Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
All Provider Bulletin 251
August 2015

TO: All Providers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary and Director of MassHealth

RE: **Enhancements to the Claiming Process and New Certification Process for MassHealth Limited Program**

Background

The purpose of this bulletin is to communicate enhancements to the MassHealth Limited Program, including enhanced claim edits and requirements for the submission of the new Certification of Treatment of Emergency Medical Condition form (the "Certification Form") for appeal of denied claims.

As clarified in All Provider Bulletin 101, issued in June 1997, MassHealth covers only emergency services as described in 130 CMR 450.105 (F) for MassHealth Limited members as described in 130 CMR 505.006 and 519.009.

MassHealth will only pay 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.

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

Effective September 1, 2015 MassHealth is implementing 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 should document in the medical records that the treatment provided is for an emergency medical condition as defined in 130 CMR 450.105 (F), and reproduced above. Specifically, the medical records should 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 in the claim as the primary or secondary diagnosis code.

Denied Claims and Certification Form

This process does not apply to pharmacy claims.

(continued on next page)

Denied Claims and Certification Form, cont'd

Starting September 1, 2015, if any claim for a MassHealth Limited member is denied for one of the following edits, providers may resubmit the claim for payment with a completed Certification Form.

4016 – Limited benefit plan/rendering provider type restriction on diagnosis
4021 – Procedure not covered for benefit plan
4029 – Limited benefit plan/Place of Service restriction on diagnosis
4244 – Diagnosis not covered for Limited benefit plan
4314 – Limited benefit plan/claim type restriction on diagnosis
4903 – Limited benefit plan restriction on diagnosis

The Certification Form, which must be completed, signed and dated by the treating clinician, shall indicate the following.

1. Diagnosis
2. Diagnosis code
3. Treatment provided
4. Procedure code
5. An explanation of the emergency nature of the condition
6. Date of service
7. An attestation by the 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 should 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.

*Follow us on Twitter **@MassHealth**.*