



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-125
January 2004

TO: All Providers Participating in MassHealth
FROM: Beth Waldman, Acting Commissioner *Beth Waldman*
RE: *All Provider Manuals* (Changes to MassHealth Copayment Policy)

This letter transmits revisions to the administrative and billing regulations about copayments. Effective February 1, 2004, MassHealth has changed the copayment amount from \$2 for all drugs, to \$1 for generic drugs and nonlegend (over-the-counter) drugs, and \$3 for all other drugs. MassHealth has also established a copayment of \$3 for nonpsychiatric acute inpatient hospital stays. This copayment is in addition to the existing MassHealth hospital copayment of \$3 for nonemergency use of a hospital emergency department. MassHealth collects copayments from the provider by deducting the amount of the copayment from the MassHealth payment to the provider.

In addition, MassHealth has established calendar-year copayment caps of \$200 for pharmacy services and \$36 for nonpharmacy services. These caps are the maximum amounts that a member can be charged in copayments within a calendar year. Since this new policy is effective February 1, 2004, MassHealth has adjusted these caps for calendar year 2004 to \$184 for pharmacy services and \$33 for nonpharmacy services.

The information in this transmittal letter primarily affects pharmacies and acute hospitals participating in MassHealth. All providers, however, should be aware of these copayments, especially when prescribing drugs or referring MassHealth members for services in an acute inpatient hospital setting or a hospital emergency department.

Individuals Excluded from the MassHealth Copayment Requirement

The following individuals cannot be charged a copayment:

- members under 19 years of age;
- members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15, she is exempt from the copayment requirement until August 1);
- MassHealth Limited members;
- MassHealth Senior Buy-In members or MassHealth Standard members for Medicare-covered drugs only, when provided by a Medicare-certified provider;
- members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded, or who are admitted to a hospital from such a facility;
- members receiving hospice services; and persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106, if they do not receive MassHealth Basic, MassHealth Essential, or MassHealth Standard.

Additional Exclusions for MassHealth Copayment for Pharmacy Services

There is no MassHealth pharmacy copayment for:

- family-planning services and supplies;
- members who have reached their pharmacy copayment cap—meaning those members who pay and/or incur charges for MassHealth pharmacy copayments totaling \$184 in calendar year 2004 (\$200 in succeeding years);
- members who are inpatients in hospitals (There is no separate copayment for pharmacy services provided as part of a hospital stay.); and
- emergency services.

Additional Exclusions for Nonpharmacy Services

There is no MassHealth nonpharmacy copayment for:

- family-planning services and supplies;
- hospital services provided to members who have other comprehensive medical insurance, including Medicare;
- members who have reached their nonpharmacy copayment cap—meaning those members who pay and/or incur charges for MassHealth no-pharmacy copayments totaling \$33 in calendar year 2004 (or \$36 in succeeding calendar years);
- mental health and substance abuse-related services; and
- emergency services.

Determining if a Member Needs to Pay a MassHealth Copayment

A member may not know if he or she has met an annual cap or does not otherwise need to pay a MassHealth copayment. The Recipient Eligibility Verification System (REVS) will usually indicate if a member is excluded from the copayment, except if the member is pregnant or in the postpartum period described on page 1 of this letter. The Pharmacy On-line Processing System (POPS) identifies if any copayment amount is due on each claim. REVS will indicate if the member has met the calendar-year cap for nonpharmacy services and pharmacy services, respectively, based on information available to MassHealth through claims.

Collecting Copayments from the Member

It is the provider's responsibility to collect the copayment from the member, if a copayment is due.

Providers must give members who pay a copayment a receipt. If a copayment is due, but the member does not pay it at the time of service, the member remains responsible for the copayment, and the provider may bill the member for the copayment. However, providers may not refuse to provide a covered service to a MassHealth member who is unable to pay the copayment at the time of service.

Copayment Cap Letter

When a member reaches either copayment cap for the calendar year, MassHealth sends the member a letter stating that the particular copayment cap has been met. If the member is enrolled with a MassHealth managed care organization (MCO), the MCO sends the letter to the member. The member may use this letter as proof of having met the copayment cap. When a member presents such a letter, the provider should not charge the member a copayment. If the copayment is for a pharmacy service, and POPS shows that there is a copayment due, the pharmacist should call the ACS Hotline at 1-866-246-8503 and fax the letter to ACS at 1-866-556-9314 to ensure that the copayment is properly applied.

Self-Declaration of Exclusion from Copayment Requirement

Because of the time required for claims processing and data-sharing, it is possible for a member to have met a copayment cap or otherwise be excluded from the copayment requirement, and not be identified as such on REVS or POPS.

Providers may not charge a copayment at the time of service to a member who states that he or she has met one of the exclusions from the copayment requirement. If the provider does not charge the member a copayment and later discovers that the member was not excluded from the copayment requirement, the provider may bill the member for the unpaid copayment.

Claims That Are Reduced by the Amount of the Copayment

When a service requiring a MassHealth copayment is provided to a member who is subject to the copayment requirement, MassHealth will reduce the payment for the service by the amount of the required copayment. The following claims will be reduced by the amount of the required copayment:

- pharmacy claims for covered drugs;
- acute inpatient hospital claims for nonpsychiatric acute inpatient hospital stays with Value Code X1 (standard payment amount per discharge); and
- acute outpatient hospital claims with HCPCS code and modifier T1023-U1 (emergency department screening).

If a copayment is not due because the member is exempt, the service is exempt, or the member has met his or her copayment cap, MassHealth will not deduct the amount of the copayment from the MassHealth payment to the provider.

Correcting the Deduction of a Copayment Amount from a Claim

If a **pharmacy** provider believes that a copayment was incorrectly deducted from a claim, the provider can void and replace the claim on POPS. (See "Copayment Cap Letter" on page 2 of this letter.)

If a **hospital** believes that a copayment was incorrectly deducted from a claim, the hospital may submit an adjustment claim. For a hospital claim where a copayment was deducted for a pregnant member, the hospital can adjust the claim by ensuring that a pregnancy diagnosis code is indicated on the claim and submitting an adjusted claim.

If a hospital believes that a copayment was incorrectly deducted from a claim for a reason other than pregnancy, the hospital can submit the adjusted claim to the address below with a written explanation.

MassHealth Operations
Claims Operations
Attn: Copayments
600 Washington Street
Boston, MA 02111

Incorrectly Collected Copayment

A provider must reimburse the copayment to a member who has paid the provider a copayment, but who is exempt, has reached his or her calendar-year cap, or has been charged a copayment for an excluded service. Providers must keep all records necessary to determine if a copayment was collected from a member for a service on a specific date.

Special Rules for Members Enrolled in a MassHealth MCO

MassHealth members enrolled with an MCO must make copayments in accordance with the MassHealth copayment policy. These MassHealth MCO copayments exclude the same persons and services as the fee-for-service MassHealth copayment requirements, and cannot exceed the amounts charged to Primary Care Clinician (PCC) and fee-for-service MassHealth members.

Poster

Pursuant to 130 CMR 450.130(F), pharmacies and hospitals must post in a conspicuous area a notice that specifies the exclusions from the MassHealth copayment requirement. MassHealth has developed a sample notice that providers may download from www.mass.gov/dma.

Questions

Nonpharmacy MassHealth providers may call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231 with any questions about the information in this bulletin. Pharmacy providers may call the ACS Provider Hotline at 1-866-246-8503.

These regulations are effective February 1, 2004.

NEW MATERIAL

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

All Provider Manuals

Pages i, 1-3, 1-4, and 1-23 through 1-26

OBSOLETE MATERIAL

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

All Provider Manuals

Page i — transmitted by Transmittal Letter ALL-118

Pages 1-3, 1-4, and 1-23 through 1-26 — transmitted by Transmittal Letter ALL-113

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MassHealth Enrollment Center (MEC) — a regional office of MassHealth that determines MassHealth eligibility of individuals and families who do not receive cash assistance (TAFDC, EAEDC, SSI).

MassHealth Managed Care Provider — a Primary Care Clinician participating in the Primary Care Clinician Plan or a managed care organization that has contracted with MassHealth to provide and coordinate primary care and certain other medical services to certain MassHealth members.

Medicaid — see “MassHealth.”

Medical Services — medical or related care, including goods and services provided to members, the cost of which is paid or payable by MassHealth.

Medicare — a federally administered health insurance program for persons eligible under the "Health Insurance for the Aged Act," Title XVIII of the Social Security Act (42 U.S.C. 1395-1395pp).

Member — a person determined by MassHealth to be eligible for MassHealth.

Multiple-Source Drug — a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Nonlegend Drug — any drug for which no prescription is required by federal or state law.

Overpayment — a payment made by MassHealth to or for the use of a provider to which the provider was not entitled under applicable federal and state laws and regulations.

Party in Interest — a person with an ownership or control interest.

Peer Review — an evaluation of the quality, necessity, and appropriateness of medical services provided by a provider, to determine compliance with professionally recognized standards of health care or compliance with laws, rules, and regulations under which MassHealth is administered.

Primary Care — the provision of coordinated, comprehensive medical services, on both a first-contact and a continuous basis, to members enrolled in managed care. Services include: an initial medical history intake, medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services.

Primary Care Clinician (PCC) Plan — a managed care option administered by MassHealth through which enrolled members receive primary care and certain other medical services.

Provider — an individual, group, facility, agency, institution, organization, or business that furnishes medical services and participates in MassHealth under a provider contract with MassHealth. For purposes of applying 130 CMR 450.235 through 450.240, the term "provider" includes formerly participating providers.

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Provider Contract (also referred to as “Provider Agreement”) — a contract between MassHealth and a contractor for medical services.

Provider Type — a provider classification specifying and limiting the kinds of medical services for which the provider may be paid under MassHealth.

Provider under Common Ownership — two or more providers in which a person or corporation has or had, at any time, an ownership or control interest, whether concurrently, sequentially, or otherwise. See 130 CMR 450.221(A)(9)(a), (b), (c), or (f).

Recipient Eligibility Verification System (REVS) — the member eligibility verification system accessible to providers.

Sanction — an administrative penalty imposed by MassHealth pursuant to M.G.L. c. 118E, § 37 against a provider found to have violated MassHealth laws, regulations, or contract requirements. Sanctions include, but are not limited to, administrative fines, suspension, and termination from participation in MassHealth.

Statutory Prerequisite — any license, certificate, permit, or other requirement imposed by state or federal law or regulation as a precondition to the practice of any profession or to the operation of any business or institution in or by which medical services are provided. Statutory prerequisites include, but are not limited to, licenses required by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health, licenses and certificates issued by the Massachusetts boards of registration, and certificates required by the Massachusetts Department of Public Safety.

Third Party — any individual, entity, or program other than MassHealth that is or may be liable to pay all or part of the costs for medical services.

Transitional Aid to Families with Dependent Children (TAFDC) — a federally funded program administered by the Massachusetts Department of Transitional Assistance that provides cash assistance to certain low-income families.

Urgent Care — medical services that are not primary care, and are needed to treat a medical condition that is not an emergency medical condition.

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450.124: Behavioral Health Services

(A) Behavioral Health Contractor. Except as provided in 130 CMR 450.124(B) and (C), all behavioral health (mental health and substance abuse) services will be authorized, provided, and solely paid by MassHealth's behavioral health contractor (the Contractor). Payment for such services will be subject to the terms of the Contractor's provider contracts including, but not limited to, provisions governing service authorization and billing requirements. Any provider seeking a contract with the Contractor should contact the Contractor directly.

(B) Emergency Services. Emergency services may be provided by any provider regardless of whether that provider has entered into an agreement with the Contractor. However, all providers of emergency services (except those provided to exempt members pursuant to 130 CMR 450.124(C)) may claim payment for such services solely from the Contractor and such payment will be subject to the Contractor's billing requirements.

(C) Services to Exempt Members. Services provided to the following MassHealth members are not subject to 130 CMR 450.124:

- (1) members who are enrolled in a MassHealth-contracted MCO; and
- (2) members who are excluded from participating in managed care under 130 CMR 508.004.

(130 CMR 450.125 through 450.129 Reserved)

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450.130: Copayments Required by MassHealth

(A) Copayment Requirement. MassHealth requires its members to make the copayments described in 130 CMR 450.130(B) up to the calendar-year maximum described in 130 CMR 450.130(C), except as excluded in 130 CMR 450.130(D) and (E). Providers may collect copayments only in the amounts and for the services listed in 130 CMR 450.130(B). If the usual and customary fee is less than the copayment amount, the member must pay the amount of the service. Members who are enrolled in MassHealth MCOs must make copayments in accordance with the MCO's MassHealth copayment policy. Those MCO copayment policies must:

- (1) be approved by MassHealth;
- (2) exclude the persons and services listed in 130 CMR 450.130(D) and (E);
- (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 450.130(B); and
- (4) not exceed the calendar-year maximum set forth in 130 CMR 450.130(C). (See also 130 CMR 508.016 through 508.019 and 520.035 through 520.039.)

(B) Services Subject to Copayments. MassHealth members are responsible for making the following copayments unless excluded in 130 CMR 450.130(D) or (E).

- (1) Pharmacy Services. The copayment for pharmacy services is
 - (a) \$1 for each prescription and refill for each generic drug, and nonlegend drug covered by MassHealth; and
 - (b) \$3 for each prescription and refill for all other drugs covered by MassHealth;
- (2) Nonpharmacy Services. The copayment for nonpharmacy services is
 - (a) \$3 for nonemergency services covered by MassHealth provided in a hospital emergency department. (See 130 CMR 450.118 for a discussion of payment for hospital emergency department services for members who are enrolled with a MassHealth managed-care provider.); and
 - (b) \$3 for an acute inpatient hospital stay.

(C) Calendar-Year Maximum. Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B), up to the following calendar-year maximums:

- (1) \$200 for pharmacy services; and
- (2) \$36 for nonpharmacy services.

(D) Excluded Individuals.

- (1) The following individuals do not have to pay the copayments described in 130 CMR 450.130(B):
 - (a) members under 19 years of age;
 - (b) members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15, she is exempt from the copayment requirement until August 1);
 - (c) MassHealth Limited members;
 - (d) MassHealth Senior Buy-In members or MassHealth Standard members for Medicare-covered drugs only, when provided by a Medicare-certified provider;
 - (e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded or who are admitted to a hospital from such a facility or hospital;
 - (f) members receiving hospice services; and

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(g) persons receiving medical services through the EAEDC Program pursuant to 130 CMR 450.106, if they do not receive MassHealth Basic, MassHealth Essential, or MassHealth Standard.

(2) Members who have accumulated copayment charges totaling the calendar-year maximum of \$200 on pharmacy services do not have to pay further MassHealth copayments on pharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for pharmacy services.

(3) Members who have accumulated copayment charges totaling the calendar-year maximum of \$36 on non-pharmacy services do not have to pay further MassHealth copayments on nonpharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for nonpharmacy services.

(4) Members who have other comprehensive medical insurance, including Medicare, do not have to pay MassHealth copayments on nonpharmacy services.

(5) Members who are inpatients in a hospital do not have to pay a separate copayment for pharmacy services provided as part of the hospital stay.

(E) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 450.130(B):

- (1) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
- (2) nonpharmacy behavioral health services; and
- (3) emergency services.

(F) Notice to Members about Exclusions from the Copayment Requirement. Pharmacies and hospitals must post a notice about MassHealth copayments in areas where copayments are collected. The notice must be visible to the public and easily readable and must specify the exclusions from the copayment requirement listed in 130 CMR 450.130(D) and (E), and instruct members to inform providers if members believe they are excluded from the copayment requirement.

(G) Collecting Copayments.

(1) A member must pay the copayment described in 130 CMR 450.130(B) at the time the service is provided unless the member is exempt under 130 CMR 450.130(D) or (E), claims that he or she is exempt from the copayment, or claims that he or she is unable to make the copayment at the time the service is provided. The member's inability to make the copayment at the time service is provided does not eliminate the member's liability for the copayment, and providers may bill the member for the copayment amount.

(2) MassHealth will deduct the amount of the copayment from the amount paid to the provider, whether or not the provider collects the copayment from the member, unless the member or service is exempt according to 130 CMR 450.130(D) or (E). Providers should not deduct the copayment amount from the amount claimed. Providers may not refuse services to any members who are unable to pay the copayment at the time service is provided.

(H) Receipt. The provider must give the member a receipt identifying the provider, service, date of service, member, and amount paid.

(I) Recordkeeping. Providers must keep all records necessary to determine if a copayment was collected from a member for a service on a specific date.

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450.140: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction

(A) Legal Basis.

- (1) In accordance with federal law at 42 U.S.C. § 1396d(a)(4)(b) and (r) and 42 CFR 441.50, MassHealth has established a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for MassHealth Standard members under age 21 years, including those who are parents.
- (2) Any MassHealth provider may deliver EPSDT services. However, in delivering well-child care, providers must follow the EPSDT Medical Protocol and Periodicity Schedule.
- (3) EPSDT screening services include health, vision, dental, hearing, and immunization status screening services.
- (4) The regulations governing the EPSDT program are set forth in 130 CMR 450.140 through 450.149.

(B) Program Objectives. The objectives of the EPSDT program are:

- (1) to provide comprehensive and continuous health care designed to prevent illness and disability;
- (2) to foster early detection and prompt treatment of health problems before they become chronic or cause irreversible damage;
- (3) to create an awareness of the availability and value of preventive well-child care services; and
- (4) to create an awareness of the services available under the EPSDT program, and where and how to obtain those services.

450.141: EPSDT Services: Definitions

EPSDT Medical Protocol and Periodicity Schedule (the Schedule) — a schedule (see Appendix W of all MassHealth provider manuals) developed and periodically updated by MassHealth in consultation with the Massachusetts Chapter of the American Academy of Pediatrics, Massachusetts Department of Public Health, dental professionals, the Massachusetts Health Quality Partners, and other organizations concerned with children's health. The Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Interperiodic Visit — the provision of screening procedures or treatment services at an age other than those indicated on the Schedule. Interperiodic visits may be:

- (1) screenings that are medically necessary to determine the existence of a suspected illness or condition, or a change in or complication of a preexisting condition;
- (2) the provision of the full-range of EPSDT screening services delivered at an age other than one listed on the Schedule to update the member's care according to the Schedule; or
- (3) additional screening services provided to a member whose care is already up-to-date according to the Schedule.

Periodic Visit — the provision of screening procedures appropriate to the member's age and medical history, as prescribed by the Schedule.