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Part 1. Eligibility

The MassHealth Card

The MassHealth card identifies a person as being a MassHealth member. However, it does not guarantee that the cardholder is eligible for the specific date or date range of service, or that MassHealth will pay for the services. Therefore, the provider should request to see the card and must access the eligibility verification system (EVS) to verify eligibility for a specific date or range of dates.

Examples of the MassHealth card may be found in the EVS User Guide. You can download it at www.mass.gov/masshealth/newmmis. Click on Read Updated Billing Guides, Companion Guides, and Other Publications.

Verifying Eligibility

EVS provides you with eligibility information for all MassHealth members. By verifying a member's eligibility on the day or date range of service, you may be able to reduce the risk of your claims being denied.

All providers are required to have a user ID and password to use EVS. To obtain a user ID and password, each provider must sign a MassHealth Trading Partner Agreement (TPA).

To access EVS, go to the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter.

For providers who conduct electronic eligibility verification transactions, and have Internet access, the following options are available:

- [Provider Online Service Center](#); and
- Third-party vendor software.

All these methods can be used for eligibility verification, while some of these methods can also be used to check the status of a claim that has been fully processed by MassHealth.

Providers without Internet access can call the automated voice response (AVR) system at 1-800-554-0042 or call the eligibility operator at 1-800-841-2900. Contact information for MassHealth Customer Service appears in Appendix A of your provider manual. Active EVS codes and their respective service restriction messages are available in Appendix Y of your provider manual. You may also refer to the EVS User Guide for more information about these and other access methods. Go to www.mass.gov/masshealth/newmmis and click on Read Updated Billing Guides, Companion Guides, and Other Publications.

Trading Partner Agreements (TPAs)

To access EVS, an authorized MassHealth provider must first have submitted a signed TPA. The primary contact for the Health Insurance Portability and Accountability Act (HIPAA) at your

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organization should be able to tell if there is a signed TPA on file. The [TPA](#) is part of the MassHealth provider enrollment packet. To navigate to the TPA document, go to www.mass.gov/masshealth. In the lower right section of the home page, under Publications, click on MassHealth Provider Forms. Select the Trading Partner Agreement from the list of forms.

Other related information is available on the MassHealth Web site in the [MassHealth Provider Forms](#) section. To navigate to the page, go to www.mass.gov/masshealth. In the lower right section of the home page, under Publications, click on MassHealth Provider Forms.

User ID and Password

You must have a valid user ID and password to access EVS. To determine if you have a valid user ID and password, call the EVS Help Desk after submitting the signed TPA referred to in the preceding section. Details about the user ID and password may be found in the EVS User Guide.

HIPAA Compliance

EVS meets the ANSI ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response standards. Data transmissions to and from the Provider Online Service Center meet the security standards of the HIPAA security regulations. Associated companion guides for the HIPAA 270/271 transactions are available on the MassHealth Web site. To navigate to the companion guides, go to www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library.

Security and Privacy

Your current MassHealth provider agreement, in combination with the TPA, requires you to make every effort to secure and protect information transmitted to and from our system. The HIPAA Privacy Rule (45 CFR Part 164.500, et seq.) governs uses and disclosures of protected health information. MassHealth's Data Protection Policies and Procedures contain information on workforce compliance with state and federal confidentiality laws for reference.

Explanation of MassHealth Coverage Types

Based on eligibility requirements, MassHealth members receive benefits according to specific coverage types. EVS provides the member's coverage type as part of the eligibility verification transaction. Providers should refer to MassHealth regulations at 130 CMR 450.105 for a list of covered services by coverage type and for other information and requirements about each coverage type. Provider regulations are available on our Web site at www.mass.gov/masshealth in the Provider Library.

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Part 2. Prior Authorization

MassHealth requires providers to obtain prior authorization (PA) for certain services. See the MassHealth program regulations for the proposed service to determine when PA is required. In addition to program regulations, PA requirements may appear in Subchapter 6 of certain provider manuals, provider bulletins, or in other written issuances from MassHealth. MassHealth posts its publications in the Provider Library on the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library. To identify which drugs require PA, go to the MassHealth Drug List at www.mass.gov/druglist.

MassHealth reviews PA requests on the basis of medical necessity only and does not establish or waive any other prerequisites for payment, including eligibility or referral. The approval of a PA is not a guarantee of payment. You must still verify the member's eligibility, other insurance, and any other restrictions before providing service. If PA is required for a service that you want to provide, follow these guidelines when submitting your request to MassHealth.

The following information and instructions about PA are for:

- non-pharmacy services;
- pharmacy services; and
- nonemergency transportation services.

Requesting Prior Authorization for Non-pharmacy Services

For non-pharmacy medical services, MassHealth strongly encourages providers to request PA using the Provider Online Service Center (POSC) at www.mass.gov/masshealth/provider-service-center. Providers can use the POSC to submit PA requests and all attachments electronically and to review the status of PA requests.

Providers may also request PA for non-pharmacy services using the paper Prior Authorization Request form (PA-1). The PA-1 form and attachments should be sent to the appropriate address listed on the PA form or in Appendix A of your MassHealth provider manual.

- PA requests for members of the Massachusetts Commission for the Blind (MCB) will be handled by the Prior Authorization unit. These PAs can also be submitted via the POSC.
- If the PA request is for a member of Community Case Management (CCM), CCM will process the request, which can be submitted via the POSC;
- If the PA request is for dental services, a third-party administrator processes the request. This request must be submitted on the ADA dental claim form, not the PA-1 form.

For any subsequent request for the same service, you must request a new PA. Subsequent requests may be submitted via the POSC. If you choose to complete a paper PA request, mail it along with a copy of the initial request and any required supporting documentation to the appropriate address listed in Appendix A of your MassHealth provider manual.

For address and telephone information for non-pharmacy PA services, refer to Appendix A of your MassHealth provider manual.

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Other Required Prior Authorization Forms

PA requests for certain services require additional forms that must accompany the request. These supplemental forms (attachments) may be submitted via the Provider Online Service Center, along with the paper PA form, or on the ADA form for dental requests.

Dental Services

- **Supplemental Dental Prior Authorization Form**

The supplemental dental prior authorization form (DEN-1) is a two-sided form on which the provider charts the current status of the member's teeth. This form must accompany the PA request for all dental services except orthodontics. This form may be submitted as an attachment via the POSC or as an attachment submitted with the paper PA form.

- **Orthodontics Prior Authorization Form**

For full orthodontic treatment and treatment visits that are billed quarterly, the orthodontist must complete an orthodontics prior authorization form (DEN-2). This form may be submitted as an attachment via the POSC or as an attachment submitted with the paper PA form.

For continuation of orthodontic services for the second year, the orthodontist must submit a new PA request with updated information and a copy of the original orthodontic prior authorization form (DEN-2). The same procedure must be used for the first half of the third year, if this treatment is necessary.

- **Peer Assessment Rating Index (PAR Index Recording Form)**

Orthodontists must complete the PAR Index Recording Form (DEN-7) when requesting PA for full orthodontic treatment (see 130 CMR 420.428(H) in the [dental regulations](#)). This form may be submitted as an attachment via the Provider Online Service Center or as an attachment submitted with the paper PA request form. Refer to Appendix D of the *Dental Manual* for detailed instructions and examples of the use of the PAR Index Recording Form.

Nursing Services

- **Request and Justification for Continuous Skilled Nursing Services**

When requesting PA for continuous skilled nursing services for members over the age of 21, the provider must complete both a PA-1 form and a request and justification for continuous skilled nursing services (PA/PDN-1). This form may be submitted as an attachment via the POSC or as an attachment submitted with the paper PA form.

If the member is under the age of 22, PA requests must be obtained from Community Case Management (CCM). Direct your requests to the appropriate address provided in Appendix A of your MassHealth provider manual.

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Therapy Services: Physical, Occupational, and Speech/Language

- **Request and Justification for Therapy Services**

When requesting PA for therapy services, the provider must complete both a PA-1 form and a request and justification for therapy services form (THP-2).

If the member is under the age of 22, PA requests must be obtained from CCM. Direct your request to the appropriate address in Appendix A of your MassHealth provider manual.

Obtaining Forms

You may download PA forms from www.mass.gov/masshealth, by clicking on the MassHealth Provider Forms link. You may also request supplies of all PA forms from the appropriate address listed in Appendix A of your MassHealth provider manual.

Notice of Prior Authorization Decision for Non-pharmacy Services

MassHealth notifies both the provider and the member in writing, of its decision on PA requests. The letter indicates whether the services were approved, modified, or denied. The letter also contains the PA number assigned to the request, even if the request was denied. If the service was approved or modified, you must include the PA number on the claim when submitting it for payment. If you have submitted your PA request via the POSC, you can also find out the status of your request using the same service. MassHealth responds to PA requests that contain all required information within the time periods specified in 130 CMR 450.303(A):

- **Nursing** – within 14 calendar days from the date the PA unit receives the request;
- **DME** – within 15 calendar days from the date the PA unit receives the request; and
- **For all other services** – within 21 days from the date the PA unit receives the request.

Prior Authorization Decisions for Non-pharmacy Services

MassHealth may make any of the following decisions on a PA request.

Note: See PA notice for decision on a PA request.

- **Approve the request** – the request is authorized.
- **Modify the request** – the authorization is for a service or item that is different in quantity or nature than that which was originally requested.
- **Deny the request** – the request is denied and MassHealth will not pay for the service.
- **Defer the request** – the PA is returned to the provider with a request for additional information and status of “deferred,” that must be submitted before a decision can be made. If the deferral is via the POSC, the screen is titled “Additional Information.”

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Requesting Prior Authorization for Pharmacy Services

For pharmacy services, MassHealth encourages providers to request PA using a drug-specific PA form, if applicable, or the MassHealth drug prior authorization request form. All PA forms for pharmacy services, along with the MassHealth Drug List, are available on the Web at www.mass.gov/druglist. All PA requests for drugs must be submitted by mail or faxed to the address or fax number listed on the PA form or listed in Appendix A of your MassHealth provider manual.

Notice of Prior Authorization Decision for Pharmacy Services

The Drug Utilization Review (DUR) program notifies the pharmacy, the provider, and the member, in writing, of its decision within 24 to 48 hours of the date the DUR program receives the request. A fax is sent to the pharmacy and the provider, and the member receives a letter. The PA number is provided on the fax only if the request is approved. The pharmacy provider should not enter this number on the online transaction. A PA tracking number is assigned regardless of whether the request was approved or denied.

Requesting Prior Authorization for Non-emergency Transportation

For nonemergency transportation services, the provider of the medical service for which the member needs transportation must fill out the Prescription for Transportation (PT-1) form to verify that the member's need for transportation is medically necessary. The request for transportation is approved only when public and private transportation resources are not available and door-to-door transportation is medically necessary. Providers must send completed PT-1 forms to the appropriate address listed in Appendix A of their MassHealth provider manual. See the MassHealth transportation regulations for more information about MassHealth coverage for nonemergency transportation services. PT-1 forms are processed within four business days from receipt.

Notice of Prior Authorization Decision for Transportation Services

Transportation authorization specialists may take any of the following actions on a request (PT-1).

- **Authorize the request** – the request is approved and MassHealth will pay for the service.
- **Deny the request** – the request is denied and MassHealth will not pay for the service.
- **Mail back the request** – the form is incomplete and is being returned to gather missing information.

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Part 3. Billing MassHealth

Electronic Claims

Electronic submission of claims is the most efficient, cost-effective, and accurate method of submitting claims for MassHealth payment. Electronic claims, on average, contain 25% fewer errors, and are processed faster than paper claims. This method also eliminates mailing and handling times.

Pharmacy Claims

All MassHealth retail and 340B pharmacy claims must be submitted electronically via the pharmacy Online Processing System (POPS). Affiliated Computer Services (ACS) operates POPS under the general framework of standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). Pharmacy providers must work with their switch and software vendors to ensure compliance.

For information about pharmacy claims submission, visit www.mass.gov/masshealth/pharmacy, or contact the ACS Help Desk using the information found in Appendix A of your MassHealth provider manual.

Dental Claims

All claims for dental services are handled through the dental third-party administrator. For information about dental claims submission and the MassHealth dental program, visit www.masshealth-dental.net, or contact the third-party administrator at the phone number listed in Appendix A of your MassHealth provider manual.

All Other MassHealth Claims

With the exception of pharmacy and dental providers (as directed above), all other MassHealth providers interested in submitting claims electronically should contact [MassHealth Customer Service](#) or the provider's software vendor or billing intermediary.

There are several methods of electronic claim submission available, including direct billing, the use of a vendor (billing intermediary or clearinghouse) that submits claims on your behalf, and direct data entry (DDE) of claims through the Provider Online Service Center.

Direct Billing

Electronic claim files can be submitted directly to MassHealth via the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter. You must go through testing procedures before submitting claims electronically. If you are interested in submitting claims using this method, contact [MassHealth Customer Service](#) using the contact information listed in Appendix A of your MassHealth provider manual, to learn more about testing procedures.

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Using a Vendor

If you currently submit paper claims through a vendor, [MassHealth Customer Service](#) can assist you and your vendor in the transition to electronic billing. If you do not have a vendor but are interested in using one, or to check if your current vendor works with MassHealth, view the [MassHealth approved vendor list](#) on the MassHealth Web site.

Direct Data Entry (DDE)

You can use the the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter to submit claims to MassHealth using direct data entry. The online panels are similar to what Provider Claim Submission Software (PCSS, which is no longer used) offered and the claims submitted by this mechanism are adjudicated online real-time by MassHealth. You can see the status of the claim in the response panel within seconds of its submission.

You do not need to download any software to use this feature, and it requires only Internet to access to the Provider Online Service Center.

If you have additional questions, contact MassHealth Customer Service using the information in Appendix A of your MassHealth provider manual.

Additional Resources

More information about electronic billing is available in the [MassHealth companion guides](#), found on the MassHealth Web site in the MassHealth Provider Library.

Paper Claims

MassHealth uses industry-standard claim forms – the CMS-1500 and UB-04. For information about which claim form to use, and for instructions to complete and submit them to MassHealth, go to www.mass.gov/masshealthpubs. Click on Provider Library, then on MassHealth Billing Guides for Paper Claim Submitters. These instructions should be used along with the MassHealth regulations. The proper completion and submission of claim forms is essential for timely and accurate claims processing and payment.

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Part 4. Required Forms and Documentation

For certain services, MassHealth requires other forms and documentation. Some services require you to submit a specific attachment with your claim, while others may require you to just keep the documentation in the member's medical record. See the applicable program regulations in your MassHealth provider manual for specific report requirements. You can access the provider manuals from the Provider Library on the MassHealth Web site. Go to www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library.

Types of Attachments

The following types of attachments may be required for your claims.

General Report or Supplier's Invoice

- You must submit a general written report or a discharge summary when the service code description stipulates "with report only," individual consideration (I.C.), or when you use a service code for an unlisted procedure. Consult the applicable program regulations in your MassHealth provider manual for additional information.
- If the I.C. service is a laboratory or radiology service, and all the required information is entered on the claim form in the space for description, you do not need to attach additional documentation.
- Claims for medical supplies, medications, or injectables provided outside a pharmacy may require a supplier's invoice as the attachment.

Operative Report

For surgery service codes designated I.C., you must submit operative notes in addition to the claim.

MassHealth Forms

When applicable, you may also be required to submit other attachments (e.g., Certification for Payable Abortion or Sterilization Consent Form). The forms may be downloaded from the Provider Library at www.mass.gov/masshealth.

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Other Forms

You may be required to complete and submit certain other forms before providing a service. Refer to other sections of your MassHealth provider manual for additional required forms and reports that are specific to the services you provide. These forms may include

- prior authorization and supplemental authorization forms;
- medical necessity forms; or
- other admission, election, or screening forms.

Obtaining Forms

You may download provider forms from the MassHealth Web site at www.mass.gov/masshealth, by clicking on the MassHealth Provider Forms link. You can also request supplies of these forms from the appropriate address listed in Appendix A of this manual.

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Part 5. Claim Status and Payment

The claim status inquiry functionality in the Provider Online Service Center allows you to verify the status of a claim submitted to MassHealth for services provided. This is conducted through the HIPAA transaction sets 276/277 or through direct data entry (DDE) panels.

- **Pharmacy claims** – For retail and 340B pharmacy claims, refer to the POPS Billing Guide for information about claim status (claim response formats).
- **All other claims** – MassHealth reports claim status and payment information through the 276/277 transaction and through its remittance advices (RAs).

For information about checking the status and correcting claims for retail pharmacy claims, refer to the POPS Billing Guide, the related 835 Companion Guide, and/or the 835 transaction (remittance advice displayed as a PDF file allowing you to save it on your system for future reference).

Dental providers can check claim status with the third-party administrator for dental claims.

Verifying Claim Status

The 276/277 HIPAA-compliant electronic transaction is the standard for claim-status inquiries to determine if a claim is paid, denied, or suspended. Through the 276/277 transaction, claim status can be verified 24 hours a day, seven days a week using the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter.

After MassHealth processes a claim, providers can upload a 276 batch file and download the 277 response for the status of the claim through the Provider Online Service Center at www.mass.gov/masshealth/providerservicecenter. The status is also available on the MassHealth-issued remittance advice (RA). The 276/277 transaction provides fast and accurate information about the status of a claim.

Direct Data Entry (DDE)

Providers can enter the information for a single claim on the Search for Claims panel (276). In return, they will receive a Claims Search Results response (277).

To use the DDE panels on the Provider Online Service Center, the claim submitter must be a MassHealth trading partner with a valid user ID and password. If you do not have a user ID and password, contact EDI Support (see Appendix A).

Claim Status Reporting

Claim status is reported through the 276/277 transaction and the RA issued by MassHealth.

The RA is a helpful tool when reconciling accounts, as it reports the status of a claim submitted to MassHealth. The RA is available in two forms: the 835 electronic RA, and the downloadable PDF RA, which is available online.

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835 Remittance Advice

The 835 RA can be downloaded from the Provider Online Service Center by a provider who has a signed Trading Partner Agreement (TPA) on file with MassHealth. Format requirements and applicable standard codes are listed in the Implementation Guide, which can be accessed from the HIPAA section of the [Washington Publishing Company \(WPC\)](#) Web site. If you are not able to download this transaction from the MassHealth Web site, contact [MassHealth Customer Service](#) using the contact information listed in Appendix A of your MassHealth provider manual.

The [MassHealth 835 Companion Guide](#) provides MassHealth-specific information for the data content, codes, business rules, characteristics of the 835 transaction, technical requirements, and transmission options. The guide is available on the MassHealth Web site or by contacting [MassHealth Customer Service](#) using the contact information in Appendix A of your MassHealth provider manual.

PDF Remittance Advice

The RA in PDF format also displays information about claim status, although it appears in a format that is unique to MassHealth. You will be able to review, download, or print the PDF RA on the Provider Online Service Center at www.mass.gov/masshealth/provider-service-center. Generally, claims appear on an RA within 30 days of receipt by MassHealth (with the exception of Medicare crossover claims that are forwarded by the Medicare intermediary).

For more information about the PDF RA, review the MassHealth Guide to the Remittance Advice for Paper Claims and Electronic Equivalents. This document is available in the Provider Library on www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library, then on MassHealth Billing Guides for Paper Claim Submitters. Both billing instructions and the guide to remittance advice are available from this page.

Payment

MassHealth offers two options for receiving payment for services provided to MassHealth members: electronic funds transfer (EFT) and paper checks. MassHealth strongly encourages providers to choose EFT for payment.

Please note that all payments, whether electronic or paper check, are issued by the Office of the Comptroller. Account reconciliation is the provider's responsibility. Although MassHealth does not reconcile provider accounts, if you have a claim-related issue, contact [MassHealth Customer Service](#) using the information provided in Appendix A of your MassHealth provider manual.

Electronic Funds Transfer (EFT)

EFT is a safe and secure payment method that allows MassHealth to directly deposit payments into a bank account designated by the provider. To receive payment through EFT, you must submit an application with an original signature to MassHealth. It will take approximately 14 business days to start receiving EFT payments after a completed application has been processed. Mail the EFT form to [MassHealth Customer Service](#) at the address listed in Appendix A of your MassHealth provider manual. More information is available on the MassHealth Web site at www.mass.gov/masshealth or the VendorWeb site, which can be accessed from <https://massfinance.state.ma.us>.

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Paper Check

Providers who do not sign up for EFT receive payment through traditional paper checks. Paper checks are sent via U.S. mail and, therefore, may encounter time delays that the electronic methods of payment avoid. Reconciling the RA should be done with a corresponding check stub or transaction notification from the submitter’s financial institution.

If you have additional questions about how to determine the status of a claim or which payment method is best for you, please contact [MassHealth Customer Service](#) using the contact information provided in Appendix A of your MassHealth provider manual.

VendorWeb

[VendorWeb](#) is the Commonwealth’s online source for financial information. Once assigned a vendor code, providers can access information about payments issued to them by the Commonwealth through the VendorWeb site at <https://massfinance.state.ma.us>. For example, providers who receive payment via EFT can view their payment schedules online and download payment histories at their convenience.

Providers receiving payment via paper checks can find their vendor code on their checks. Vendor codes are alpha-numeric, beginning with the letters “VC” followed by a 10-digit number. Vendor codes are not related to your federal tax identification number. If you receive EFT reimbursement, but are unsure of your vendor code, contact [MassHealth Customer Service](#).

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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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Part 7. Other Insurance

This part contains instructions for submitting claims for services provided to members who have other health insurance or Medicare, in addition to MassHealth.

MassHealth regulations at 130 CMR 450.316 generally require providers to make “diligent efforts” to identify and obtain payment from all other liable parties, including insurers. “Diligent efforts” is defined as making every effort to identify and obtain payment from all other liable parties, and include, but are not limited to,

- determining the existence of health insurance by asking the member if he or she has other insurance and by using insurance databases available to the provider; and
- verifying the member’s other health insurance coverage, currently known to MassHealth through its Eligibility Verification System (EVS), on each date of service and at the time of billing. See Part 1 of these administrative and billing instructions for instructions on using EVS.

For additional information about third-party-liability requirements, see MassHealth regulations at 130 CMR 450.316 through 450.321.

Updating Other Insurance Information

If you have evidence that a member’s other health insurance information differs from what appears on EVS, you must fax or mail a Third-Party Liability Indicator (TPLI-MH) form to the TPL Unit. To download this form, go to Provider Library at www.mass.gov/masshealth. Click on MassHealth Provider Forms and scroll down the list. In addition to the TPLI-MH form, please submit acceptable documentation verifying the coverage change to ensure that the member’s file is updated to reflect current information. Acceptable documentation for updating member’s insurance information includes an explanation of benefits (EOB), a letter from an employer or health insurance carrier, and a copy of the health insurance card for any new insurance.

Contact information for the TPL Unit is at the bottom of the [TPLI-MH form](#). This information can also be found in [Appendix A](#) of your MassHealth provider manual.

Member Has Other Health Insurance

If the member has other insurance, submit the claim to the other insurance carrier, following the other insurer’s billing instructions. If the claim is denied for reasons other than a correctable error, or is partially paid by the other insurance carrier, you may submit the claim to MassHealth. You may not submit the claim to MassHealth if the claim is denied for noncompliance with any one of the insurer’s billing and authorization requirements. For general information about submitting the claim to MassHealth, see Part 3 of these administrative and billing instructions.

Coordination of Benefits Claim Submission

837 Transaction

All MassHealth claims must be submitted electronically unless a provider has been approved for a temporary electronic claims submission waiver. (Refer to *All Provider Bulletin 223* (February 2012).)

Providers may submit Coordination of Benefits (COB) claims to MassHealth following instructions found in the HIPAA 837 implementation guides and MassHealth companion guides. Include the other insurer’s adjudication information in the transaction as outlined in the guides. Information on how to obtain the *MassHealth Companion Guides* is available in the Provider Library at www.mass.gov/masshealth.

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To start submitting claims electronically, contact the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648), e-mail your inquiry to EDI@mahealth.net, or fax your inquiry to 617-988-8974.

Provider Online Service Center Direct Data Entry Claim

You can use the Provider Online Service Center (POSC) at www.mass.gov/masshealth/providerservicecenter to submit COB claims to MassHealth using direct data entry (DDE). Job aids are available on the Web to assist providers with COB claim submissions.

To download POSC Job Aids, go to <http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/mmis-posc/training/get-trained.html> and choose a job aid from the list.

If you have more questions about DDE claim submission, contact the MassHealth Customer Service Center (above).

Medicare Crossover Claims

After Medicare has made a payment or applied the charge to the deductible, the Benefits Coordination and Recovery Center (BCRC) will automatically transmit claims for dual-eligible members (Medicare and MassHealth) to MassHealth for adjudication. A claim must contain at least one Medicare-approved service line in order for the entire claim to be crossed over automatically to MassHealth. For Medicare crossover payment methodology, please refer to 130 CMR 450.318.

Providers may directly submit electronic claims for dual-eligible members to MassHealth using the 837 Transaction or POSC if one of the following statements is true:

- The member has other insurance in addition to Medicare and MassHealth; or
- The member's Medicare claim has not appeared on a MassHealth crossover remittance advice and/or the claim cannot be located in POSC during a claim status inquiry.

Providers must follow instructions described in the HIPAA 837 implementation guides and MassHealth companion guides when submitting COB claims for dual eligible members for the reasons listed above. Providers must include all the COB information on their claim submission to MassHealth as it is reported on the other payer's Explanation of Benefits (EOB).

When Medicare Denies Your Entire Claim

If there are no Medicare-approved services on your Medicare claim, you may submit a MassHealth claim after you have received an Explanation of Medicare Benefits (EOMB) indicating that the claim was denied for reasons other than a correctable error. COB information, including all valid HIPAA Claim Adjustment Reason Codes (CARC) as reported on the Medicare EOMB, must be submitted in the MassHealth claim.

Adjusting a COB Claim

When the primary insurer (Medicare or other insurance) voids or adjusts a claim that has been previously paid by MassHealth, providers should submit an adjustment claim to MassHealth including the revised COB information on the claim. Refer to MassHealth billing guides for instructions to submit an adjustment claim to MassHealth.

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Preventive Pediatric Care and Prenatal Care Services

Preventive pediatric care services may be billed by the provider to MassHealth as primary when the patient has other insurance (as described in the EPSDT and PPHSD Billing Guidelines for MassHealth Physicians and Mid-level Providers, for members younger than 21 years of age, and prenatal care services including routine prenatal office visits and tests for members of any age).

Dependent Has Insurance through a Noncustodial Parent

Providers may bill services to MassHealth as the primary insurer if **both** the following conditions are true.

- The dependent has insurance through a noncustodial parent against whom child support enforcement is being carried out by the State Title IV-D agency (Department of Revenue).
- The provider has billed the other insurer and has not received payment or a response for 30 days after billing.

Providers should include the correct carrier code and the noncovered amount on their claim submission.

Supplemental Instructions

Please refer to the appendix in your MassHealth provider manual (as listed in the table below) for supplemental instructions that may be applicable to your provider type.

Provider Type	Location
All providers subject to provider preventable conditions	Appendix V, All Provider Manuals
Acute inpatient hospitals	Appendix D, <i>Acute Inpatient Hospital Manual</i>
Chronic disease and rehabilitation inpatient hospitals	Appendix D, <i>Chronic Disease and Rehabilitation Inpatient Hospital Manual</i>
Community health centers	Appendix D, <i>Community Health Center Manual</i>
Home health agencies	Appendix D, <i>Home Health Agency Manual</i>
Mental health centers	Appendix D, <i>Mental Health Center Manual</i>
Nursing facilities	Appendix G, <i>Nursing Facility Manual</i>
Psychiatric inpatient hospitals	Appendix D, <i>Psychiatric Inpatient Hospital Manual</i>

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