Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
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Boston, MA 02111
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MASSHEALTH
TRANSMITTAL LETTER ALL-106
September 2002

TO: All Providers Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: *All Provider Manuals* (Payment for Experimental or Unproven Services and Monies Owed by Providers)

The Division has revised its administrative and billing regulations at 130 CMR 450.000.

The first change revises the regulations governing provider participation and the medical services available under MassHealth. The new regulations clarify the Division's exclusion from payment of experimental or unproven services by defining experimental treatment as treatment that has not been demonstrated to be medically necessary, as defined in 130 CMR 450.204(A)(1).

The second revision clarifies the requirements for repayment of overpayments and other amounts owed by providers participating in MassHealth. Specifically, the administrative regulations found at 130 CMR 450.260 are being amended.

In particular, 130 CMR 450.260(D) is revised to include all provider types in conformance with M.G.L. c. 118E, §36, as amended by Chapter 194 of the Acts of 1998, effective July 1, 1998. Therefore, as of July 1, 1998, all providers who participate in MassHealth have been held responsible, under M.G.L. c. 118E, §36, for overpayments made to a predecessor. This regulatory change simply conforms the Division's regulations to state law. For purposes of 130 CMR 450.260, a "successor owner" is any successor owner, operator, or holder of any right to operate all or a part of the prior owner's health-care business, which includes, but is not limited to, the business management, personnel, physical location, assets, or general business operations.

These regulations are effective October 1, 2002.

NEW MATERIAL

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

All Provider Manuals

Pages 2-1, 2-2, and 2-31 through 2-34

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 2-1 and 2-2 — transmitted by Transmittal Letter ALL-82

Pages 2-31 through 2-34 — transmitted by Transmittal Letter ALL-70

450.200: Payment Methods and the Provider Agreement

In cases where the regulations in 130 CMR 450.000, concerning payment methods and conditions of provider participation, conflict with a provider agreement or other contract with the Division, signed on or after October 1, 1991, and in effect at the time any such conflict arises, such provider agreement or contract will supersede.

450.201: Choice of Provider

Pursuant to federal regulations set forth in 42 CFR 431.51, members have the right to choose providers from whom they may obtain medical services with certain exceptions that are specified in the Division's program regulations, including, but not limited to, 130 CMR 450.117(B). However, a member's right to choose a provider does not permit or require payment by the Division to any person or institution not eligible for such payment under the Division's regulations in effect at the time a medical service is provided.

450.202: Nondiscrimination

(A) M.G.L. c. 151B, s. 4, clause 10, prohibits discrimination against any individual who is a recipient of federal, state, or local public assistance, including MassHealth, solely because the individual is such a recipient. Accordingly, except as specifically permitted or required by regulations relative to institutional providers, no provider may deny any medical service to a member eligible for such service unless the provider would, at the same time and under similar circumstances, deny the same service to a patient who is not a MassHealth member (for example, no new patients are being accepted, or the provider does not furnish the desired service to any patient). A provider may not specify a particular setting for the provision of services to a member that is not also specified for nonmembers in similar circumstances.

(B) No provider may engage in any practice, with respect to any member, that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80 (relative to discrimination on account of race, color, or national origin), 45 CFR Part 84 (relative to discrimination against handicapped persons), and 45 CFR Part 90 (relative to age discrimination).

(C) Violations of 130 CMR 450.202(A) and (B) may result in administrative action, referral to the Massachusetts Commission Against Discrimination, or referral to the U.S. Department of Health and Human Services, or any combination of these.

450.203: Payment in Full

Federal and Massachusetts law require that participation in MassHealth be limited to providers who agree to accept, as payment in full, the amounts paid in accordance with the applicable fees and rates or amounts established under a provider agreement or regulations applicable to MassHealth reimbursement (see 42 CFR 447.15, M.G.L. c. 118E, s. 36, and M.G.L. c. 118G, s. 7). No provider may solicit, charge, receive, or accept any money, gift, or other consideration from a member, or from any other person, for any item of medical service for which payment is available under MassHealth, in addition to, instead of, or as an advance or deposit against the amounts paid or payable by the Division for such item, except to the extent that the Division's regulations specifically require or permit contribution or supplementation by the member or by a health insurer. (For instances of retroactive member eligibility, see 130 CMR 450.311(C).)

450.204: Medical Necessity

The Division will not pay a provider for services that are not medically necessary; and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

(A) A service is "medically necessary" if:
(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the Division. Services that are less costly to the Division include, but are not limited to, health care reasonably known by the provider, or identified by the Division pursuant to a prior authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.

(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records available to the Division upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the Division.

(D) Additional requirements about the medical necessity of acute inpatient hospital admissions are contained in 130 CMR 415.414.

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

450.259: Overpayments Attributable to Rate Adjustments

(A) Whenever an overpayment occurs due to a rate adjustment that is certified by the Division of Health Care Finance and Policy or otherwise established by the Division in accordance with applicable law, the Division shall notify the provider in writing by issuing a remittance advice identifying the impact of the rate adjustment on all previously paid claims and stating the amount of the overpayment.

(B) A provider is obligated to pay to the Division the full amount of any overpayment attributable to a rate adjustment within 30 calendar days after the date of issuance of a remittance advice under 130 CMR 450.259(A), unless the provider enters into a payment agreement with the Division under 130 CMR 450.260(G).

(C) If a provider disputes the Division's computation of an overpayment attributable to a rate adjustment, the provider must submit proposed corrections, including a detailed explanation, in writing to the Division within 30 calendar days after the date of issuance of the remittance advice under 130 CMR 450.259(A). The fact that any rate adjustment certified by the Division of Health Care Finance and Policy is under appeal shall not be considered a factor in determining the amount of liability. The fact that a provider has submitted proposed corrections to the Division shall not delay or suspend the provider's payment obligations set forth under 130 CMR 450.259(B).

(D) If proposed corrections are timely submitted in accordance with 130 CMR 450.259(C), the Division shall review the proposed corrections and notify the provider of its decision in writing within 30 calendar days of receipt of the provider's corrections. If the Division determines that corrections are required, the Division shall make any appropriate payment adjustments reflecting the corrections.

(E) A provider is obligated to pay the Division the full amount of the overpayment stated in a remittance advice under 130 CMR 450.259(A), regardless of any pending appeal, action, or other proceeding contesting the overpayment, including but not limited to, any appeal, action, or other proceeding contesting any rate on which the overpayment is computed. If required by a final disposition of any such appeal, action, or proceeding, the Division shall issue a revised remittance advice and shall make any appropriate payment adjustments to effect the final disposition.

450.260: Monies Owed by Providers

(A) Provider Liability. A provider is liable for the prompt payment to the Division of the full amount of any overpayments, sanctions, or other monies owed under 130 CMR 450.000 et seq, or under any other applicable law or regulation. A provider that is a group practice is liable for any overpayments owed and subject to sanctions imposed as a result of any violation of any statute or regulation committed by the individual practitioner that provided the service.

(B) Ownership Liability. Any owner of an institutional provider is liable for the monetary liability of the institutional provider under 130 CMR 450.260(A) to the extent of the owner's ownership interest. For purposes of 130 CMR 450.260, an "owner" is a person or entity having an ownership interest in an institutional provider, as such interest is defined in 130 CMR 450.221(A)(9)(a), (b), (c), or (f). An "institutional provider" is any provider that provides nursing facility services, or acute, chronic, or rehabilitation hospital services.

(C) Common Ownership Liability. Any two or more providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or otherwise, are jointly and severally liable for each of their obligations to pay the full amount of any monies owed under 130 CMR 450.260(A).

(D) Successor Liability. Any successor owner of a provider is liable for the obligation of any prior owner to pay the full amount of any monies owed by the prior owner under 130 CMR 450.260(A). For purposes of 130 CMR 450.260, a “successor owner” is any successor owner, operator, or holder of any right to operate all or a part of the prior owner’s health-care business, which includes, but is not limited to, the business management, personnel, physical location, assets, or general business operations. A successor owner of a nursing facility, or acute, chronic, psychiatric, or rehabilitation hospital includes any successor owner or holder of a license to operate all or some of the beds of a nursing facility, or acute, chronic, psychiatric, or rehabilitation hospital.

(E) Recoupment. If a provider fails to pay the full amount of any monies owed under 130 CMR 450.260(A), the Division may hold back or recoup up to 100 percent of any and all payments to the provider, without further notice or demand, until such time as the full amount of any monies owed under 130 CMR 450.260(A) is paid in full.

(F) Set-Off. The Division may apply a set-off against payments to a provider in the following circumstances.

(1) Providers Under Common Ownership. Whenever any monies are owed by a provider under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to any providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or otherwise, without further notice or demand, until such time as the full amount of the monies owed under 130 CMR 450.260(A) is repaid in full.

(2) Successors. Upon the sale or transfer of all or part of a provider, the Division may set off up to 100 percent of any and all payments to any successor owner, without further notice or demand, until such time as the full amount of any monies owed by any prior owner under 130 CMR 450.260(A) is repaid in full.

(G) Payment Agreements. At its discretion, the Division may enter into a written agreement with a provider, its owner, any provider under common ownership, or any successor owner to establish a schedule to pay to the Division the full amount of any monies owed, on such terms as are acceptable to the Division. The agreement may provide for such guarantees or collateral as may be acceptable to the Division to secure the payment schedule.

(H) Court Action. The Division may recover the full amount of any monies owed to the Division under 130 CMR 450.260(A) by commencing an action in any court of competent jurisdiction. Such action may be commenced against the provider, its owner, any provider under common ownership, and/or any successor owner.

(I) Joint and Several Obligations. All obligations of providers, owners of providers, providers under common ownership, and successor owners of providers, as described under 130 CMR 450.260, are joint and several.

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