

108 CMR 10.00: MEDICAL CARE

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10.01: Medical Care

- (1) Applicants who are recipients of M.G.L. c. 115 benefits requiring medical benefits shall also apply for medical assistance under M.G.L. c. 118E, if eligible.
- (2) Veterans' agents shall complete and file applications authorized by the Division of Medical Assistance (DMA) for any veteran, and dependent as defined in 108 CMR 3.05(1) applying for such medical assistance pursuant to the Secretary's directives.
- (3) The veterans' agent shall advise the applicant of the right to M.G.L. c. 115 medical benefits pending approval of his or her M.G.L. c. 118E application. The Secretary may supplement M.G.L. c. 118E medical assistance with medical benefits coverage under M.G.L. c. 115 if the Secretary determines that supplemental coverage is necessary to afford the applicant sufficient relief and support. Benefits paid to an applicant pursuant to M.G.L. c. 115 shall not be considered income for the purposes of determining eligibility under M.G.L. c. 118E. However, an applicant's annuity benefits under M.G.L. c. 115, § 6B shall be considered income under M.G.L. c. 118E.

10.02: Fee Schedules

- (1) Local veterans' services departments shall conform to the procedures, methods of payment and statewide fee schedules. Medical services and supplies begin with either the personal physician or clinic and, when recommended, must be approved and paid for in accordance with established fee schedules. Fee schedules for medical services and supplies are part of 114.3 CMR and generally represent rates as established by the Division of Health Care Finance and Policy (DHCFP), formerly the Massachusetts Rate Setting Commission. Established fee schedules for professional services may not be exceeded. A veterans' agent must refer medical fees and fees for medical services not on fee schedules to the DVS.

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(2) Items of medical care must be recommended in accordance with standards outlined in the Division of Health Care Finance and Policy (DHCFP) regulations at 114.3 CMR. Most items require evaluation and recommendation of the attending physician. In some instances, the professional opinion of a specialist or clinical physician is required; in others, the assessment by a specialized agency such as a hearing evaluation center for a hearing aid or a physical therapist for a wheelchair will be required. A veterans' agent may approve purchase of recommended items of medical care only when the standards of 114.3 CMR have been satisfied.

10.03: Prohibition of Charges to Recipients

Any provider of health care services which receives reimbursement or payment from any governmental unit for general health supplies or services shall accept reimbursement or payment at the rate established by the DHCFP as payment in full. Recipients shall not be charged.

10.04: Eligibility

The definitions and methods of determining reimbursements contained herein are regulations promulgated by the DHCFP. All fee schedules that are changed and promulgated by the DHCFP will be sent to all veterans' agents as the changes occur.

(1) Unlimited Medical Benefits. Medical services for eligible veterans and their dependents who are unemployable, permanently disabled, in receipt of Social Security, VA pension, or other retirement pensions shall be all benefits that are currently included in 114.3 CMR.

(2) Limited Medical Benefits. Medical services for eligible veterans and their dependents who are in receipt of ordinary benefits because of unemployment or illness, but who are expected to return to employment, shall be limited to emergency cases or cases of elimination of pain. All other cases considered medically essential require prior approval by the Secretary.

10.05: Community Resources, Alternative Sources for Medical Care and Prescription Drugs

All community resources, both public and private, should be used both for the prevention of disease and treatment of illness. Procedures for the use of these health services should be carefully planned so that all agencies concerned, as well as recipients involved, will understand the purpose of the services and the method of obtaining them. If these services are not readily available in a particular city or town, adjacent communities should be utilized. An applicant who is a veteran shall agree to utilize alternative sources of medical care and prescription drugs such as Department of Veterans Affairs Medical Centers, Outpatient Clinics and the Soldiers' Homes in Chelsea and Holyoke. Any co-payment or fees assessed the veteran by these facilities for medical care or prescription drugs may be reimbursed to the veteran. This provision shall not apply when it would be unreasonable for the veteran due to age, physical condition or distances involved in traveling to utilize such alternative sources.

10.06: Rehabilitation

The veterans' agent is responsible for locating all possible facilities for applicants or recipients who need rehabilitation and directing them there. These facilities include rehabilitation clinics, the services of the Massachusetts Rehabilitation Commission, shelter workshops, and other agencies providing services.

10.07: Home Health Aid Services

When the need is identified as a component of a medical treatment plan, home health aid services may be provided when authorized by DVS. Prior approval is needed. Rates are subject to the rates established by the DHCFP.

10.08: Visiting Nurse Service

Services of visiting nurse associations shall be provided by veterans' agents to recipients whenever bedside nursing is required and cannot be furnished by members of the family. This service is permitted only on a recommendation by a physician and requires prior approval. The physician must submit to the veterans' agent the plan of treatment, treatment needed, amount of time involved and projected number of visits needed to complete the treatment plan. The rate of payments to eligible providers are subject to the rates established by the DHCFP.

10.09: Nursing Home Care

(1) When eligible applicants are recommended for care in a nursing home by their attending physicians, or the hospitals, the veterans' agent should process an application (Form VS-1) and submit it to DVS. The veterans' agent must also verify that the nursing home is properly licensed and verify the per diem rate as set by the DHCFP. The veterans' agent shall assist eligible patients in filing for all possible available resources pursuant to 108 CMR 6.01(3). Particular attention must be paid to those patients who are in receipt of VA pensions. The Department's offices in Boston and in Providence should be utilized to file for additional benefits.

(2) The total monthly income of the patient, with the exception of an allowance for personal needs, must be applied toward payment of the nursing home bill. The balance will be paid by the veterans' agent at the state approved *per diem* rate.

(3) The patient's personal needs allowance shall not be used to purchase items included in the per diem rate set by the DHCFP for the facility. Maximum accumulated personal needs benefits are subject to the provisions of 108 CMR 5.02(11).

10.10: Retroactive Rate Adjustments

Retroactive rate adjustments are necessary whenever the DHCFP changes rates for a long-term care facility. When there is a retroactive increase, the DVS incurs a liability to the provider. When there is a retroactive decrease, the provider must repay DVS.

10.11: Hospital Health Insurance

When a veterans' agent notes on a Form VS-1 that the applicant has some type of hospital insurance, the veteran's agent must properly submit the following information:

- (1) Name of company
- (2) Persons covered under plan
- (3) Full details of plan
- (4) Regular insurance plan
- (5) Master Medical plan (MM)
- (6) Unlimited Medical plan (UMC)
- (7) Prolonged Illness plan (PIC)

10.12: Hospital Billing with Insurance

| INPATIENT HOSPITAL BILLING | OUTPATIENT HOSPITAL BILLING |
|--|--|
| If applicant eligible, bill must show: Total amount of charges X percentage of charges Total public assistance bill minus insurance payment Balance - paid by DVS | If applicant eligible, bill must show: Total amount of charges X percentage of charges Total public assistance bill minus insurance payment Balance - paid by DVS |

10.13: Physicians' Payments

- (1) If applicant is eligible, bills must be addressed to the veterans' agent, and services must be coded according to the DHCFP (114.3 CMR).
- (2) A veterans' agent must not submit a request for reimbursement for services provided by a physician or vendor when health insurance is in force, until proof, in writing, is received from the insurance company that the request for payment has been approved or disapproved. This written proof must be submitted to the appropriate DVS authorizer with each request for reimbursement.

10.14: Supplemental Payment to Insurance Prohibited

- (1) Applicants Not Covered by Medicare. DVS will not allow payment for services by a physician in cases where the applicant has medical insurance and that insurance has already made payment. Payment by the insurance company means the bill is paid in full.
- (2) Applicants Covered by Medicare-Part B Supplemental Insurance. DVS will not authorize payment to any physician for services performed to an eligible applicant who is covered under Medicare B and also has supplemental insurance. This policy applies only to physicians and does not affect other providers of medical care under Part B of Medicare. DVS will continue to participate in the payment of premiums. For those applicants without supplemental insurance, the DVS will continue to pay the deductibles and the 20% balance of the allowable rate pursuant to M.G.L. c. 112 § 2.

10.15: Inpatient Days Disallowed by Medicare

In those instances where inpatient payment has been denied by Medicare as medically unnecessary, no payment will be authorized by DVS.

10.16: Physicians' Services, Exclusion and Exceptions

- 108 CMR 10.00 and fees for payment shall not apply to the rates of payment to physicians for medical, surgical, anesthesia and X-ray services provided in state institutions by state-employed physicians or physician consultants in state hospitals. Also, 108 CMR 10.00 and fees for payment shall not apply to:
- (1) Physicians whose contractual arrangements with hospitals and affiliated medical schools involve a salary, compensation in kind, teaching research or payment from any other source resulting in dual compensation for professional, supervisory or administrative services related to patient care.
 - (2) Physicians who serve as interns, residents, fellows or house officers.
 - (3) Physicians who serve as attending, visiting, or supervisory physicians in a hospital, if any of the following conditions exists:
 - (a) the physician does not customarily bill private patients without insurance under comparable circumstances

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- (b) the physician is not legally responsible for, or the physician does not control management of the patient's case with respect to medical, surgical anesthesia or X-ray services
- (c) the physician does not perform the medical, surgical, anesthesia or X-ray services
- (d) the physician does not meet DVS's conditions of participation for physicians

10.17: Dental Services

DVS will reimburse for necessary dental services essential to the maintenance of oral health for eligible recipients, but not provide elective or cosmetic services. Prior approval must be requested in conjunction with the total treatment plan for all dental services other than basic restorative or prophylactic services.

10.18: Prescribed Drugs

By 114.3 CMR 31.00, the DHCFP determines the rates of payments to be used by DVS for prescribed drugs dispensed to eligible recipients of veterans' benefits. The rates of payment represent full compensation for professional services rendered, as well as for any related administrative or supervisory duties.

10.19: Procedures for Prescription Authorization

- (1) The veterans' agents should inform pharmacists in their area that billing should be on a monthly basis to the veterans' agent; and bills should clearly state:
 - (a) name and address of the recipient
 - (b) number of the prescription (identity)
 - (c) type, quantity, dosage of the medicine, and date filled
 - (d) number of refills
 - (e) when it is a refill, if provided by the pharmacist it must state which refill of the original prescription it covers: "Third of Five": etc.
- (2) In cases where the veterans' agent is in doubt, he or she should make a written request to DVS for a prior approval.

10.20: Podiatry Services

- (1) Reimbursement for Essential Services. DVS will reimburse for podiatric services essential for the prevention and treatment of disease. It is not the intent of the program to provide cosmetic or unnecessary services. Podiatric services will not be approved without a statement of medical necessity from a physician.
- (2) Number of Allowed Visits. Recipients will be allowed one visit per month. Other service must be documented, including diagnosis, and description of treatment plan, and reviewed by the DVS. Procedures for specific foot problems which require surgery, either in the podiatrist's office or in a hospital, shall be referred to a medical consultant. Podiatric services will not be approved without a statement of medial necessity from a physician and they require prior DVS approval.

10.21: Chiropractic Services

Chiropractic services will not be approved without a statement of medical necessity from a physician and they require prior DVS approval.

10.22: Mental and Behavioral Health

Eligible veterans with an approved treatment plan shall, subject to appropriation, be provided with outpatient services related to mental and behavioral health. Treatment plans shall be reviewed by the recipients VSO then submitted to the appropriate EOVS Authorizer. A recipient of the behavioral health assistance benefit shall, where applicable, make use of private, state or federally funded resources before seeking aid under 108 CMR 10.22.

10.23: Special Review: Appeals

When the physician provider believes that circumstances warrant special consideration and review by the DVS the physician should enclose a written request to this effect, accompanied by pertinent documents. This request for review should be sent to DVS. Any claims for surgical procedures not listed in the fee schedule should be sent to DVS for review.

10.24: Conflict of Regulations

Medical care shall be provided in accordance with the standards and limitations of 114.3 CMR which embodies the policies, procedures, standards and fees relating to administration of the medical care aspects of the public assistance programs in the Commonwealth of Massachusetts. In the event of discrepancies or conflicts between 108 CMR 10.00 and any other chapter of 108 CMR, the provisions of 108 CMR 10.00 shall apply.

REGULATORY AUTHORITY

108 CMR 10.00: M.G.L. c. 115.