service on the claim, you can send the corrected claim as a new claim irrespective of the data elements being changed. If more than 90 days have passed since the oldest date of service on the claim, the resubmittal process varies depending on the data elements being corrected.

- If you are changing the member ID, provider ID, or claim type, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same but the date of service, procedure code, or modifier is being changed, send in the claim as a resubmittal by identifying the ICN of the originally denied claim as the former ICN.
- If the member ID, provider ID, claim type, date of service, procedure code, and modifier are all the same, send the claim back to MassHealth as an original claim. The system finds the original denied ICN and will not reject the resubmitted claim for late filing.

Long Term Care (LTC) and Inpatient Claims

Paid Claims

MassHealth classifies an LTC or inpatient claim as paid only if all detail lines on it have paid.

If you have a paid claim and want to adjust it, you can send in appropriate detail lines on that claim as a replacement claim with additions, deletions, or corrections up to one year from the through date of service on the claim.

You cannot change the member ID, provider ID, or claim type and *must* include the former ICN on replacement claims.

If more than 90 days have passed since the oldest date of service on the claim, and if you want to change the member ID, provider ID, or claim type, you can send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.

Note: If your previously paid claim required an attachment, the attachment must be submitted again with the replacement claim. Otherwise a previously paid claim may be denied.

Denied Claims

MassHealth classifies an LTC or inpatient claim as denied in the following two situations:

- if the claim had a header level error that caused it to deny; or
- if one of the detail lines on the claim denied.

You can resubmit a denied LTC or inpatient claim by sending in appropriate detail lines of the claim. Omit lines that have denied correctly and should not be resubmitted, or add additional lines, if necessary. If you are not changing the member ID, provider ID, revenue codes or claim type, you can send in the claim as an original claim and the system will identify the former ICN. However, if any of the data elements mentioned above need to be changed, you must submit a new claim.

If you are submitting the claim after 90 days from the oldest date of service on the claim, you can send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.

Home Health Claims

Paid Claims

MassHealth classifies a home health claim as paid in the following two situations:

- all details lines have paid; or
- some detail lines have paid and some have denied.

If you are correcting the claim within 90 days of the oldest date of service on the denied claim detail lines, send in a new claim with only the corrected denied lines. If more than 90 days have passed since the oldest date of service on the denied claim detail lines, the process for correcting the denied lines depends on the data elements being corrected.

- If the member ID, provider ID, or claim type is being changed, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same, send in a replacement claim with all appropriate lines from the original claim (both paid and denied). Omit lines that have denied correctly and should not be resubmitted, add additional lines if necessary, and correct data elements on existing detail lines, as appropriate. Identify the ICN of the originally paid claim as the former ICN for the replacement claim.

Note: If any of the previously paid lines required an attachment, the attachment must be submitted again with the replacement claim. Otherwise a previously paid line may be denied.

Denied Claims

MassHealth classifies a home health claim as denied only if all the detail lines on the claim have denied. If the errors on the claim that caused it to deny can be corrected, you may correct and resubmit the claim to MassHealth.

If you correcting the claim within 90 days of the oldest date of service on the claim, you can send the corrected claim in as a new claim irrespective of the data elements being changed. If more than 90 days have passed since the oldest date of service on the claim, the resubmittal process varies depending on the data elements being corrected.

- If you are changing the member ID, provider ID, or claim type, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same but the date of service, revenue code, procedure code, or modifier is being changed, send in the claim as a resubmittal by identifying the ICN of the originally denied claim as the former ICN.
- If the member ID, provider ID, claim type, date of service, revenue code, procedure code, and modifier are all the same, then the claim can be sent back to MassHealth as an original claim. The system finds the original denied ICN and will not reject the resubmitted claim for late filing.

Outpatient Claims

Paid Claims

MassHealth classifies an outpatient claim as paid in the following two situations:

- all details lines have paid; or
- some detail lines have paid and some have denied.

If you are correcting the claim within 90 days of the oldest date of service on the denied claim lines, you can send in a new claim with only the corrected denied lines. If more than 90 days have passed since the oldest date of service on the denied claim lines, the process for correcting the denied lines depends on the data elements being corrected.

- If the member ID, provider ID, or claim type is being changed, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same, send in a replacement claim with the appropriate lines from the original claim (both paid and denied). Omit lines that have denied correctly and should not be submitted, add additional lines if necessary, and correct data elements on existing detail lines as appropriate. Identify the ICN of the originally paid claim as the former ICN for the replacement claim.

Note: If any of the previously paid lines had required an attachment, the attachment must be submitted again with the replacement claim. Otherwise a previously paid line may now be denied.

Denied Claims

MassHealth classifies an outpatient claim as denied only if all the detail lines on the claim have denied. The errors on the claim that caused it to deny can be corrected and the claim can be sent back to MassHealth.

If you are correcting the claim within 90 days of the oldest date of service on the claim, you can send the corrected claim in as a new claim irrespective of the data elements being changed. If more than 90 days have passed since the oldest date of service on the claim, the resubmittal process varies depending on the data elements being corrected.

- If the member ID, provider ID, or claim type is being changed, send in a 90-day waiver request as described in the Requesting a 90-Day Waiver section of this document.
- If the member ID, provider ID, and claim type are the same but the date of service, revenue code, procedure code, or modifier is being corrected, send in the claim as a resubmittal by identifying the ICN of the originally denied claim as the former ICN.
- If the member ID, provider ID, claim type, date of service, revenue code, procedure code, and modifier are all the same, then the claim can be sent back to MassHealth as an original claim. The system finds the original denied ICN and will not reject the resubmitted claim for late filing.

Requesting a 90-Day Waiver

You may request a 90-day waiver when the submission date of the claim is beyond 90 days from the service date or the date on an explanation of benefits (EOB) from another insurer and you meet one or more of the following conditions:

- you are changing the member ID number;
- you are changing the pay-to provider number;
- you are changing the claim form/claim type; or
- you are billing the claim for the first time, and meet the criteria outlined in MassHealth regulations at 130 CMR 450.309 through 450.314.

If your claim meets the requirements for requesting a 90-day waiver, follow the steps below for each claim.

1. Prepare a new paper claim form.
2. Attach a copy of all RAs where the claim has appeared to each claim if applicable.
3. Attach any other supporting documentation, such as copies of retroactive enrollment notices, to each claim.
4. Attach the 90-Day Waiver Request Form to each claim stating the reason for the waiver request.
5. Do not enter resubmittal or adjustment information and do not enter a former ICN.

6. Mail the information to the address for 90-day waivers listed in Appendix A of your MassHealth provider manual.

The following circumstances do not require a 90-day waiver:

- claims that will be received within 90 days from the date on a third-party payor's EOB and still within 18 months of the service date; and
- claims that can be resubmitted according to the instructions in this document.

Voiding Claims

If you receive an overpayment that cannot be corrected by adjusting the claim, you must request that the payment be voided. If all payments on a particular RA need to be refunded to MassHealth, do not return the original check received from the State Comptroller's Office. Instead, deposit the check and follow the void procedures outlined below.

The following are some common reasons for requesting a void.

- Payment was made to the wrong provider.
- Payment was made for the wrong member.
- Payment was made for overstated services.
- Payment for services was made in full by other third-party payors.

MassHealth adjudicates claims on a claim level basis, so the whole claim must be voided. If one or more lines need to be removed from the claim, send in a replacement claim as explained in the Paid Claim sections for each claim type.

You may void claims either electronically or via paper.

Electronically

Send in an 837 transaction with a frequency code of 8 and identify the former ICN in the appropriate field. Refer to the appropriate 837 Implementation Guide and MassHealth Companion Guide for more information.

Paper Voids

Circle the claims to be voided on a printout of the PDF RA and attach a signed letter or a completed Void Request Form (available at www.mass.gov/masshealthpubs) authorizing the void transactions. Mail the void request to the appropriate address listed in Appendix A of your MassHealth provider manual.

Institutional claims may also be voided by completing a UB-04 claim form and using a frequency code of "8" as part of the Type of Bill to indicate that the claim is to be voided.

After MassHealth has processed the void request, the transaction appears on the RA. The total amount originally paid appears as a negative amount owed to MassHealth and will be deducted from current or subsequent payments until the full amount is recouped by MassHealth.

Requesting a Final Deadline Appeal

MassHealth denies any claim received more than 12 months after the date of service (up to 18 months for those involving a third-party insurer) for exceeding the final billing deadline. It may, however, be submitted for consideration as a final deadline appeal when the criteria below are met.

A claim submitted after 36 months from the oldest date of service cannot be appealed and will appear on the remittance advice as denied.

Criteria for Filing a Final Deadline Appeal

The provider must meet all of the following criteria:

- The claim must have service dates over 12 months or 18 months when another insurer is involved.
- The claim must have appeared as denied on a remittance advice for "Final Deadline Exceeded," with the error code 853 or 855.
- The appeal must be filed within 30 days of the date on the remittance advice with error 853 or 855 that first denied the claim for this reason.
- MassHealth must have denied or underpaid the claim as a result of a MassHealth error.
- You must have exhausted all available correction procedures outlined in these administrative and billing instructions, before the final deadline.
- You must have originally submitted the claim in a timely manner.

Accompanying Documentation

You must submit the following documentation with each claim for which you are requesting a final deadline appeal:

- a cover letter with a statement that describes the MassHealth error that resulted in the denial or underpayment of the claim;
- a copy of each remittance advice on which the claim has appeared, including the one on which the claim was denied for "Final Deadline Exceeded;"
- any other documentation supporting your claim; and
- a legible and accurately completed paper claim form.

Requests for final deadline appeals should be sent to the appropriate address listed in Appendix A of your MassHealth provider manual.

Assistance

If after reviewing these administrative and billing instructions and applicable remittance advices, you have questions about your MassHealth claims, you may contact MassHealth Customer Service at 1-800-841-2900 or send an e-mail to providersupport@mahealth.net.

To inquire about a claim by telephone, call the MassHealth Customer Service number listed in Appendix A of your MassHealth provider manual.

To inquire in writing about a claim, submit a cover letter describing the history of the claim, along with the following documentation, to the appropriate address listed in Appendix A of your MassHealth provider manual:

- a copy of the original claim;
- a copy of each remittance advice that pertains to the claims in question; and
- any other attachments that were required for the original submission, if necessary.

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