Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-182
November 2010

TO: All Providers Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director

RE: *All Provider Manuals* (Elimination of PCC Referral Requirement for Certain Services)

This letter transmits amendments to the administrative and billing regulations governing the Primary Care Clinician (PCC) Plan. MassHealth has added the following services to the list of services that do not require PCC referral.

- all items and services described in the durable medical equipment services regulations (130 CMR 409.000);
- annual gynecological exams;
- chiropractor services;
- fiscal intermediary services as described in 130 CMR 422.419(B);
- fluoride varnish administered by a physician or other qualified medical professional;
- functional skills training provided by a MassHealth personal care management agency as described in 130 CMR 422.421(B);
- hearing instrument specialist services;
- medical nutrition therapy/diabetes self-management training;
- orthotics services;
- oxygen and respiratory therapy equipment;
- prosthetic services;
- radiology and other imaging services with the exception of magnetic resonance imaging (MRI), computed tomography (CT) scans, and positron emission tomography (PET) scans;
- services provided by limited service clinics; and
- tobacco cessation counseling services.

See the full list of services that do not require PCC referral at 130 CMR 450.118(J)(5).

These regulations are effective December 1, 2010.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Questions

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 1-21 through 1-24

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 1-21 and 1-22 — transmitted by Transmittal Letter ALL-122

Pages 1-23 and 1-24 — transmitted by Transmittal Letter ALL-179

(J) Referral for Services.

(1) Referral Requirement. All services provided by a clinician or provider other than the PCC Plan member's PCC require referral from the member's PCC in order to be payable, unless the service is exempted under 130 CMR 450.118(J)(5). This referral requirement also applies to services delivered by individual practitioners who are part of a group practice PCC and who have not been identified by the group practice as providers who may be assigned PCC Plan members under 130 CMR 450.118(E). In order to make a referral, PCCs must follow the processes described in the PCC provider contract.

(2) Time Frames for Referral. Whenever possible, the PCC should make the referral before the member's receipt of the service. However, the PCC may issue a referral retroactively if the PCC determines that the service was medically necessary at the time of receipt.

(3) Payment for Services Requiring Referral. The MassHealth agency pays a provider other than the member's PCC for services that require a PCC referral only when a referral has been submitted by the member's PCC.

(4) Services Requiring Referrals. See 130 CMR 450.105 for a list of the services covered for each MassHealth coverage type and applicable program regulations for descriptions of covered services and specific service limitations. Prior-authorization requirements are described in 130 CMR 450.303, 450.144(A)(2), and applicable program regulations and subregulatory publications. Payment for services is subject to all conditions and restrictions of MassHealth, including but not limited to, the scope of covered services for a member's coverage type, service limitations, and prior-authorization requirements.

(5) Exceptions to Services Requiring Referrals. Notwithstanding 130 CMR 450.118(J)(4), the following services provided by a clinician or other provider other than the member's PCC do not require a referral from the member's PCC in order to be payable:

(a) abortion services;
(b) annual gynecological exams;
(c) chiropractor services;
(d) clinical laboratory services;
(e) diabetic supplies;
(f) durable medical equipment (items, supplies, and equipment) described in the durable medical equipment regulations at 130 CMR 409.000);
(g) fiscal intermediary services as described in 130 CMR 422.419(B);
(h) fluoride varnish administered by a physician or other qualified medical professional;
(i) functional skills training provided by a MassHealth personal care management agency as described in 130 CMR 422.421(B);
(j) hearing instrument specialist services;
(k) HIV pre- and post-test counseling services;
(l) HIV testing;
(m) hospitalization
  (i) Elective Admissions. All elective admissions are exempt from the PCC referral requirement and are subject to the MassHealth agency's admission screening requirements at 130 CMR 450.208(A). The hospital must notify the member's PCC within 48 hours following an elective admission;
  (ii) Nonelective Admissions. Nonelective admissions are exempt from the PCC referral requirement. The hospital must notify the member's PCC within 48 hours following a nonelective admission;
(n) medical nutrition therapy/diabetes self-management training;
(o) obstetric services for pregnant and postpartum members provided up to to the end of the month in which the 60-day period following the termination of pregnancy ends;
(p) orthotic services;

(q) oxygen and respiratory therapy equipment;
(r) pharmacy services (prescription and over-the-counter drugs);
(s) prosthetic services;
(t) radiology and other imaging services with the exception of magnetic resonance imaging (MRI) computed tomography (CT) scans, and positron emission tomography (PET) scans, which do require a referral;
(u) services delivered by a behavioral health (mental health and substance abuse) provider (including inpatient and outpatient psychiatric services);
(v) services delivered by a dentist;
(w) services delivered by a family planning service provider, for members of childbearing age;
(x) services delivered by a hospice provider;
(y) services delivered by a limited service clinic;
(z) services delivered in a nursing facility;
(aa) services delivered by an anesthesiologist;
(bb) services delivered in an intermediate care facility for the mentally retarded (ICF-MR);
(cc) services delivered to a homeless member outside of the PCC office pursuant to 130 CMR 450.118(K);
(dd) services delivered to diagnose and treat sexually transmitted diseases;
(ee) services delivered to treat an emergency condition;
(ff) services provided under a home- and community-based services waiver;
(gg) sterilization services when performed for family planning services;
(hh) surgical pathology services;
(ii) tobacco-cessation counseling services;
(jj) transportation to covered care; and
(kk) vision care in the following categories (see Subchapter 6 of the *Vision Care Manual*): visual analysis frames, single-vision prescriptions, bifocal prescriptions, and repairs.

(K) Services to Homeless Members. To provide services to homeless members according to 130 CMR 450.118(J)(5)(cc), the provider must furnish written evidence of demonstrated experience in delivering medical care in a nonmedical setting, and request, in writing, designation from the MassHealth agency that the PCC is approved to provide services to homeless members. The MassHealth agency retains the right to approve or disapprove such a request or revoke an approval of such a request at any time.

(L) Recordkeeping and Reporting.

(1) PCC Recordkeeping Requirement. The PCC must document all referrals in the member's medical record by recording the following:
(a) the date of the referral;
(b) the name of the provider to whom the member was referred;
(c) the reason for the referral;
(d) number of visits authorized; and
(e) copies of the reports required by 130 CMR 450.118(L)(2).

(2) Reporting Requirements. The PCC who made the referral must obtain from the provider who furnished the service the results of the referred visit by telephone and in writing whenever legally possible.

(M) Other Program Requirements. Payment for services provided to members enrolled with a MassHealth managed care provider is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(N) PCC Contracts. Providers that are PCCs are bound by and liable for compliance with the terms of the most recent PCC contract issued by the MassHealth agency, including amendments to the contract, as of the effective date specified in the PCC contract or amendment.

(130 CMR 450.119 through 450.123 Reserved)

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 over-the-counter drug covered by MassHealth in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and
(b) $3 for each prescription and refill for all other generic, brand-name, and over-the-counter 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