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-176
December 2009

TO: All Providers Participating in MassHealth

FROM: Terence G. Dougherty, Interim Medicaid Director

RE: All Provider Manuals (Dental Benefits for Certain MassHealth Members)

MassHealth has revised the regulations about benefits for certain members of MassHealth Family Assistance.

Dental services, as described in 130 CMR 420.000, are available to children eligible for Family Assistance premium assistance payments.

These emergency regulations are effective retroactive to October 1, 2009.

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 1-1, 1-2, and 1-11 through 1-18

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 1-1, 1-2, 1-17, and 1-18 — transmitted by Transmittal Letter ALL-122

Pages 1-11 and 1-12 — transmitted by Transmittal Letter ALL-170

Pages 1-13 and 1-14 — transmitted by Transmittal Letter ALL-171

Pages 1-15 and 1-16 — transmitted by Transmittal Letter ALL-132

450.101: Definitions

A number of common words and expressions are specifically defined here. Whenever one of them is used in 130 CMR 450.000, or in a provider contract, it will have the meaning given in the definition, unless the context clearly requires a different meaning. When appropriate, definitions may include a reference to federal and state laws and regulations.

Administrative Action — a measure taken by the MassHealth agency to correct or prevent the recurrence of an unacceptable course of action by a provider, including but not limited to the imposition of an administrative fine or other sanction.

Applicant — A person who completes and submits an application for MassHealth, and is awaiting the decision of eligibility.

Audit — an examination by the MassHealth agency of a provider's practices by means of an on-site visit, a review of the MassHealth agency's claim and payment records, a review of a provider's financial, medical, and other records such as prior authorizations, invoices, and cost reports. The MassHealth agency conducts audits to ensure provider and member compliance with laws and regulations governing MassHealth.

Billing Agent — an entity that contracts with a provider to act as the provider's representative for the preparation and submission of claims.

Claim — a request by a provider for payment for a medical service or product, identified in a format approved by the MassHealth agency, that contains information including member information, date of service, and description of service provided.

Commissioner — the commissioner of the Division of Medical Assistance appointed pursuant to M.G.L. c. 118E, § 2.

Coverage Type — a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria.

Day — a calendar day unless a business day is specified.

DHCFP – the Massachusetts Division of Health Care Finance and Policy.

Division — the Massachusetts Division of Medical Assistance organized under M.G.L. c. 118E, or its agent.

Eligibility Verification System (EVS) — the member eligibility verification system accessible to providers. EVS also may be referred to as the Recipient Eligibility Verification System (REVS).

Emergency Aid to the Elderly, Disabled and Children Program (EAEDC) — a cash assistance program administered by the Department of Transitional Assistance for certain residents of Massachusetts that also covers certain medical services. The medical services component of the program is administered by the MassHealth agency.

Emergency Medical Condition — a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Emergency Services — medical services that are provided by a provider that is qualified to provide such services, and are needed to evaluate or stabilize an emergency medical condition.

Final Disposition — a written response by a health insurer to a request for payment, such as a rejection notice, an explanation of benefits (EOB), or a similar letter or form, by which the insurer either denies coverage, or acknowledges coverage and indicates the amount that the health insurer will pay.

Group Practice —a legal entity that employs or contracts with individual practitioners who have arranged for the joint use of facilities, and for payment into a common account of proceeds from the delivery of medical services by individual practitioners within the group. A sole proprietorship is not a group practice. An entity that qualifies under the MassHealth agency's program regulations as another discreet provider type, such as a community health center, is not a group practice. A "participant" in a group practice is any owner, employee, contractor, or provider delivering services through the group practice.

Health Insurer — a private or public entity (including Medicare) that has issued a health insurance plan or policy under which it has agreed to pay for medical services provided to a member.

Individual Practitioners — physicians, dentists, psychologists, nurse practitioners, nurse midwives, and certain other licensed, registered, or certified medical practitioners.

Managed Care — a system of primary care and other medical services that are provided and coordinated by a MassHealth managed care provider in accordance with the provisions of 130 CMR 450.117 et seq. and 130 CMR 508.000.

Managed Care Organization (MCO) — any entity with which the MassHealth agency contracts to provide and coordinate care and certain other medical services to members on a capitated basis, including a senior care organization or an entity that is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), or that otherwise meets the State Plan definition of an HMO.

MassHealth — the medical assistance and benefit programs administered by the MassHealth agency pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

(2) Managed Care Member Participation.

(a) MassHealth CommonHealth members have the option of participating in managed care through MassHealth unless excluded pursuant to 130 CMR 508.004. For CommonHealth members who choose to participate in managed care, the provisions of 130 CMR 450.105(A)(3) and (4) apply.

(b) MassHealth CommonHealth members who are under the age of 21 and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(A) must enroll with the MassHealth behavioral-health contractor.

(c) MassHealth CommonHealth members who are under the age of 21 and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(I) through (L) may choose to enroll with the MassHealth behavioral-health contractor.

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

(F) MassHealth Prenatal.

(1) Covered Services. For MassHealth Prenatal members (see 130 CMR 505.003), the MassHealth agency pays only for ambulatory prenatal care provided by a MassHealth provider.

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

(G) MassHealth Limited.

(1) Covered Services. For MassHealth Limited members (see 130 CMR 505.008 and 519.009), the MassHealth agency pays only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in

(a) placing the member's health in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(2) Organ Transplants. Pursuant to 42 U.S.C. 1396b(v)(2), the MassHealth agency does not pay for an organ-transplant procedure, or for care and services related to that procedure, for MassHealth Limited members, regardless of whether such procedure would otherwise meet the requirements of 130 CMR 450.105(G)(1).

(3) Managed Care Member Participation. MassHealth Limited members are excluded from participation in managed care pursuant to 130 CMR 508.004.

(H) MassHealth Family Assistance.

(1) Premium Assistance. The MassHealth agency provides benefits for MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B), (C), or (D).

(a) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B)(4) and (C), the only benefit the MassHealth agency provides is partial payment of the member's employer-sponsored health insurance, except as provided in 130 CMR 450.105(H)(1)(b) and (H)(2).

(b) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B)(4), the MassHealth agency provides dental services as described in 130 CMR 420.000.

(c) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(D), the MassHealth agency issues a MassHealth card and provides

(i) full payment of the member's private health-insurance premium; and

(ii) coverage of any services listed in 130 CMR 450.105(H)(3) not covered by the member's private health insurance. Coverage includes payment of copayments, coinsurance, and deductibles required by the member's private health insurance.

(2) Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance.

(a) For children who meet the requirements of 130 CMR 505.005(B)(6), the MassHealth agency pays providers directly, or reimburses the member, for

(i) copayments, coinsurance, and deductibles relating to well-baby and well-child care; and

(ii) copayments, coinsurance, and deductibles for services covered under the member's employer-sponsored health insurance once the member's family has incurred and paid copayments, coinsurance, and deductibles for eligible members that equal or exceed five percent of the family group's annual gross income.

(b) Providers should check the Eligibility Verification System (EVS) to determine whether the MassHealth agency will pay a provider directly for a copayment, coinsurance, or deductible for a specific MassHealth Family Assistance member.

(3) Covered Services for Members Who Are Not Receiving Premium Assistance. For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B)(3), (E), (F), or (G), the following services are covered:

(a) abortion services;
(b) acute inpatient hospital services;
(c) ambulance services (emergency only);
(d) ambulatory surgery services;
(e) audiologist services;
(f) behavioral-health (mental health and substance abuse) services;
(g) Chapter 766: home assessments and participation in team meetings;
(h) chiropractor services;
(i) chronic disease and rehabilitation inpatient hospital services;
(j) community health center services;
(k) dental services;
(l) durable medical equipment and supplies;
(m) early intervention services;
(n) family planning services;
(o) hearing aid services;
(p) home health services;
(q) hospice services;
(r) laboratory services;
(s) nurse midwife services;
(t) nurse practitioner services;

(u) orthotic services;
(v) outpatient hospital services;
(w) oxygen and respiratory therapy equipment;
(x) pharmacy services;
(y) physician services;
(z) podiatrist services;
(aa) prosthetic services;
(bb) rehabilitation services;
(cc) renal dialysis services;
(dd) speech and hearing services;
(ee) therapy services: physical, occupational, and speech/language;
(ff) vision care; and
(gg) X-ray/radiology services.

(4) Managed Care Participation.

(a) MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(E) must enroll with a Primary Care Clinician (PCC) or a MassHealth-contracted managed care organization (MCO) (see 130 CMR 450.117).

(b) MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(F) must enroll with a PCC (see 130 CMR 450.118.)

(5) Managed Care Organizations. For MassHealth Family Assistance members who are enrolled in a MassHealth MCO, 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(H)(3) 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.

(6) Behavioral Health Services.

(a) MassHealth Family Assistance members enrolled in the PCC Plan receive behavioral-health services only through the MassHealth behavioral-health contractor. (See 130 CMR 450.124 et seq.)

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

(c) MassHealth Family Assistance members who are not receiving premium assistance, and have not enrolled in an MCO or been enrolled with the MassHealth behavioral-health contractor may receive behavioral-health services from any participating MassHealth provider of such services.

(I) MassHealth Essential. MassHealth Essential members receive services through either the purchase of medical benefits or premium assistance.

(1) Covered Services. The following services are covered for MassHealth Essential members (see 130 CMR 505.007 and 519.013):

(a) abortion services;
(b) acute inpatient hospital services;

(c) ambulance services (emergency only);
(d) ambulatory surgery services;
(e) behavioral health (mental health and substance abuse) services;
(f) community health center services;
(g) dental services;
(h) durable medical equipment and supplies;
(i) family planning services;
(j) laboratory services;
(k) nurse practitioner services;
(l) outpatient hospital services;
(m) oxygen and respiratory therapy equipment;
(n) pharmacy services;
(o) physician services;
(p) podiatrist services;
(q) prosthetic services;
(r) rehabilitation services (except in inpatient hospital settings);
(s) renal dialysis services;
(t) speech and hearing services;
(u) therapy services: physical, occupational, and speech/language;
(v) vision care services provided by a licensed doctor of optometry, including eye exams and supplementary testing services, but not including the provision or dispensing of ophthalmic materials such as eyeglasses, contact lenses, or other visual aids; and
(w) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Essential members for whom eligibility is determined under 130 CMR 505.007 must enroll with a Primary Care Clinician as described in 130 CMR 450.117(B)(1). These members are eligible to receive services listed in 130 CMR 450.105(I)(1) only after enrolling with a Primary Care Clinician in accordance with 130 CMR 508.002(I)(2), except as described in 130 CMR 505.007(E).

(3) Behavioral Health Services. MassHealth Essential members enrolled in the PCC Plan receive behavioral-health services only through the MassHealth behavioral-health contractor. (See 130 CMR 450.124 et seq.)

(4) Premium Assistance. For adults who meet the eligibility requirements for MassHealth Essential but have health insurance, the MassHealth agency pays part, or all, of the member's health insurance premium. The amount of the payment for premium assistance is based on the MassHealth agency's determination of cost effectiveness. The MassHealth agency does not pay for any other benefits for these members, except as described in 130 CMR 505.007(E). Premium assistance members are excluded from participation in managed care in accordance with 130 CMR 508.004(B).

(J) Children's Medical Security Plan. Children determined to be eligible for the Children's Medical Security Plan (CMSP) receive benefits described in 130 CMR 522.004(G).

450.106: Emergency Aid to the Elderly, Disabled and Children Program

(A) Covered Services. The following services are covered for EAEDC recipients:
(1) physician services specified in 130 CMR 433.000;
(2) community health center services specified in 130 CMR 405.000;

(3) prescription drugs (those drugs that require a prescription under federal or state law) specified in 130 CMR 406.000;
(4) insulins (the only over-the-counter drugs that are covered) and diabetic supplies;
(5) infusion (intravenous) therapy, including chemotherapy, pain management, antibiotics, chelation, and cardiac management;
(6) oxygen and respiratory therapy services specified in 130 CMR 427.000;
(7) substance abuse treatment services as specified in 130 CMR 418.000 if provided in public detoxification and outpatient substance abuse treatment centers; and
(8) diagnostics and testing (such as laboratory, radiology, magnetic resonance imaging, or psychological testing) necessary for the determination or redetermination of eligibility for the EAEDC Program, upon referral from a physician or a community health center.

(B) Responsibilities of Acute Hospitals. Acute outpatient and inpatient hospitals are obligated under M.G.L. c. 118G, §13 to provide medically necessary services to recipients of the EAEDC Program. EAEDC recipients are entitled to receive the services described in 130 CMR 410.000 and 415.000 to the same extent that such services are provided to MassHealth members under M.G.L. c. 118E.

(C) Prior Authorization. Any covered services that require prior authorization in the MassHealth regulations (130 CMR 400.000 through 499.000) require prior authorization for the EAEDC Program.

450.107: Eligible Members and the MassHealth Card

(A) Eligibility Determination. MassHealth eligibility is determined in accordance with 130 CMR 501.000 et seq. Eligibility for the EAEDC Program is determined pursuant to 106 CMR 319.000 through 321.000, 701.000 through 701.600, 705.000 through 705.950, and 706.000 through 706.800.

(B) Eligibility Verification System. The MassHealth agency uses the Eligibility Verification System (EVS) for day-specific eligibility verification, and to communicate a member's MassHealth eligibility, coverage type, managed care status, restrictions, and other insurance information to health-care providers.

(C) MassHealth Card. The MassHealth agency issues a plastic identification card for most MassHealth members. The MassHealth card contains information necessary to access EVS. Members for whom the MassHealth agency pays health insurance premiums only may not have a MassHealth card.

(D) Temporary MassHealth Eligibility Card. When necessary, the MassHealth agency or the Department of Transitional Assistance will issue a temporary MassHealth card to the cardholder for use until a plastic MassHealth card is issued. The temporary MassHealth card shows dates of eligibility, service restrictions, and other insurance information. If a discrepancy occurs between information given on a temporary MassHealth card and by EVS, the information on the temporary card prevails. To be paid for a covered service that was provided based on information given on a temporary card, a provider must produce a copy of the temporary card, and have otherwise met all other prerequisites for payment.

(E) Time-Limited Eligibility. The MassHealth agency may determine certain individuals to be eligible for MassHealth Standard or MassHealth Family Assistance coverage for a limited period of time if, on the basis of preliminary information, the individual appears to meet the applicable requirements. Coverage for members with time-limited eligibility begins 10 days before the date on which the MassHealth agency receives the Medical Benefit Request (MBR). The MassHealth agency may determine time-limited eligibility for

(1) MassHealth Standard or MassHealth Family Assistance for children under age 19; and

(2) MassHealth Family Assistance for persons who claim to have a positive human immunodeficiency virus (HIV) status.

450.108: Selective Contracting

(A) Use of Selective Contracts. The MassHealth agency may provide some services through selective contracts where such contracts are permitted by federal and state law.

(B) Termination of Provider Contracts. The MassHealth agency may terminate, in whole or in part, existing provider contracts where selective contracts are in effect. In the event of any such termination, the MassHealth agency notifies the affected providers in writing, at least 30 days prior to termination. Such termination does not affect payments to providers for services provided prior to the date of termination.

450.109: Out-of-State Services

(A) MassHealth covers services provided in another state to a MassHealth member, subject to all applicable limitations, including service coverage, prior authorization, and provider enrollment, only in the following circumstances:

(1) medical services are needed because of a medical emergency;

(2) medical services are needed and the member's health would be endangered if the member were required to travel to Massachusetts; or

(3) it is the general practice for members in a particular locality to use medical resources in another state.

(B) MassHealth does not cover services provided outside the United States and its territories.

(130 CMR 450.110 and 450.111 Reserved)

450.112: Advance Directives

(A) Provider Participation. All hospitals, nursing facilities, MCOs, home health agencies, personal care agencies, hospices, and the MassHealth behavioral-health contractor must

(1) provide to all adults aged 18 or over, who are receiving medical care from the provider, the following written information concerning their rights, which information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change to

(a) make decisions concerning their medical care;

(b) accept or refuse medical or surgical treatment; and

(c) formulate advance directives (for example, living wills or durable powers of attorney for health care, or health-care proxy designations);

(2) provide written information to all adults about the provider's policies concerning implementation of these rights;
(3) document in the patient's medical record whether the patient has executed an advance directive;
(4) not condition the provision of care or otherwise discriminate against a patient based on whether that patient has executed an advance directive;
(5) ensure compliance with requirements of state law concerning advance directives; and
(6) educate staff and the community on advance directives.

(B) When Providers Must Give Written Information to Adults.
(1) A hospital must give written information at the time of the person's admission as an inpatient.
(2) A nursing facility must give information at the time of the person's admission as a resident.
(3) A provider of home health care or personal care services must give information to the person before services are provided.
(4) A hospice program must give information to the person before services are provided.
(5) An MCO must give information at the time the person enrolls or reenrolls with the MCO.

(C) Incapacitated Persons. If a person is admitted to a facility in an incapacitated state and is unable to receive information or articulate whether he or she has executed an advance directive, the facility must include materials about advance directives in the information to the families or to the legal representatives, surrogates, or other concerned persons of the incapacitated patient to the extent it does so in accordance with state law. This does not relieve the facility of its obligation to provide this information to the patient once the patient is no longer incapacitated.

(D) Previously Executed Advance Directives. When the patient or a relative, surrogate, or other concerned or related person presents the provider with a copy of the person's advance directive, the provider must comply with the advance directive, including recognition of the power of attorney, to the extent allowed under state law. Unless contrary to state law, if no one comes forward with a previously executed advance directive and the patient is incapacitated or otherwise unable to receive information or articulate whether he or she has executed an advance directive, the provider must note in the medical record that the person was not able to receive information and was unable to communicate whether an advance directive existed.

(E) Religious Objections. No private provider will be required to implement an advance directive if such action is contrary to the formally adopted policy of such provider that is expressly based on religious beliefs, provided
(1) the provider has informed the person or, if the person is incapacitated at the time of admission and unable to receive information due to the incapacitated condition or mental disorder, the person’s family or surrogate, of such policy prior to or upon admission, if reasonably possible; and
(2) the person is transferred to another equivalent facility that is reasonably accessible to the person's family and willing to honor the advance directive. If the provider or the health care agent is unable to arrange such a transfer, the provider must seek judicial guidance or honor the advance directive.

(130 CMR 450.113 through 450.116 Reserved)

450.117: Managed Care Participation

(A) MassHealth members are required to participate in managed care unless they are excluded from such participation under 130 CMR 508.004.

(1) Members who participate in managed care must enroll with either a Primary Care Clinician (PCC) or a MassHealth-contracted managed care organization (MCO).

(2) MassHealth Family Assistance members described in 130 CMR 450.105(H)(4)(b) can enroll only with a PCC.

(3) MassHealth Essential members described in 130 CMR 450.105(I)(2) can enroll only with a Primary Care Clinician.

(4) Members excluded from managed care under 130 CMR 508.004 receive those MassHealth services for which they are eligible through any participating MassHealth provider.

(B) MassHealth managed care options provide for the management of medical care, including primary care, behavioral-health services, and other medical services.

(1) Members who enroll with a PCC obtain primary care through the PCC, and behavioral-health services through the MassHealth behavioral-health contractor.

(2) Members who enroll with an MCO obtain all medical services, including behavioral health services, through the MCO, except those services not covered under the MassHealth contract with the MCO.

(C) Members who participate in managed care are identified on EVS (see 130 CMR 450.107). For members enrolled with a MassHealth managed care provider, this system will give the name and telephone number of the managed care provider (the PCC, the MCO, and the behavioral-health contractor, as applicable). The conditions under which the MassHealth agency pays other providers for services provided to MassHealth members enrolled with a MassHealth managed care provider are limited to those described in 130 CMR 450.105 and 450.118.

(D) MassHealth managed care options include a senior care organization for MassHealth Standard members aged 65 and over, who voluntarily enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008.

(1) Members who participate in a senior care organization must select a primary care physician.

(2) Members who participate in a senior care organization obtain all covered services through the senior care organization.

(3) Members who are enrolled in a senior care organization are identified on EVS (see 130 CMR 450.107). For a MassHealth member enrolled with a senior care organization, EVS will identify the name and telephone number of the senior care organization. The MassHealth agency will not pay a provider other than a senior care organization for any services that are provided to the MassHealth member while the member is enrolled in a senior care organization.