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 ALL-149
August 2007

TO: All Providers Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: All Provider Manuals (Revisions to Regulations about Copayments)

This letter transmits changes to the regulations about hospital emergency department copayments. MassHealth has eliminated the copayment on emergency screening that hospitals previously collected when delivering nonemergency services to members in the emergency department.

These regulations are effective for services delivered on or after January 1, 2007.

This change is a result of new requirements enacted in the federal Deficit Reduction Act of 2005, which became effective January 1, 2007. This also affects regulations in the *Chronic Disease and Rehabilitation Outpatient Hospital Manual* and the *Acute Outpatient Hospital Manual.* Similar regulation changes are concurrently being promulgated to reflect this.

Additional changes are included for 130 CMR 450 (see pages 1-3, 1-9, 2-11, and 3-4) with updates and minor edits.

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.)

All Provider Manuals

Pages 1-3, 1-4, 1-9, 1-10, 1-23, 1-24, 2-11, 2-12, 3-3, and 3-4

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(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 1-3 and 1-4 — transmitted by Transmittal Letter ALL-130

Pages 1-9 and 1-10 — transmitted by Transmittal Letter ALL-118

Pages 1-23 and 1-24 — transmitted by Transmittal Letter ALL-147

Pages 2-11, 2-12, 3-3 and 3-4 — transmitted by Transmittal Letter ALL-113

MassHealth Agency — the Executive Office of Health and Human Services in accordance with the provisions of M.G.L. c. 118E.

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 the MassHealth agency 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 the MassHealth agency.

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 the MassHealth agency 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 the MassHealth agency 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 the MassHealth agency 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 the MassHealth agency. For purposes of applying 130 CMR 450.235 through 450.240, the term "provider" includes formerly participating providers.

Provider Contract (also referred to as "Provider Agreement") — a contract between the MassHealth agency 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 the MassHealth agency 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.

(3) Premium Assistance. For adults who meet the eligibility requirements of MassHealth Basic, but who have health insurance, the MassHealth agency pays part or all of the member's health insurance premium. The amount of the payment is based on the MassHealth agency's determination of cost effectiveness. The MassHealth agency does not pay for any other benefits for these members.

(4) Managed Care Organizations. For MassHealth Basic members who are enrolled in MassHealth MCOs, the following rules apply.

(a) The MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency'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 MassHealth agency's contract with the MCO.

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

(5) Behavioral Health Services.

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

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

(C) MassHealth Buy-In.

(1) For a MassHealth Buy-In member who is aged 65 or older or is institutionalized (see 130 CMR 519.011), the MassHealth agency pays all of the member's Medicare Part B premium. The MassHealth agency does not pay for any other benefit for these members.

(2) MassHealth Buy-In members are responsible for payment of copayments, coinsurance, and deductibles. MassHealth Buy-In members are also responsible for payment for any services that are not covered by the member's insurance.

(3) The MassHealth agency does not pay providers directly for any services provided to any MassHealth Buy-In member, and therefore does not issue a MassHealth card to MassHealth Buy-In members.

(4) MassHealth Buy-In members are excluded from participation in any of the MassHealth agency's managed care options pursuant to 130 CMR 508.004.

(D) MassHealth Senior Buy-In.

(1) Covered Services. For MassHealth Senior Buy-In members (see 130 CMR 519.010), the MassHealth agency pays the member's Medicare Part B premiums, and where applicable, Medicare Part A premiums. The MassHealth agency also pays for coinsurance and deductibles under Medicare Parts A and B.

(2) Managed Care Member Participation. MassHealth Senior Buy-In members are excluded from participation in managed care pursuant to 130 CMR 508.004.

(E) MassHealth CommonHealth.

(1) Covered Services. The following services are covered for MassHealth CommonHealth members (see 130 CMR 505.004 and 519.012).

(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.

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 paid solely by the MassHealth agency'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)

450.130: Copayments Required by the MassHealth Agency

(A) Copayment Requirement. The MassHealth agency 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 the MassHealth agency;
(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 $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 drugs covered under Medicare Parts A and B 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;
  (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; and

(D) A Qualified Medicare Beneficiaries (QMB)-only provider is a provider who provides medical services only to those MassHealth members who are MassHealth Senior Buy-In members described in 130 CMR 450.105(D) and certain MassHealth Standard members described in 130 CMR 450.105(A), and submits claims only for the benefits described in 130 CMR 450.105(D). QMB-only providers are subject to all regulations pertaining to providers participating in MassHealth except as provided in 130 CMR 450.212(D)(1) through (3) or as otherwise specified in 130 CMR 450.000.

(1) QMB-only providers may not bill for medical services other than those specified in 130 CMR 507.500(B).

(2) QMB-only providers may bill for providing benefits specified in 130 CMR 519.010(B) whether or not the associated medical services are specified in 130 CMR 400.000 through 499.000.

(3) QMB-only providers may bill only for benefits pertaining to medical services that are payable under Title XVIII of the Social Security Act (Medicare).

(E) All individual practitioners comprising the group and the group practice entity shall be jointly and severally 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.

450.213: Provider Eligibility: Termination of Participation for Ineligibility

When a provider fails or ceases to meet any one or more of the eligibility criteria applicable to such provider, the provider's participation in MassHealth may be terminated, subject to 130 CMR 450.212(B) and 450.216. If such termination is based upon a finding, ruling, decision, order, notification, or statement of any nature (including an agreement with the provider) by any federal, state, or quasi-public board, department (other than the MassHealth agency), or other agency that revokes, voids, suspends, or denies the issuance, renewal, or extension of a license, certificate, or other statement of qualification that constitutes a statutory prerequisite or other eligibility criterion, or that takes any action of the nature set forth in 130 CMR 450.212(A)(6), the correctness or validity of the action taken by the issuing agency will be presumed, the termination will be effective as of the earliest date on which the provider failed or ceased to meet any of such criteria, and the MassHealth agency will not afford a hearing as to the correctness or validity of such action. If such termination is based solely upon a determination of ineligibility by the MassHealth agency, the provider will be afforded notice and an opportunity for hearing in substantially the manner set forth in 130 CMR 450.241 through 450.248, and any termination will be effective as of the date of receipt of notice thereof.

450.214: Provider Eligibility: Suspension of Participation Pursuant to U.S. Department of Health and Human Services Order

When a provider is the subject of a notice by the U.S. Department of Health and Human Services (DHHS) requiring the provider's suspension or the denial, termination, or refusal to renew a provider contract pursuant to §1902(a)(39) (42 U.S.C. 1396a(a)(39)) or any other section of the Social Security Act, the provider's participation in MassHealth will be suspended or its provider contract will be denied, terminated, or not renewed in accordance with the DHHS notice, subject, however, to the provisions of 130 CMR 450.216. The MassHealth agency will not afford a hearing to the provider as to the correctness or validity of the action taken by DHHS.

450.215: Provider Eligibility: Notification of Potential Changes in Eligibility

(A) The provider must notify the MassHealth agency in writing, within 14 days of receipt, of any written communication from an issuing agency that expresses an intention, conditionally or otherwise, to alter, revoke, void, suspend, or deny the issuance, renewal, or extension of any license, certificate, or other statement of qualification that constitutes a provider eligibility criterion, or take any action of the nature set forth in 130 CMR 450.212(A)(6).

(B) The provider must notify the MassHealth agency in writing, within 14 days of sending to an issuing agency, of any communication that expresses an intention or desire to register as an inactive practitioner, resign, surrender, terminate, or substantially modify the conditions of any such license, certificate, or other statement of qualification that constitutes a provider eligibility criterion.

(C) Without limiting the generality of 130 CMR 450.215(A), the provider must notify the MassHealth agency in accordance with 130 CMR 450.215(A) and (B) whenever the provider

(1) has received notice of denial of Medicare or Medicaid certification from the Massachusetts Department of Public Health;
(2) has received notice of a denial of an application for renewal of a license;
(3) has filed application with the Department of Public Health to convert from nursing facility to rest home status;
(4) has received an order to show cause from a board of registration; or
(5) becomes subject to any action of the nature set forth in 130 CMR 450.212(A)(6).

450.216: Provider Eligibility: Limitations on Participation

If termination or suspension of a provider's participation in MassHealth has occurred or is imminent, the MassHealth agency will take such action as may be reasonably necessary or appropriate to prevent or to mitigate injury to members or MassHealth or both, resulting from such termination or suspension. Such action may be taken immediately upon notice to the provider notwithstanding the exercise of such rights as the provider may have to secure administrative or judicial review of the action of the issuing agency, or of the U.S. Department of Health and Human Services, or of the MassHealth agency, or any combination of them. With respect to chronic disease and rehabilitation hospitals and other long-term-care facilities, such action may include an order barring further admissions of members pending final resolution of the issues that prompted such action, or an order that the institution will continue to be paid by the MassHealth agency, for a period specified in the order, for services to members admitted to the facility prior to an order barring new admissions, or prior to such termination. Such action will be reasonably calculated to achieve, so far as possible, the following goals:

(A) protecting the health and safety of members, including present and prospective patients of the provider; and

(B) maximizing federal financial participation in the cost of medical assistance.

450.307: Unacceptable Billing Practices

(A) No provider may claim payment in a way that may result in payment that exceeds the maximum allowable amount payable for such service under the applicable payment method.

(B) Without limiting the generality of 130 CMR 450.307(A), the following billing practices are forbidden:

(1) duplicate billing, which includes the submission of multiple claims for the same service by the same provider or multiple providers;

(2) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more-comprehensive service for which a single rate of payment is established; and

(3) submitting claims under an individual practitioner's provider number for services for which the practitioner is otherwise entitled to compensation.

(130 CMR 450.308 Reserved)

450.309: Time Limitation on Submission of Claims: General Requirements

(A) In accordance with M.G.L. c. 118E, §38, all claims must be received by the MassHealth agency within 90 days from the date of service or the date of the explanation of benefits from another insurer. When a service is provided continuously on consecutive dates, the date from which the 90-day deadline is measured is the latest date of service.

(B) For claims that are not submitted within the 90-day period but that meet one of the exceptions specified below, a provider must request a waiver of the billing deadline (a 90-day waiver) pursuant to the billing instructions provided by the MassHealth agency. The exceptions are as follows:

(1) a medical service was provided to a person who was not a member on the date of service, but was later enrolled as a member for a period that includes the date of service; and

(2) a medical service was provided to a member who failed to inform the provider in a timely fashion of the member's eligibility for MassHealth.

(C) When a medical service was provided to a MassHealth member in another state by a provider that is not enrolled in MassHealth, the MassHealth agency will consider a claim for such service to have been timely submitted if all of the following apply:

(1) the medical service was provided in accordance with 130 CMR 450.109;

(2) the provider submits an application to the MassHealth agency to become a participating provider within 90 days after the date of service and the MassHealth agency approves the application; and

(3) the provider submits the claim for payment within 90 days after the date of the notice from the MassHealth agency approving the provider's application.

(130 CMR 450.310 through 450.312 Reserved)