Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MASSHEALTH
TRANSMITTAL LETTER AIH-41
June 2006

TO: Acute Inpatient Hospitals Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: *Acute Inpatient Hospital Manual* (Coverage of Administrative Days for Members Aged 21 Years or Older)

Due to a new state law, effective July 1, 2006, MassHealth will cover payment of administrative days in an acute inpatient hospital for eligible members aged 21 years or older.

This letter transmits an amendment to the acute inpatient hospital regulations that reflects this change. All other conditions of 130 CMR 415.000 and 450.000 continue to apply.

These regulations were filed as emergency regulations, effective July 1, 2006.

This letter also transmits revised appendices E and F of the *Acute Inpatient Hospital Manual*, to update terminology. This letter makes obsolete Appendix D of the *Acute Inpatient Hospital Manual*. The information in Appendix D is no longer valid.

This transmittal letter, including the attached pages, and other publications issued by MassHealth are available on the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library.

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

NEW MATERIAL

(The pages listed here contain new or revised language.)

Acute Inpatient Hospital Manual

Pages iv, vi, vii, 4-3, 4-4, E-1, E-2, and F-1 through F-4

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Acute Inpatient Hospital Manual

Page iv — transmitted by Transmittal Letter AIH-39

Pages vi and F-1 through F-4 — transmitted by Transmittal Letter AIH-34

Page vii — transmitted by Transmittal Letter IH/AC-27

Pages 4-3 and 4-4 — transmitted by Transmittal Letter AIH-40

Pages D-1 and D-2 — transmitted by Transmittal Letter IH/AC-31

Pages E-1 and E-2 — transmitted by Transmittal Letter AIH-35

4. Program Regulations

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Manuals in the series contain administrative regulations, billing regulations, program regulations, service codes, administrative and billing instructions, and general information. MassHealth regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. MassHealth regulations are assigned Title 130 of the Code. The regulations governing provider participation in MassHealth are assigned Chapters 400 through 499 within Title 130. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For acute inpatient hospitals, those matters are covered in 130 CMR Chapter 415.000, reproduced as Subchapter 4 in the *Acute Inpatient Hospital Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which furnish instructions for making changes by hand ("pen-and-ink" revisions), and by substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth’s effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and its members.

Outpatient Services – medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home.

Reasonable Distance – generally, 25 miles from the home or usual noninstitutional residence of the member. This definition does not preclude longer distances in such instances as, but not limited to, rural areas or in cases where the member has no family or regular visitors.

Reconstructive Surgery – a surgical procedure that is performed to correct, repair, or ameliorate the physical effects of physical disease or defect (for example, correction of a cleft palate), or traumatic injury.

Sterilization – any medical procedure, treatment, or operation that renders an individual permanently incapable of reproducing. A sterilization is "nontherapeutic" when the individual has chosen sterilization as a permanent method of contraception. A sterilization is "therapeutic" when it occurs as a necessary part of the treatment of an existing illness or injury or is medically indicated and performed in conjunction with surgery upon the genito-urinary tract.

Utilization Review Coordinator – an individual responsible for utilization review in a hospital.

Working Days – Monday through Friday except for legal holidays.

415.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency pays for acute inpatient hospital services provided to MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 415.000 specifically states, for each coverage type, which services are covered and which members are eligible to receive those services.
(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

415.404: Provider Eligibility

Payment for the services described in 130 CMR 415.000 will be made only to acute inpatient hospitals participating in MassHealth as of the date of service.

(A) In State. To participate in MassHealth, an acute inpatient hospital located in Massachusetts must:
(1) be licensed as a hospital by the Massachusetts Department of Public Health;
(2) have a signed provider agreement that specifies a reimbursement methodology with the MassHealth agency; and
(3) participate in the Medicare program.

(B) Out of State.

(1) Out-of-state acute inpatient hospital services are covered only as provided in 130 CMR 450.109.

(2) To participate in MassHealth, an out-of-state acute inpatient hospital must obtain a MassHealth provider number and meet the following criteria:

(a) be approved as an acute inpatient hospital by the governing or licensing agency in its state;

(b) participate in the Medicare program; and

(c) participate in that state's Medical Assistance Program (or equivalent).

415.405: Utilization Management Program

The MassHealth agency pays for procedures and hospital stays that are subject to the Utilization Management Program only if the requirements of the program, as described in 130 CMR 450.207 through 450.211, are satisfied. Appendix E of the *Acute Inpatient Hospital Manual* contains the name, address, and telephone number of the contact organization for the Utilization Management Program and describes the information that must be provided as part of the review process.

415.406: Payment Methodology

Payments to acute inpatient hospitals in Massachusetts for services provided to MassHealth members equals the rate established in the signed provider agreement with the MassHealth agency.

415.407: Covered Administrative Days: Payment Methodology

Payment for covered administrative days provided on or after October 1, 1991, is made in accordance with the methodology established by the signed provider agreement with the MassHealth agency. The per diem rate must be accepted by the hospital as payment in full for all days determined to be administratively necessary, in accordance with 130 CMR 415.414.

415.408: Nonpayable Services

The following are not payable:

(A) drugs and durable medical equipment prescribed for take-home use that are readily available from pharmacies or medical providers;

Information Required for Admission Screening

The following is a list of information the admitting provider or designee must give the MassHealth Utilization Management contractor when proposing an elective admission. MassHealth may request additional information at any time to clarify the details of any admission. See 130 CMR 450.208 for regulations about admission screening.

- the member's name and address
- the member's sex
- the member's date of birth
- the member's MassHealth identification number
- the guardian's name and address, if applicable
- if applicable, the name of the member's primary care clinician (PCC) and one of the following:*
  - the telephone number of the PCC
  - the provider number of the PCC
  - the address of the PCC.
- if applicable, whether the PCC has been notified of the proposed admission
- other health-insurance information
- whether the member is being treated as a result of an accident, and if available, the date and type of accident
- the expected or actual dates of admission and expected discharge date
- the name and provider number of the attending physician
- the name of the hospital
- the primary and secondary diagnoses
- the primary and secondary procedures, if applicable
- the ICD-9-CM codes for both the diagnoses and procedures, if available
- CPT codes for procedures when the facility is out of state
- clinical information that supports the medical necessity of the proposed admission and/or procedure
- other pertinent information the admitting provider has considered in deciding to admit the member

***** Information about the member's PCC is not required if the admission is for dental, oral-surgery, family-planning, or abortion services.

Please Note: Admission screening does not satisfy the need to obtain prior authorization (PA) for services that require PA. See 130 CMR 450.303 and 415.000 to determine what services require PA. See Subchapter 5 of the *Acute Inpatient Hospital Manual* for instructions for requesting PA.

Contact for Utilization Management Program

Contact information for the MassHealth Utilization Management Program contractor is given below. (See 130 CMR 450.207 through 450.209 for the Utilization Management Program regulations.)

MassPRO, Inc.
235 Wyman Street
Waltham, MA 02451-1231

Fax: 1-800-752-6334
Telephone: 1-800-732-7337

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Acute Inpatient Hospital Admission Guidelines

A. Introduction

This appendix is intended to help providers make appropriate decisions about the medical necessity of acute inpatient hospital admissions. These guidelines have been approved by physicians from several medical specialties who have active practices in Massachusetts. Providers making decisions on whether to admit a member as an inpatient should use their medical judgment and these guidelines. Services that meet medical-necessity criteria at 130 CMR 450.204 and the rules governing reimbursement of inpatient, outpatient, and observation services in 130 CMR 410.414 (see section D of this appendix) and 415.414 are reimbursable by MassHealth.

B. Definitions for Inpatient, Observation, and Outpatient Services

The reimbursability of services defined below is not determined by these definitions, but by application of the MassHealth regulations in 130 CMR 410.000, 415.000, and 450.000.

Inpatient Services — medical services provided to a member admitted to an acute inpatient hospital.

Observation Services — outpatient hospital services provided anywhere in an acute inpatient hospital, to evaluate a member's condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Outpatient Hospital Services — medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, day-surgery services, and recovery-room services.

Outpatient Services — medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home.

C. Admission Guidelines

The following guidelines describe admissions that generally are not medically necessary. This is not an all-inclusive list. The MassHealth agency or its agent may also determine that other admissions not characterized in this list are medically unnecessary and nonreimbursable on an inpatient basis.

1. The admission occurs following observation services, and the admitting provider has not documented at least one of the following in the medical record at the time the decision to admit is made:
   - Failure to respond to outpatient treatment and a clear deterioration of the patient's clinical status;
   - a significant probability that the treatment plan will continue to need frequent clinical modifications and what specific modifications are necessary;
   - instability of the patient that is a deviation from either normal clinical parameters or the patient's baseline; or
   - a requirement for more intensive services than were already being delivered while the patient was on observation status, and a physician's order for each specific new service.

2. The admission occurs when the member's condition had improved significantly in response to outpatient treatment with a progression toward either normal clinical parameters or the member's baseline.

3. The admission is for further monitoring or observing for potential complications when the member undergoes a procedure that is appropriately performed in an outpatient setting according to the current standards of care, the procedure is performed without complications, and the member's clinical status is approaching either normal clinical parameters or his or her baseline.

4. The admission is primarily for providing or monitoring the services and treatment of a member with multiple or complex medical needs whose needs were adequately being met in a setting other than an acute inpatient hospital prior to that admission.

5. The admission of a member whose baseline clinical status is outside of the normal clinical parameters and whose condition has been managed successfully on an outpatient basis, when the admission is based primarily on the member's abnormal status, unless that status has significantly deteriorated.

6. The admission is primarily to observe for the possible progression of labor when examination and monitoring does not indicate definite progression of active labor leading to delivery.

7. The admission is primarily for education, teaching, minor medication changes and/or monitoring, or adjustment of therapies associated with a medically stable condition(s).

8. The admission is primarily because the member requires sedation or anesthesia in order to conduct diagnostic tests that are appropriately performed in an outpatient setting according to the current standards of care, when there are no serious complications requiring inpatient services.

9. The admission of a member whose baseline condition requires the use of complex medical technology, when the admission is primarily due to the need for such technology or other maintenance services related to the pre-existing medical condition(s), unless the member's condition is significantly deteriorating.

10. The admission is primarily for a continuation of treatment or monitoring that has already been delivered effectively in the home, hospital outpatient department, or other institutional setting.

11. The admission of a member who is a patient or resident in another institutional setting, and is admitted primarily for diagnostic or treatment services that could have been provided in the member's current institutional setting or by using outpatient services.

12. The admission of a member who has simple, uncomplicated, outpatient surgery and is being admitted primarily because of the time of day or the need for postoperative observation.

13. The admission is primarily due to the:
    - amount of time a member has spent as an outpatient in a hospital or other outpatient setting;
    - time of day a member recovers from outpatient surgery;
    - need for education of the member, parent, or primary caretaker;
    - need for diagnostic testing or obtaining consultations;
    - need to obtain medical devices or equipment or arrange home care or other noninstitutional services;
    - age of the member;
    - convenience of the physician, hospital, member, family, or other medical provider;
    - type of unit within the hospital in which the member is placed; or
    - need for respite care.

D. Observation Services

[excerpted from the MassHealth outpatient hospital regulations at 130 CMR 410.414]

Reimbursable Services. The Division covers medically necessary observation services provided by acute inpatient hospitals. Reimbursable observation services may exceed 24 hours, and do not need to be provided in a distinct observation unit. To qualify for reimbursement of observation services, the medical record must specifically document when those services began and ended, the purpose of observation, and the name of the physician who ordered it. Acute inpatient hospitals will be reimbursed for these observation services on an outpatient basis in accordance with the signed provider agreement with the Division.

Nonreimbursable Services.

(1) Nonreimbursable observation services include but are not limited to:
    (a) services that are not reasonable or necessary for the diagnosis or treatment of the member; and
    (b) routine preparation and recovery services associated with diagnostic testing or outpatient surgery.

(2) The following services are not reimbursable as a separate service:
    (a) postoperative monitoring during a standard recovery period that should be characterized as recovery-room services; and
    (b) observation services provided concurrently with therapeutic services such as chemotherapy.

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