Webinar 5: Understanding Claims & Billing as an HRSN Provider

August 6, 2024
9:00 to 10:30 AM

MassHealth

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Agenda

Topic	Time
Welcome & Introductions	*5 minutes*
Recap of HRSN Webinars to Date	*5 minutes*
Understanding Claims & Billing	*15 minutes*
Overview of HRSN Provider Codes for Billing	*10 minutes*
Overview of Claims Submissions Process	*25 minutes*
Recap on Hubs, Third Party Agents and Vendor Supports	*5 minutes*
Next Steps & Questions	*25 minutes*

Recap of HRSN Webinars to Date

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Recap of HRSN Webinars to Date

Webinar 1 (March 2024):
Transition from Flex Services to Managed Care Health-Related Social Needs (HRSN) Framework

Webinar 2 (May 2024):
Becoming an HRSN Provider – Contracting, Credentialing, & Enrollment

Webinar 3 (May 2024):
How to Apply for a National Provider Identifier (NPI)

Webinar 4 (June 2024):
Hubs & Third Party Options to Support HRSN Transition

Website: www.hria.org/tmf/hrsn-integration-fund

Understanding Claims & Billing

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Claims & Billing

A **claim** is a **formal request** for reimbursement submitted in a particular format by an HRSN Provider to the Managed Care Entity (MCE) for services provided.

- Claims compile all relevant information and codes related to the HRSN services provided, as well as member demographics, and are submitted to the MCE for review.

Billing is the **process of submitting claims** to the MCE to obtain payment for services rendered by providers and provider organizations.

- Billing may also include following up on and rebilling unpaid or denied claims.

Developing Your Claim-Check list and Reminders

1) Gather pertinent information to prepare the 1500 Billing Form:	2) Document the HRSN services you provided to the insured member. This includes:	3) Include the relevant Provider Identifier

• Insured Member's Name (e.g., HRSN client)
• Address
• Date of Birth
• Sex
• I.D. Number
 	
Verify the insured member's eligibility by utilizing the MCE Provider Portals. Member data submitted on a claim must match exactly the plan's data.
	• The date(s) services were provided
	• All required coding:
	  ○ Relevant HRSN Service HCPCS code(s)
	  ○ Modifiers
	  ○ ICD-10 Diagnosis code(s)
	  ○ Place of Service (POS) code
	• Cost of service or charged amount
	• Unit amount
	
	Establish the cost or unit price for HRSN services. Approved rates of payment will be provided by the MCE.
		• Provider Name (e.g., your organization's name)
		• Address
		• Tax ID
		• National Provider Identifier (NPI)
		• Taxonomy Code
		
		Establish an internal claim identifier that can be matched to the plan-assigned claim number in order to maintain a record of the claim for reconciliation and auditing purpose
		
		Note: On the CMS-1500 claim form, there is space for the provider to indicate an internal claim number for their own tracking and documentation purposes. It is strongly recommended that potential HRSN Providers establish an internal process to track and maintain a record of the claim for reconciliation and auditing purposes.

Overview of HRSN Provider Codes for Billing

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Types of Codes HRSN Providers Will Use for Billing

There are four types of codes that HRSN Providers will use in the claims and billing process

Types of Codes	Example of Nutritionally Appropriate Food Boxes – Individual with food insecurity at home	Location of Code on 1500 Form	MassHealth Guidance
Healthcare Common Procedure Coding System (HCPCS) is a uniform *coding* system that identifies and describes medical and other procedures.	**S9977**	Box 24D	HRSN Services Manual
Modifier Codes are two characters (letters or numbers) appended to a HCPCS code to provide additional information about the procedure	**U7**	Box 24D	HRSN Services Manual
International Classification of Diseases, 10th Revision Codes (ICD-10) is a system used by physicians to classify and code all diagnoses or conditions in the case of HRSN Providers, symptoms, and procedures for claims processing.	**Z59.41**	Box 21A-L	HRSN Services Manual
Place of Service (POS) Codes contain two digits that describe where a service is provided.	**12**	Box 24D	All POS codes are acceptable. See CMS list here. See Appendix for nutrition recommended codes.

Overview of the Claims Submissions Process

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Methods of Claims Submission

There are three different ways to submit claims to MCEs. Directions and/or electronic specifications are available via the MCE's billing Manuals, Portals, and Websites. You may choose to begin with Paper Claim submissions initially but can switch to other methods as you choose, and as MCEs make them available. Make sure to discuss with your MCE what method(s) they have.

Paper Claims (CMS 1500 02-12) -Can be mailed to a designated mailing address published in the MCE's Billing Manual. Blank 1500 Forms may be properly completed using black 10-12-point font typed in capital letters. Do not use bold print. You can purchase blank 1500 Forms from suppliers such as Amazon, office supply stores, or other local printing companies in your area. There are options available online for Fillable CMS 1500 Forms to download, complete, and save. Note: paper claims have a longer processing time than the submission processes listed below.

Direct Data Entry (DDE) – Certain MCEs offer options to submit claims using this method in which you can enter all the claim information through their portal. This option may vary depending on the MCE; therefore, it is always best for HRSN Providers to consult with the Health Plan to verify whether this method is available.

Electronic Claims Submission – The 837P (Professional) is the standard industry format used by health care professionals and suppliers to transmit health care claims electronically. Although this claim transaction is standardized, it is best to obtain the electronic specifications from each ACO. Note: The 837P does require a special system that must be purchased and set up.

Allowable Methods & Timeline of Claims Submission-HRSN Supplemental Services

Managed Care Entity	Method for Submitting Claims	Timeline for Claims Submission (initial submission)
WellSense	Paper Claims, Electronic Claim Submission (highly recommended), DDE	120 Days
Tufts/Point 32	Paper Claims, Electronic Claim Submission, DDE	90 Days
Health New England (HNE)	Paper Claims, Electronic Claim Submission, DDE	90 Days
Massachusetts Behavioral Health Partnership (MBHP)	Paper Claims, Electronic Claim Submission, DDE	90 Days
Fallon	Paper Claims and Electronic Claim Submission (DDE anticipated to be available sometime in 2025)	120 Days
Massachusetts General Brigham (MGB)	Paper Claims, Electronic Claim Submission, DDE	90 Days

Claims Submission Guidance & Timelines

HRSN providers typically have **90** days from the date of service to submit a claim to the MCE (1500 Claim Form, DDE, 837P). Claims should be reviewed for accuracy to ensure that you are billing a "clean claim," meaning all necessary information is included. The earlier the claim is submitted, the quicker the response time to achieve payment or denial. *See slide 12 for MCEs' Claim Submission timelines.*

MCEs have different methods of reporting claims status back to providers. These are electronic files and paper remittance advice reports also referred to as Explanation of Benefits (EOB). HRSN Providers will need to consult with each MCE to determine the procedure.

HRSN Providers can also access a claim's status through the MCE's provider portal after a claim is processed. Remittance Advice Reports may also be available to download via the portal.

*****Talk to your MCE to access their Direct Data Entry portal*****

Claims Adjudication Guidance & Timelines

A claim adjudication is the process of determining the payment or denial of an HRSN service claim.

All adjudications, regardless of the type, will include the claim status of pending, paid, or denied.

- Denied claims will include denial codes that will assist you with understanding the reason for the denial.
- If you are unclear about the denial reason, the Provider/Customer Service Representatives' phone numbers are available to call for assistance. *See Appendix for each MCEs' Point of Contact for HRSN Providers.*
- Provider Manuals are also available via MCEs' websites and offer guidance for various denials.

Claim resubmission timelines and final submission timelines are determined by the MCEs and it is important to become familiar with them. Diligent follow-up and timely resubmission are crucial for successful billing.

****The industry standard for claims resubmission is 60 days from denial for resubmission.****

Proper and dedicated staffing of the HRSN claims process from start to finish plays a key role in successfully billing HRSN claims. The staff allocated will depend on the volume of claims. All claims billed will require a reconciliation process to conclude them.

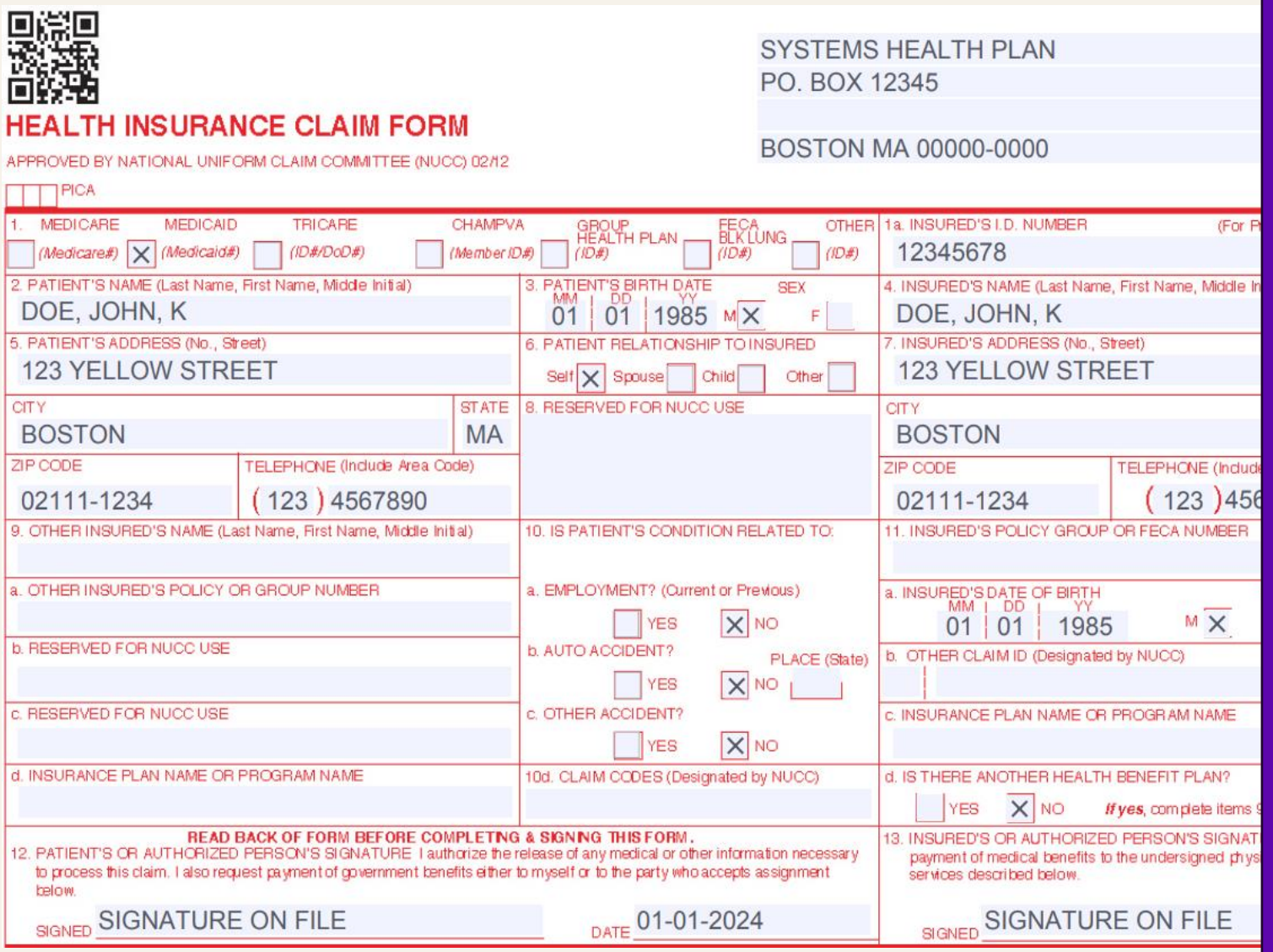
Managing Your Organizations Claims & Billing Process

If you decide to manage your **claims and billing process internally, we recommend that you have a dedicated staff member** who will manage your claims and billing process. These decisions will build a foundation for a successful transition that will be financially beneficial for your organization.

This dedicated staff should:

- Maintain a list of procedures that HRSN Providers follow to submit claims and receive payment for the HRSN Services they provide.
- Determine how your organization is going to collect the data needed during an HRSN client visit.
- Stay up-to-date with the evolving regulatory and compliance requirements that govern the Massachusetts healthcare industry relevant to HRSN services.
- Ensure that the claims are accurate, complete, and comply with the relevant HRSN Service Manual regulations and guidelines.

Completing the CMS 1500 Billing Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

SYSTEMS HEALTH PLAN
PO. BOX 12345

BOSTON MA 00000-0000

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 12345678

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN, K

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1985 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle In): DOE, JOHN, K

5. PATIENT'S ADDRESS (No., Street): 123 YELLOW STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 YELLOW STREET

CITY: BOSTON STATE: MA

8. RESERVED FOR NUCC USE

CITY: BOSTON

ZIP CODE: 02111-1234 TELEPHONE (Include Area Code): (123) 4567890

ZIP CODE: 02111-1234 TELEPHONE (Includ: (123)456

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 01 01 1985 M [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 01-01-2024

13. INSURED'S OR AUTHORIZED PERSON'S SIGNAT payment of medical benefits to the undersigned phys services described below.

SIGNED SIGNATURE ON FILE

1) Fill out all of the information listed below:

John, a MassHealth member eligible to receive HRSN service met with staff at our organization. We are now preparing a claim for those encounters.
In Box 1a – Insured's ID Number, we verified and entered John's insurance ID number.

Next, we verified John's demographic information (Boxes 2-5) to ensure that we enter this information as the MCE has it on file.

- **Box 2- Insured's Name**
- **Box 3 - Insured's Date of Birth and Sex**
- **Box 4 - Insured's Name**
- **Box 5 - Insured's Address**

For Box 6-Patient Relationship to Insured, we checked off 'Self' and added John's home address and phone number again in Box 7.

Box 10a-c - Check off 'No' on all.

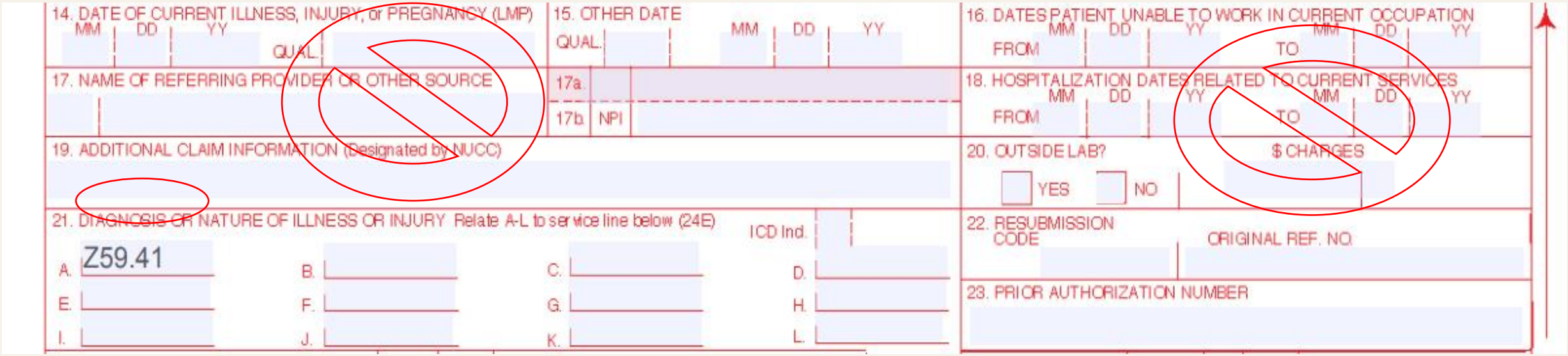
We entered John's date of birth and sex in Box 11a and checked off 'No" for Box 11d .

Finally, in Box 12 & 13 we Notate Signature on File.

Completing the CMS 1500 Billing Form

2) In Boxes 14-19, 16-20 and 23, HRSN Providers will not need to fill those areas.

- **Box 22 - Resubmission Code-is a code an HRSN Provider will add if the original claim that was submitted is denied.**
- **In Box 21 A-L , we listed John's ICD-10 Diagnosis code or HRSN condition that corresponds with the services we provided to him. In this case Z59.41 in the HRSN Service Manual is the code for HRSNs addressed with this service**



Completing the CMS 1500 Billing Form

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDER PROVIDER
1																133N00000X
	01	01	24	01	01	24	10		S9452		A	180.00	2		NPI	9875643210
2																133N00000X
	01	02	24	01	02	24	10		S9452	U1	A	90.00	1		NPI	9875643210
3																133N00000X
	01	03	24	01	03	24	10		S9452	U2	A	90.00	1		NPI	9875643210
4																
															NPI	
5																
															NPI	
6																
															NPI	

3) Fill out the following information:

- **In Box 24A – Line 1 – we added all the Dates of Service, for each encounter that we had with John . In this example we met with him on three occasions and provided two units of service during one encounter (2 nutrition education classes).**
- **Box 24B – Line 1 –Place of Service**
- **In Box 24D – Lines 1 -3 we went into the HRSN Service Manual and included the HCPCS and Modifiers for each of the encounters we had with John.**
- **Box 24E – Line 1 -3 – The Diagnosis pointers-The diagnosis pointer should reference the diagnosis that the service relates to.**
- **We listed the cost or charged amount for the services rendered to John in Box 24F – Lines 1-3. The rates listed are based on the ACOs rates.**
- **In Box 24G – Line 1 –3, we've listed the Days or Number of Units for John's encounter with us.**
- **HRSN Taxonomy codes can be found in the NPI Taxonomy Codes Reference for MassHealth Services document. We used this to fill out Box 24J – Lines 1–3 Taxonomy code shaded area**
- **Finally, we used our organization's unique NPI number in Box 24J – Lines 1 –3**
- ****If the HRSN Provider is billing for additional services the Insured received, mimic the process for lines 2-6****

Completing the CMS 1500 Billing Form


25. FEDERAL TAX I.D. NUMBER SSN EIN
012345678 X
26. PATIENT'S ACCOUNT NO.
JD12345
27. ACCEPT ASSIGNMENT? (For govt claims, see back)
YES NO
28. TOT
$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Jane Smith
01/10/2024
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
Food Pantry
123 Red Road
Boston MA 02111-1111
a. 9876543210 b. EI012345678
33. BILL
Food P
PO Box
Boston
a. 987
NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE

4) Complete the following information:

In Boxes 25-26, and Boxes 31-33 we are filling out our organization's information.

- **Box 25 – Provider's Tax ID Number – We checked off 'EIN' and entered our organization's Tax ID #.**
- **Box 26 – Internal Claim Number (Provider Created)- we entered our ICN, the tracking number for John's claim.**
- **Box 28 – Total Amount of Cost, we entered the total charged amount for HRSN services rendered to John.**
- **Box 31 – We entered our organization's Authorized Representative , Jane Smith and the date.**
- **Box 32 – We entered our organization's name & address . In Box 32a we added our organization's NPI # and in Box 32b, we added our Tax ID numbe**
  - **32a – NPI & 32b Tax ID #- We entered our organization's name and address, the NPI # for the service we provided to John and our Tax ID again.**
- **Box 33 – We entered our organizations name and address where payment should be sent to. In our case, we sent it to our PO. Box (If you have a PO Box, enter it here.) In 33a, we entered our NPI and Tax ID # once again.**

Recap on Hubs, Third Party Agents and Vendors-Support for HRSN Providers

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Organizational Considerations & Options

If your organization is new to contracting with MCEs or healthcare claiming, you can partner with companies or organizations that are already doing this work or have the infrastructure to start. All of these models detailed below can come in various shapes and sizes.

HRSN Provider Support	Description:	Specialties:
Third-Party Billing Agents	Professionals such as accountants or firms who specialize in medical billing and contract for this service.	Billing & claims management
Vendor Supports	Entity contracted to perform a specific portion of work, supply certain expertise, supports, or support a project.	Billing & claims management, provider credentialing, tech/IT support, training on aforementioned topics
Hubs – Parent Entity	Performs the majority of the administrative and organizational components of the Hub's work. The Parent Entity supports Satellite Entities by centralizing administrative functions.	Claims management, service delivery coordination, MCE Contracting

Questions

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Thank You.

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HRSN Provider Resources

- HRSN Integration Funds Website –For all previous presentation and additional information
- https://www.mass.gov/info-details/information-for-masshealth-acos-and-hrsn-providers?auHash=R8HaWRSTfMc-Ish0kn4ZHllMsiS3VS8SiNR-YP2WtPQ -HRSN Services Manual
- https://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2023_07-v11.pdf - National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual
- https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets - CMS Place of Service Code Set
- HRSN Public Facing Sign Up Sheet-Hubs.

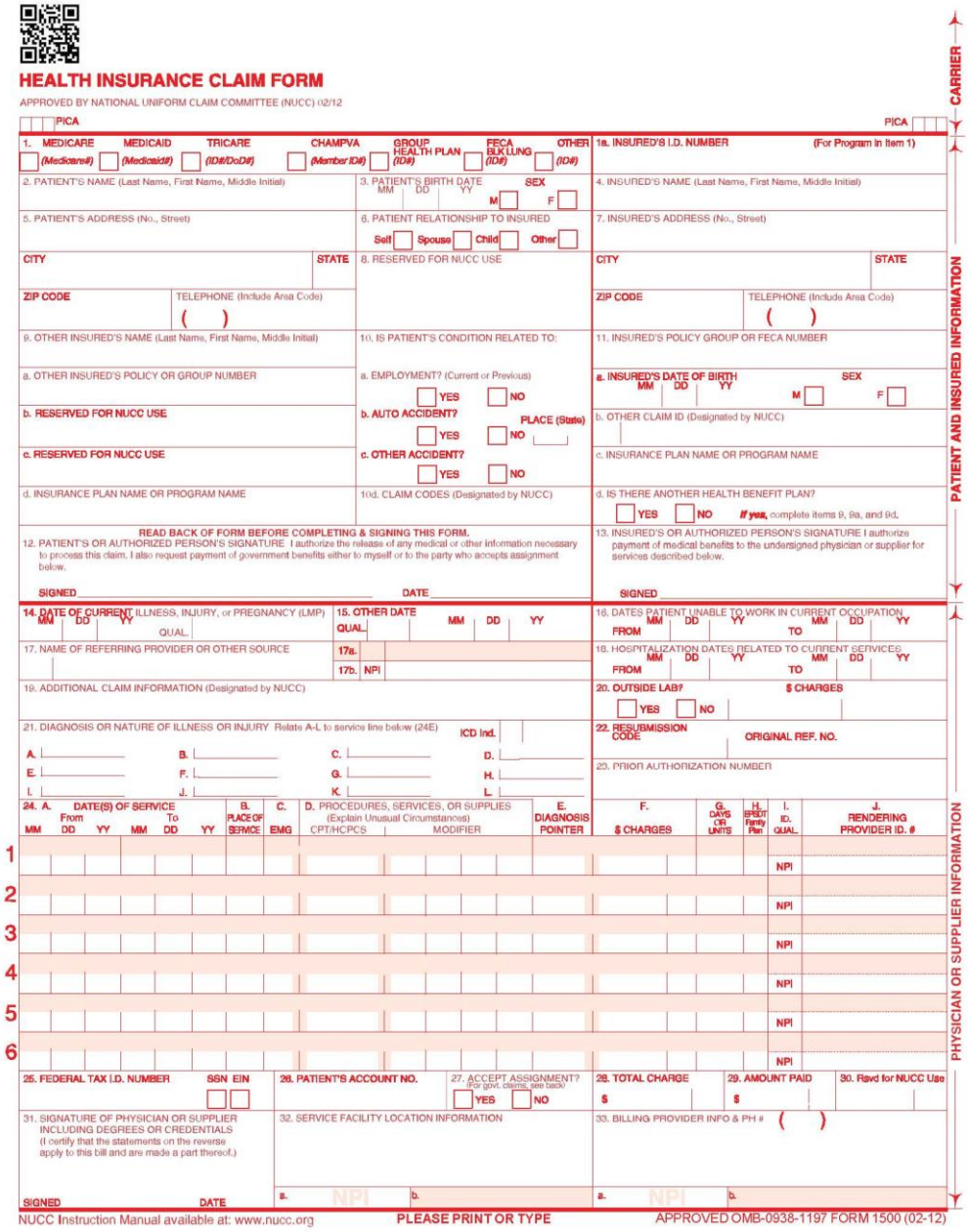
Full 1500 Billing Form

Box 1 – Check off Medicaid
Box 1a – Insured's ID Number
Box 2 – Insured' Name
Box 3 – Insured's Date of Birth and Sex
Box 4 – Insured's Name
Box 5 – Insured's Address
Box 6 – Check off Self
Box 7 – Insured's Address
Box 10a-c – Check off No on all
Box 11a – Insured's Date of Birth and Sex
Box 11d – Check off No
Box 12 & 13 – Notate Signature on File

- Box 21 A-L
- List the ICD10 Diagnosis codes that correspond with the services

Box 24A – Line 1 – List the Date of Service
Box 24B – Line 1 – List the Place of Service
Box 24D – Line 1 – List the HCPC and Modifiers
Box 24E – Line 1 – List the Diag pointers
Box 24F – Line 1 – Enter the Cost for the service
Box 24G – Line 1 – Enter the Number of Units
Box 24J – Line 1 – Enter the Taxonomy code in Shaded Area
Box 24J – Line 1 – Enter the NPI
****If Insured has more services; mimic the process for lines 2-6****

Box 25 – Providers Tax ID Number – Check off EIN
Box 26 – Internal Claim Number Provider Created
Box 28 – Total amount of Cost
Box 31 – Type Authorized Representative and Date
Box 32 – Providers Name & Address – 32a – Provider's NPI
Box 33 – Providers Name & Pay to address – if you have PO Box – this is where you would want to enter it. 32a – NPI & 32b Tax ID #



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Recommended Place of Service Codes: HRSN Supplemental

Nutrition Services

These codes are recommendations. MassHealth recognizes that services may be provided elsewhere. Providers should use the code that best describes the POS.

POS 12: Home

- Medically Tailored Meals
- Home Delivered Meals
- Medically Tailored Food Boxes
- Nutritionally Appropriate Food Boxes / CSA Shares
- Medically Tailored Food Prescription and Voucher Program
- Nutritionally Appropriate Food Prescription and Voucher Program
- Kitchen Supplies
- Nutrition Class Materials

POS 10: Telehealth Provided in Patient's Home

- Nutrition Class
- Nutrition 1:1 Education
- Nutritional Counseling, diet
- Application Assistance
- Benefit Maintenance Assistance

POS 99: Other Place of Service

- Services provided at a Nutrition Hub (grocery store; food mart; farmers market) or transportation to such location.

POS 12: Office

- Nutrition Class Materials
- Nutrition Class
- Nutrition 1:1 Education
- Nutritional Counseling, diet
- Application Assistance
- Benefit Maintenance Assistance

Points of Contact for Claims Inquiries

Potential HRSN Providers should reach out to the points of contact for each health plan listed below for questions or for support regarding claims.

Health Plan	Key Contact	Email Address
WellSense	Lori Marshall	lori.marshall@wellsense.org
	Naomi Lisan	naomi.lisan@wellsense.org
Tufts / Point32	Provider Account Management Team	BHPAM@point32health.org
Health New England (HNE)	Preeti Nakrani	pnakrani@hne.com
	Kerry LaBounty	klabounty@hne.com
Fallon Health	Christa Diaz	christa.diaz@fallonhealth.org
Mass General Brigham (MGB)	David St. Pierre	dstpierre2@mgb.org
Massachusetts Behavioral Health Partnership (MBHP)	Jennifer LaRoche	jennifer.laroche@carelon.com