Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER ALL-111
December 2002

TO: All Providers Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: *All Provider Manuals* (Age Limitations for Certain Services and Revised Appendix Z)

Beginning January 1, 2003, age restrictions on certain services have been added to other limitations on coverage types. The Division's current budget appropriation requires these changes, at a minimum, to cover expected deficiencies.

The following services will no longer be covered for MassHealth members aged 21 and older:

- chiropractor services;
- eyeglasses, eyeglass parts, eyeglass dispensing, contact lenses, and other visual aids, except for visual magnifying aids used by members who are both diabetic and legally blind (Visual magnifying aids do not include eyeglasses or contact lenses.);
- prosthetics and orthotics, except in hospital settings (Orthotic shoes for members with severe diabetic foot disease continue to be covered in all settings.);
- dentures and related services, except for members who qualify for special circumstances under Division regulations at 130 CMR 420.410(D).

This letter transmits revision to the Division's regulations at 130 CMR 450.000. **The changes to the regulations do not alter services for members under age 21.**

MassHealth will continue to pay any Medicare-MassHealth crossover claims according to the Division's current crossover pricing policy.

Service-Specific Prior Authorizations Approved or Appealed Prior to January 1, 2003

If MassHealth approved a prior-authorization (PA) request for a member aged 21 and older on or before October 25, 2002, and the request was for services with age-related limitations, MassHealth will continue to pay for those services through the authorized period. Until December 31, 2002, MassHealth will approve PA requests for members aged 21 and older for a 90-day period from the date the PA request is approved or changed. After December 31, 2002, MassHealth will no longer approve PA requests for members aged 21 and older for these services.

If a member appeals any prior-authorization decision made prior to January 1, 2003, the Division will pay for the service if the Board of Hearings or a court does not uphold the Division's decision.

Claims for Custom-Made Goods

The Division will pay for custom-made goods in the following circumstances for dates of service after January 1, 2003:

- custom-made goods started before January 1, 2003, but not completed until after; and
- custom-made goods where the prior-authorization expiration date is after January 1, 2003.

As stated in 130 CMR 450.231(B), "the 'date of service' is the date on which a medical service is furnished to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers medical goods to a member, which goods had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date prior to the final delivery of the goods, the Division will reimburse the provider for the goods..."

Providers must submit paper claims for these services with all applicable documentation as outlined in 130 CMR 450.231(B) to the following address.

Division of Medical Assistance
Claims Operations Unit
Attention: After Cancel Unit
600 Washington Street
Boston, MA 02111

Revised Appendix Z (EPSDT Services)

This letter also transmits revisions to Appendix Z: EPSDT Services. The Centers for Medicare and Medicaid Services (CMS) have revised the Healthcare Common Procedure Coding System (HCPCS) for 2002. New national service codes have been added, and MassHealth local codes have been removed from the attached pages of Appendix Z. These revisions are effective for dates of service on or after January 1, 2003.

The MassHealth local service code for a titmus vision test (X9335) has been replaced with CPT code 99173, screening test of visual acuity, quantitative, bilateral.

How to Obtain a Fee Schedule with the New Service Codes

If you wish to obtain a fee schedule with the new service codes, you may purchase Division of Health Care Finance and Policy regulations from either the Massachusetts State Bookstore or from the Division of Health Care Finance and Policy (see addresses and telephone numbers below). You must contact them first to find out the price of the publication. The Division of Health Care Finance and Policy also has the regulations available on disk.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.gov/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcfp

Web Site Access and Questions

This transmittal letter and the revised regulations are available on the Division's Web site at www.mass.gov/dma.

If you have any questions, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

NEW MATERIAL

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

All Provider Manuals

Pages 1-7, 1-8, 2-21, and 2-22

Pages Z-1 and Z-2

OBSOLETE MATERIAL

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

All Provider Manuals

Pages 1-7 and 1-8 — transmitted by Transmittal Letter ALL-79

Pages 2-21 and 2-22 — transmitted by Transmittal Letter ALL-71

Pages Z-1 and Z-2 — transmitted by Transmittal Letter ALL-92

450.105: Coverage Types

A member is eligible for services and benefits according to the member's coverage type. Each coverage type is described below. Reimbursement for the covered services listed in 130 CMR 450.105 is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment. See individual program regulations for information on covered services and specific service limitations, including age restrictions applicable to certain services.

(A) MassHealth Standard.

(1) Covered Services. The following services are covered for MassHealth Standard members (see 130 CMR 505.002 and 130 CMR 519.002).

(a) abortion services;
(b) acute inpatient hospital services;
(c) adult day health services;
(d) adult foster care services;
(e) ambulance services;
(f) ambulatory surgery services;
(g) audiologist services;
(h) behavioral health (mental health and substance abuse) services;
(i) Chapter 766: home assessments and participation in team meetings;
(j) chiropractor services;
(k) chronic disease and rehabilitation inpatient hospital services;
(l) community health center services;
(m) day habilitation services;
(n) dental services;
(o) durable medical equipment and supplies;
(p) early intervention services;
(q) family planning services;
(r) hearing aid services;
(s) home health services;
(t) hospice services;
(u) laboratory services;
(v) nurse midwife services;
(w) nurse practitioner services;
(x) nursing facility services;
(y) orthotic services;
(z) outpatient hospital services;
(aa) oxygen and respiratory therapy equipment;
(bb) personal care services;

(cc) pharmacy services;
(dd) physician services;
(ee) podiatrist services;
(ff) private duty nursing services;
(gg) prosthetic services;
(hh) rehabilitation services;
(ii) renal dialysis services;
(jj) speech and hearing services;
(kk) therapy services: physical, occupational, and speech/language;
(ll) transportation services;
(mm) vision care; and
(nn) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Standard members must enroll with a MassHealth managed care provider unless excluded from participation in managed care (see 130 CMR 450.117 et seq. and 130 CMR 508.000) or during a period of presumptive eligibility. (See 130 CMR 505.002(C)(4).)

(3) Managed Care Organizations. For MassHealth Standard members who are enrolled in a MassHealth MCO:

(a) the Division will not pay a provider other than the MCO for any services that are covered by the Division's contract with the MCO, except for family planning services that were not provided or arranged for by the MCO. It is the responsibility of the provider to verify the scope of services covered by the Division's contract with the MCO.

(b) the Division will pay providers other than the MCO for those services listed in 130 CMR 450.105(A)(1) that are not covered by the Division's contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Limitations on Behavioral Health Services.

(a) MassHealth Standard members enrolled in the PCC Plan may receive behavioral health services only through the Division's behavioral health contractor. (See 130 CMR 450.124 et seq.)

(b) MassHealth Standard members enrolled in an MCO may receive behavioral health services only through the MCO. (See 130 CMR 450.117 et seq.)

(c) MassHealth Standard members who are excluded from participating in managed care under 130 CMR 508.004 or who have not yet been enrolled with the Division's behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services.

(5) Purchase of Health Insurance. The Division may purchase third-party health insurance for any MassHealth Standard member if the Division determines such premium payment is cost-effective. Under such circumstances, the Division will reimburse a provider only for those services listed in 130 CMR 450.105(A)(1) that are not available through the member's third-party health insurer.

450.231: Limitations of Payments: Participation of Both Provider and Member

(A) Except to the extent otherwise permitted under these or federal regulations, no provider shall be entitled to any payment or reimbursement under MassHealth unless the provider was a participating provider on the date of service and the person to whom the medical services were provided was a member on the date of service.

(B) The "date of service" is the date on which a medical service is furnished to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers medical goods to a member, which goods had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date prior to the final delivery of the goods, the Division will reimburse the provider for the goods only under the following circumstances:

(1) the member must have been eligible for MassHealth on the date of the member's last visit with the provider before the provider orders or fabricates the goods;
(2) the date on which the provider orders or fabricates the goods occurs no later than seven days after the last visit;
(3) the provider submits documentation with the claim to the Division that verifies both the date of the member's last visit that occurred before the provider ordered or fabricated the goods and the date on which the goods were actually ordered or fabricated;
(4) the provider must not accept any payment from the member for the goods; and
(5) the provider must attempt to deliver the goods to the member.

(C) For the purposes of 130 CMR 450.231, a provider who directly services the member and who also produces the goods for delivery to the recipient has "fabricated" an item if he or she has taken the first substantial step necessary to initiate the production process after the conclusion of all necessary member visits.

(D) For payment for services provided prior to a MassHealth eligibility determination, see 130 CMR 450.311. For payment to out-of-state providers furnishing services on an emergency basis, see 130 CMR 450.312 and 42 CFR Part 440.

(E) Payments to QMB-only providers as defined in 130 CMR 450.212(D) for MassHealth Senior Buy-In covered services described in 130 CMR 450.105(D) and MassHealth Standard members covered services described in 130 CMR 450.105(A) may be made upon the Division's receipt of a claim for payment within the time limitations set forth in provisions, regulations, or rules under Title XVIII of the Social Security Act. QMB-only providers are not required to be registered as such with the Division as of the date the medical services were delivered, but are required to sign a QMB-only provider agreement with the Division or become a participating provider in MassHealth prior to receiving payment for such claim.

450.232: Limitations of Payments: Maximum Allowable Amount to In-State Providers

(A) Payment to a Massachusetts institutional provider for any medical services reimbursable under MassHealth shall be in accordance with the payment methodology applicable to the provider, subject to federal payment limitations (see 42 CFR 447.253).

(B) Payment to a Massachusetts noninstitutional provider for any medical services reimbursable under MassHealth shall be in accordance with the applicable payment methodology established by the Massachusetts Division of Health Care Finance and Policy, subject to any limitation in the schedule expressed in terms of the provider's usual or customary fee for that service or any other payment limitation imposed by federal law (see 42 CFR 447.304).

(C) The Division shall make payments on behalf of MassHealth Senior Buy-In members for benefits specified in 130 CMR 450.105(C), subject to the third-party-liability provisions in 130 CMR 450.316 through 450.319.

450.233: Limitations of Payments: Maximum Allowable Amount to Out-of-State Providers

(A) Payment for any medical services reimbursable under MassHealth to an out-of-state institutional provider whose rates are not established by the Massachusetts Division of Health Care Finance and Policy shall be in accordance with the rate schedule applicable to the provider under that state's Medical Assistance Program. The provider must submit satisfactory evidence of such rate, such as a copy of the applicable rate schedule.

(B) Payment to an out-of-state noninstitutional provider for any medical services reimbursable under MassHealth shall be in accordance with the applicable fee schedule established by the Division of Health Care Finance and Policy, subject to any limitation in the schedule expressed in terms of the provider's usual or customary fee for that service or any other payment limitation imposed by federal law (see 42 CFR 447.304).

(C) The Division shall make payments on behalf of MassHealth Senior Buy-In members for covered services specified in 130 CMR 450.105(C) and certain MassHealth Standard members for covered services specified in 130 CMR 450.105(A), subject to the third-party-liability provisions in 130 CMR 450.316 through 450.319.

450.234: The Participant

As used in 130 CMR 450.235 through 450.249, the term "participant" includes former participating providers.

450.235: Overpayments: Definition

Overpayments include, but are not limited to, payments to a participant:

(A) for services that were not actually furnished or that were furnished to a person who was not a member on the date of service;

The following services are payable in addition to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) periodic visit when they are performed and interpreted in the office of the provider who furnished the visit.

Service Code	Service Description
	LABORATORY SERVICES
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81002	non-automated, without microscopy
82232	Beta-2 microglobulin
82465	Cholesterol, serum, total
83655	Lead
84202	Protoporphyrin, RBC; quantitative
84478	Triglycerides
84702	Gonadotropin, chorionic (hCG); quantitative
84703	qualitative
85014	Blood count; other than spun hematocrit
85018	hemoglobin
85660	Sickling of RBC, reduction
86256	Fluorescent noninfectious agent antibody; titer, each antibody
86592	Syphilis test; qualitative (e.g., VDRL, RPR, ART)
87081	Culture, bacterial, screening only, for single organisms
87110	Culture, Chlamydia
87210	Smear, primary source, with interpretation; wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
	AUDIOLOGIC FUNCTION TESTS WITH MEDICAL DIAGNOSTIC EVALUATION
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
	VISION SERVICES
99173	Screening test of visual acuity, quantitative, bilateral (use for titmus vision test)

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