



MassHealth
All Provider Bulletin 269
May 2017

TO: All Providers Participating in the MassHealth Limited Program

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: **Amendments to All Provider Bulletin 251**

This bulletin amends certain sections of the [All Provider Bulletin 251](#), “Enhancements to the Claiming Process and New Certification Process for MassHealth Limited Program,” issued in August 2015.

Starting June 1, 2017, MassHealth is revising the claim edits associated with the Limited program. This bulletin communicates the edits and reinforces the requirements for the submission of the new Certification of Treatment of Emergency Medical Condition form (the Certification form) used to appeal denied claims.

As clarified in the All Provider Bulletin 101, issued in June 1997, for MassHealth Limited Members, MassHealth covers only emergency services as detailed in 130 CMR 450.105 (F).

MassHealth pays only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention reasonably could be expected to result in

- a) placing the member’s health in serious jeopardy;
- b) serious impairment to bodily functions; or
- c) serious dysfunction of any bodily organ or part.

Limited coverage excludes organ transplants and care or services related to that procedure regardless of whether the treatment would otherwise meet the conditions of coverage set forth above.

This definition must be met at the time of the provided medical service or the provided service will not be considered treatment for an emergency medical condition. Note that not all medically necessary services meet this regulatory definition under the Limited program of emergency medical condition.

Documentation Requirements and Billing Instructions

On September 1, 2015, MassHealth implemented claim edit enhancements to verify the accuracy of submitted claim forms. Because Medicaid payment for MassHealth Limited members is only available for emergency services, the treating clinician must document in the medical records that the treatment provided is for an emergency medical condition as defined above and in 130 CMR 450.105 (F) . Specifically, the medical records must clearly document a history, physical examination, diagnosis, and procedure that support the emergency nature of the treatment. When submitting the claim, the emergent diagnosis must appear on the claim as the primary or secondary diagnosis code.

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Denied Claims and Certification Forms

Starting June 1, 2017, several new edits will replace the current edits. Changes to edits are further detailed below.

On June 1, 2017, the following edits will sunset:

- 4016 – Limited benefit plan/rendering provider type restriction on diagnosis
- 4029 – Limited benefit plan/Place of Service restriction on diagnosis
- 4038 – Services not covered by Limited BP
- 4314 – Limited benefit plan/claim type restriction on diagnosis
- 4903 – Limited benefit plan restriction on diagnosis

The following new edits will be added:

- 2020 – Treatment not allowed for Limited benefit plan
Description/Explanation – Not a covered benefit under the Limited plan due to non-emergent medical treatment
- 4141 – Benefit plan performing provider type restriction on procedure code
Description/Explanation – Not an allowed performing provider type under the Limited benefit plan for this specific procedure code on the claim
- 4142 – Benefit plan billing provider type restriction on revenue code
Description/Explanation – Not an allowed billable revenue code under the Limited benefit plan for this specific service line on the claim
- 4371 – Benefit plan claim type restriction on procedure code
Description/Explanation – Not an allowed billable claim type (i.e., Medicare Crossover, Long Term Care, or Home Health Claim) under the Limited benefit plan on the specific service line on the claim
- 4374 – Benefit plan claim type restriction on revenue code
Not an allowed billable revenue code under the Limited benefit plan on the specific service line on the claim

The following edits implemented in August 2015, will remain in place:

- 4021 – Procedure not covered for benefit plan
- 4244 – Diagnosis not covered for Limited benefit plan

As a reminder if any claim for a MassHealth Limited member is denied for one of the above active edits, providers may resubmit the claim for payment with a completed Certification form. This process does not apply to pharmacy claims.

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Denied Claims and Certification Forms (*cont.*)

The Certification form, which must be completed, signed and dated by a treating clinician, shall indicate the following:

- Diagnosis
- Diagnosis code
- Treatment provided
- Procedure code
- An explanation of the emergency nature of the condition
- Date of service
- An attestation by a treating clinician that the rendered care was for the treatment of an emergency condition

The claim must be resubmitted electronically via Direct Data Entry (DDE) on the Provider Online Service Center (POSC) using Delay Reason Code 11 (Other).

Providers must scan and submit the Certification form, the remittance advice depicting the denied claim and any other documentation in support of the request for review. If you are submitting multiple claims for the same member, submit each claim separately with a copy of the Certification form, the remittance advice and supporting documentation. These documents must be scanned and included with a DDE claim submission. Use the Attachment Tab on the POSC to upload the document(s).

Once resubmitted into the POSC, these claims will appear in a suspense status on your remittance advice with Edit 829 (Special Handle under Review). A final decision will be reflected on a subsequent remittance advice once the claim is reviewed by clinical staff.

Please note that all providers must submit claims electronically unless the provider has received a waiver of the electronic claim submission policy. If you have an existing electronic claim submission waiver, you may submit a paper claim form (UB-04 or CMS-1500) with the accompanying documentation described above to the following address.

MassHealth
ATTN: Claims Operations/Limited
100 Hancock Street, 6th Floor
Quincy, MA 02171

Questions

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