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

MassHealth
Transmittal Letter ALL-201
June 2013

TO: All Providers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: *All Provider Manuals* (Changes to MassHealth Payment Methods for Out-of-State Acute Hospitals)

This letter transmits amendments to the MassHealth administrative and billing regulations which address certain changes to the payment methods and rates for out-of-state acute hospitals. See 130 CMR 450.233(D). These changes are effective June 20, 2013.

Out-of-State Acute Hospital Rates

Under the amendments, effective June 20, 2013, MassHealth is (i) implementing hospital-specific casemix-adjusted inpatient rates for those out-of-state acute hospitals that MassHealth determines are High MassHealth Volume and Casemix Hospitals (see Section B, below); and (ii) making certain changes to the payment methods for out-of-state acute hospitals that are not High MassHealth Volume and Casemix Hospitals (see Section A, below).

A "High MassHealth Volume and Casemix Hospital" is defined in the amended regulations to mean any out-of-state acute hospital provider that, during the prior federal fiscal year, had (1) at least 150 MassHealth discharges; and (ii) a MassHealth casemix index (CMI) higher than the average in-state acute hospital CMI, both as determined by MassHealth.

A. Changes That Apply to Out-of-State Acute Hospital That Are <u>Not</u> High MassHealth Volume and Casemix Hospitals

The regulatory amendments add an inpatient transfer per diem rate that will be paid to transferring out-of-state acute hospitals for inpatient services if the hospital transfers a MassHealth inpatient to another acute hospital. The transfer per diem rate is capped at the transferring hospital's out-of-state standard payment amount per discharge (SPAD).[1] Out-of-state acute hospitals paid a transfer per diem will not also be paid an out-of-state SPAD. The transfer per diem rate for these out-of-state acute hospitals is equal to the in-state transfer per diem rate that corresponds to the median in-state acute hospital payment amount per discharge in effect on the date of transfer as determined by MassHealth, calculated utilizing the in-state acute hospital transfer per diem rate methodology.

For MassHealth members under the age of 21, the amendments also change the method for paying out-of-state acute hospitals for each acute inpatient day following the first 20 acute days of an admission. The pediatric outlier per diem payment will be equal to 75% of the transfer per diem rate described above for such hospitals.

[1] The payment method for the out-of-state SPAD is not changing for out-of-state acute hospitals that are not High MassHealth Volume and Casemix Hospitals, and continues to equal the median payment amount per discharge in effect for in-state acute hospitals on the date of admission, as determined by MassHealth. The out-of-state SPAD pays for the first 20 days of admission.

Effective June 20, 2013, the amendments also provide that for inpatient or outpatient medical services that MassHealth determines are not available in-state, an out-of-state acute hospital that is not a High MassHealth Volume and Casemix Hospital will be paid the rate of payment established for the medical service under the other state's Medicaid program as determined by MassHealth, or such other rate as MassHealth determines necessary to ensure member access to services. For an inpatient service that MassHealth determines is not available in state, payment to the out-of-state hospital under this method may also include acute hospital outpatient services that MassHealth determines are directly related to the service that is not available in-state. In order to receive payment for these services, the out-of-state acute hospital must submit to MassHealth a complete list of services, and their corresponding charges, that are to be performed, and coordinate the case with clinical staff designated by MassHealth.

B. Changes That Apply to Out-of-State Acute Hospitals That Are High MassHealth Volume and Casemix Hospitals

Effective for admissions (or in the case of per diem payments, dates of service) on or after June 20, 2013, the regulatory amendments provide for hospital-specific casemix-adjusted inpatient rates to those out-of-state acute hospitals that MassHealth determines are High MassHealth Volume and Casemix Hospitals. The hospital-specific out-of-state inpatient SPAD, transfer per diem and pediatric outlier per diem rates for the High MassHealth Volume and Casemix Hospitals are based on MassHealth statewide standards and methods utilized for corresponding in-state acute hospital rates, combined with an estimated casemix based on the hospital's admissions of MassHealth members.

Out-of-state acute hospital rates will be updated each subsequent MassHealth hospital rate year (HRY). The MassHealth HRY is generally in effect from October 1 through September 30 of a given year, and updated rates will be published on the MassHealth website at www.mass.gov/eohhs/gov/laws-regs/ (click on the link to "MassHealth Regulations and Publications" and the link to "Special Notices for Hospitals").

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website 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 2-21 and 2-38

OBSOLETE MATERIAL

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

All Provider Manuals

Page ii — transmitted by Transmittal Letter ALL-177

Page ii-a — transmitted by Transmittal Letter ALL-113

Pages 2-21 and 2-22 — transmitted by Transmittal Letter ALL-194

Pages 2-23 and 2-24 — transmitted by Transmittal Letter ALL-177

Pages 2-25 and 2-26 — transmitted by Transmittal Letter ALL-175

Pages 2-27 through 2-30 — transmitted by Transmittal Letter ALL-192

Pages 2-31 through 2-36 — transmitted by Transmittal Letter ALL-154

2. Administrative Regulations

2. ADMINISTRATIVE REGULATIONS (cont.)

450.232: Rates of Payment to In-State Providers

Payment to all providers is made in accordance with the payment methodology applicable to the provider, subject to federal payment limitations. Without limiting the generality of the foregoing, payment to a Massachusetts in-state noninstitutional provider for any medical services payable under MassHealth is made in accordance with the applicable payment methodology established by DHCFP, or the MassHealth agency, subject to any applicable federal payment limit (see 42 CFR 447.304).

450.233: Rates of Payment to Out-of-State Providers

(A) Except as provided in 130 CMR 450.233(D), payment to an out-of-state institutional provider for any medical service payable under MassHealth is made by the MassHealth agency at the lesser of

(1) the rate of payment established for the medical service under the other state's Medicaid program;
(2) the MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or
(3) the MassHealth rate of payment established for a comparable provider in Massachusetts.

(B) An out-of-state institutional provider, other than an acute hospital, must submit to the MassHealth agency a copy of the applicable rate schedule under its state's Medicaid program.

(C) Except as provided in 130 CMR 450.233(D), payment to an out-of-state noninstitutional provider for any medical service payable under MassHealth is made in accordance with the applicable fee schedule established by DHCFP or the MassHealth agency, subject to any applicable federal payment limit (see 42 CFR 447.304).

(D) Payment to an out-of-state acute hospital provider for any medical service payable under MassHealth is made as follows.

(1) Inpatient Services. Except as provided in 130 CMR 450.233(D)(3), out-of-state acute hospitals are paid for inpatient services as specified in 130 CMR 450.233(D)(1)(a) through (c). For purposes of 130 CMR 450.233(D), a "High MassHealth Volume and Casemix Hospital" means any out-of-state acute hospital provider that, during the prior federal fiscal year, had (1) at least 150 MassHealth discharges; and (2) a MassHealth casemix index (CMI) higher than the average in-state acute hospital CMI, both as determined by the MassHealth agency.

(a) Payment Amount Per Discharge. Out-of-state acute hospitals are paid a standard payment amount per discharge for inpatient services, which covers the first 20 days of an admission ("Out-of-State SPAD").

(i) The Out-of-State SPAD for all out-of-state acute hospitals that are not High MassHealth Volume and Casemix Hospitals is equal to the median payment amount per discharge in effect for in-state acute hospitals on the date of admission as determined by the MassHealth agency.

(ii) The Out-of-State SPAD for each High MassHealth Volume and Casemix Hospital is hospital-specific and is calculated based on the in-state acute hospital methodology, using the in-state statewide average payment amount per discharge and the statewide weighted average capital cost per discharge amount in effect for in-state acute hospitals on the date of admission, which is then adjusted by the average Massachusetts wage area index and the High MassHealth Volume and Casemix Hospital's hospital-specific MassHealth CMI, as determined by the MassHealth agency for the applicable hospital rate year.

(b) Transfer Per Diem. If an out-of-state acute hospital transfers a MassHealth inpatient to another acute hospital, the transferring out-of-state acute hospital is paid for inpatient services provided to that member at a per day transfer per diem rate ("Transfer Per Diem"), which is capped at the transferring hospital's Out-of-State SPAD. Out-of-state acute hospitals that are paid a Transfer Per Diem will not also be paid an Out-of-State SPAD.

(i) The Transfer Per Diem rate for out-of-state acute hospitals that are not High MassHealth Volume and Casemix Hospitals, is equal to the in-state transfer per diem rate that corresponds to the median in-state acute hospital payment amount per discharge in effect on the date of transfer as determined by the MassHealth agency, calculated using the in-state acute hospital transfer per diem rate methodology.

(ii) The Transfer Per Diem rate for each High MassHealth Volume and Casemix Hospital is hospital-specific, and is calculated based on the hospital's Out-of-State SPAD using the same methodology in effect for in-state acute hospitals on the date of transfer.

(c) Pediatric Outlier Per Diem. For members under age 21, out-of-state acute hospitals are paid at the outlier per diem rate for each acute inpatient day following the first 20 days of admission.

(i) The pediatric outlier per diem rate for out-of-state acute hospitals that are not High MassHealth Volume and Casemix Hospitals, is equal to 75% of the hospital's Transfer Per Diem rate described in 130 CMR 450.233(D)(1)(b)(i).

(ii) The pediatric outlier per diem rate for each High MassHealth Volume and Casemix Hospital is equal to 75% of the High MassHealth Volume and Casemix Hospital's Transfer Per Diem rate, described in 130 CMR 450.233(D)(1)(b)(ii).

(2) Outpatient Services. Except as provided in 130 CMR 450.233(D)(3), all out-of-state acute hospital providers are paid for outpatient services at the median payment amount per episode (PAPE) in effect for in-state acute hospitals on the date of service as determined by the MassHealth agency, or in accordance with the applicable fee schedule established by DHCFP, or the MassHealth agency, for services for which in-state acute hospitals are not paid the PAPE.

(3) Services Not Available In-State.

(a) For medical services payable by MassHealth that are not available in-state as determined by the MassHealth agency, an out-of-state acute hospital that is not a High MassHealth Volume and Casemix Hospital will be paid the rate of payment established for the medical service under the other state's Medicaid program (or equivalent) as determined by the MassHealth agency, or such other rate as the MassHealth agency determines necessary to ensure member access to services.

(b) For an inpatient service that is not available in-state, as determined by the MassHealth agency, payment to the out-of-state acute hospital under 130 CMR 450.233(D)(3)(a) will also include acute hospital outpatient services that the MassHealth agency determines are directly related to the service that is not available in-state.

(c) In order to receive payment under 130 CMR 450.233(D)(3), an out-of-state acute hospital provider must

(i) submit to the MassHealth agency a complete list of services that are to be performed, along with their corresponding charges; and

(ii) coordinate the case with clinical staff designated by the MassHealth agency.

(130 CMR 450.234 Reserved)

450.235: Overpayments

Overpayments include, but are not limited to, payments to a provider

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

(B) for services that were not payable under MassHealth on the date of service, including services that were payable only when provided by a different provider type and services that were not medically necessary (as defined in 130 CMR 450.204);

(C) in excess of the maximum amount properly payable for the service provided, to the extent of

such excess; for services for which payment has been or should be received from health insurers, worker's compensation insurers, other third-party payers, or members;

(E) for services for which a provider has failed to make, maintain, or produce such records, prescriptions, and other documentary evidence as required by applicable federal and state laws and regulations and contracts;

(F) for services provided when, as of the date of service, the provider was not a participating provider, or was in any breach or default of the provider contract;

(G) for services billed that result in a duplicate payment; or

(H) in an amount that a federal or state agency (other than the MassHealth agency) has determined to be an overpayment.

450.236: Overpayments: Calculation by Sampling

In any action or administrative proceeding to determine or recover overpayments, the MassHealth agency may ascertain the amount of overpayments by reviewing a representative sample drawn from the total number of claims paid to a provider during a given period and extrapolating the results of the review over the entire period. The MassHealth agency employs statistically valid techniques in establishing the size and distribution of the sample to ensure that it is a valid and representative sample.

450.237: Overpayments: Determination

The existence and amount of overpayment may be determined in an action to recover the overpayment in any court having jurisdiction. The MassHealth agency may also determine the existence and amount of overpayments. The procedures described in 130 CMR 450.236 and 450.237 do not apply to overpayments resulting from rate adjustments, which are governed by methods described in 130 CMR 450.259.

(A) Overpayment Notice. When the MassHealth agency believes that an overpayment has been made, it notifies the provider in writing of the facts upon which the MassHealth agency bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. When the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), the MassHealth agency will so inform the provider. The MassHealth agency may notify the provider by letter, draft audit report, computer printout, or other format.

(B) Timely Reply. To preserve its right to an adjudicatory hearing and judicial review, the provider must reply in writing to the MassHealth agency and such reply must be received by the MassHealth agency within 30 calendar days of the date on the overpayment notice. The reply must specifically identify and address all allegations in the overpayment notice with which the provider disagrees. With the reply, the provider may submit additional data and argument to support its claim for payment and must include any documentary evidence it wants the MassHealth agency to consider. Where the MassHealth agency states in the overpayment notice that the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), a provider may contest only the factual assertion that the federal or state agency made such a determination. The provider may not contest in any proceeding before or against the MassHealth agency the amount or basis for such determination.

(C) Overpayment Determination. The MassHealth agency considers and reviews only information submitted with a timely reply. If, after reviewing the provider's reply, the MassHealth agency determines that the provider has been overpaid, the MassHealth agency will so notify the provider in writing of its final determination, which will state the amount of overpayment that the MassHealth agency will recover from the provider.

(D) Adjudicatory Hearing. If the provider submits a timely reply, the provider may claim an adjudicatory hearing to appeal the MassHealth agency's final determination, in accordance with 130 CMR 450.241 and 450.243.

(E) Consequences of Failure to Submit a Timely Reply. The provider has no right to an adjudicatory hearing if it fails to submit a timely reply. The MassHealth agency will take appropriate action to recover the overpayment.

450.238: Sanctions: General

(A) Introduction. All providers are subject to the rules, regulations, standards, and laws governing MassHealth. The regulations at 130 CMR 450.238 through 450.240 set forth the MassHealth agency's procedures for imposing sanctions for violations of those rules, regulations, standards, and laws. Such sanctions may include, but are not limited to, administrative fines and suspension or termination from participation in MassHealth. The MassHealth agency determines the amount of any fine and may take into account the particular circumstances of the violation. The MassHealth agency may assess an administrative fine whether or not overpayments have been identified based on the same set of facts.

(B) Instances of Violation. Instances of violation include, but are not limited to
(1) billing a member for services that are payable under MassHealth, except copayments as provided in 130 CMR 450.130;
(2) submitting claims under an individual provider's MassHealth provider number for services for which the provider is entitled to payment from an employer or under a contract or other agreement;
(3) billing the MassHealth agency for services provided by someone other than the provider, unless expressly permitted by the applicable regulations;
(4) billing the MassHealth agency before delivery of service, unless permitted by the applicable regulations;
(5) failing to comply with recordkeeping and disclosure requirements;
(6) 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;

(7) failing to return credit balance funds to the MassHealth agency within 60 days of their receipt;
(8) failing to obtain or provide a physician's order, prescription, or referral when required by the applicable regulations;
(9) failing to comply with MassHealth enrollment, licensure, or certification requirements; and
(10) misapplication or misappropriation of personal needs allowance funds.

450.239: Sanctions: Calculation of Administrative Fine

(A) The MassHealth agency may assess an administrative fine not to exceed the greater of
(1) $100 for each instance of violation of the rules, regulations, standards, or laws governing MassHealth;
(2) $100 for each day of violation of the rules, regulations, standards, or laws governing MassHealth; or
(3) three times the payable amount of each claim, in accordance with 130 CMR 450.239.

(B) In determining the amount of any administrative fine, the MassHealth agency considers the following factors.
(1) Nature and Circumstances of the Claim. The MassHealth agency considers the circumstances to be mitigating if the violations were of the same type and occurred within a short period of time; there were only a few such instances; there was no history of similar types of violations; and the total monetary value of these instances was less than $1,000. Conversely, the MassHealth agency considers the circumstances to be aggravating if the violations were of a single type or several types and occurred over a lengthy period of time; there were many such instances; there was a history of similar types of violations; and the total monetary value of these instances was $1,000 or more.
(2) Prior Offenses. The MassHealth agency may consider the circumstances to be aggravating if the provider previously had been held liable for criminal, civil, or administrative sanctions relating to MassHealth.
(3) Financial Condition and Member-Access Considerations. The MassHealth agency considers the circumstances to be mitigating if the imposition of a full penalty will jeopardize the ability of the provider to continue as a health-care provider and if the provider's inability to continue as a health-care provider would result in a demonstrable access problem for members in the provider's geographic region. The provider has the burden of demonstrating such access problem.
(4) Other Factors. The MassHealth agency will consider other mitigating or aggravating circumstances. If there are substantial mitigating circumstances, the MassHealth agency will decrease the administrative fine to be assessed. Conversely, if there are substantial aggravating circumstances, the MassHealth agency will increase the administrative fine to be assessed.

450.240: Sanctions: Determination

(A) Sanction Notice. When the MassHealth agency believes that sanctions should be imposed, the MassHealth agency will notify the provider in writing of the alleged violations and the proposed sanctions. The notice will be sufficiently detailed to reasonably inform the provider of the acts that the MassHealth agency alleges constitute such violations.

(B) Suspension or Termination upon Sanction Notice. If the MassHealth agency seeks to suspend or terminate a provider's participation in MassHealth and finds, on the basis of information it has before it, that a provider's continued participation during the pendency of the administrative process could reasonably be expected to endanger the health, safety, or welfare of its members or compromise the integrity of MassHealth, it may suspend or terminate participation at the same time the sanction notice described in 130 CMR 450.240(A) is sent to the provider. Said suspension or termination will remain in effect until either the MassHealth agency, pursuant to 130 CMR 450.240(D), issues a final determination removing or revising said suspension or termination, or the Medicaid Director, pursuant to 130 CMR 450.248, issues a final agency decision removing or revising said suspension or termination.

(C) Timely Reply. To preserve its right to an adjudicatory hearing and judicial review, the provider must reply in writing to the MassHealth agency and such reply must be received by the MassHealth agency within 30 calendar days of the date on the sanction notice. The reply must specifically identify and address all allegations in the sanction notice with which the provider disagrees and explain any objections to the proposed sanctions. The provider must also include any additional documentary evidence it wants the MassHealth agency to consider.

(D) Sanction Determination. The MassHealth agency will consider and review only information submitted with a timely reply. If, after reviewing the provider's reply, the MassHealth agency determines that sanctions should be imposed because the provider has committed one or more violations of any rule, regulation, standard, or law governing MassHealth, the MassHealth agency will notify the provider in writing of its final determination, which will state any sanctions that the MassHealth agency will impose against the provider.

(E) Adjudicatory Hearing. If the provider submits a timely reply, the provider may claim an adjudicatory hearing to appeal the MassHealth agency's final determination, in accordance with 130 CMR 450.241 and 450.243. The MassHealth agency may amend or supplement the sanction notice at any time before the commencement of an adjudicatory hearing as long as any additional findings have been identified in a notice or amended notice. Once an adjudicatory hearing has commenced, the hearing officer may permit amendment of the sanction determination upon proper motion by the MassHealth agency and will permit amendment, where necessary, to conform the sanction determination to the evidence.

(F) Consequences of Failure to Submit a Timely Reply. The provider has no right to an adjudicatory hearing if it fails to submit a timely reply. The MassHealth agency will take appropriate action to implement the proposed sanctions.

450.241: Hearings: Claim for an Adjudicatory Hearing

A provider may challenge the findings set forth in the MassHealth agency's final determination, issued pursuant to 130 CMR 450.209(C)(3), 450.210(D)(1), 450.237(C), or 450.240(D), by filing a claim for an adjudicatory hearing (claim) with the Board of Hearings and the MassHealth agency within 30 calendar days of the date on the final determination, pursuant to 130 CMR 450.243. A claim is filed on the date actually received by both the Board of Hearings and the MassHealth agency. Failure to file a timely claim will result in implementation of the action identified in the final determination.

450.242: Hearings: Stay of Suspension or Termination

A timely claim will stay any suspension or termination described in the final determination

until there has been a final agency action pursuant to 130 CMR 450.243(D) or 450.248; provided, however, that if the MassHealth agency finds on the basis of information it has before it that a provider's continued participation in MassHealth during the pendency of the administrative appeal could reasonably be expected to endanger the health, safety, or welfare of members or compromise the integrity of MassHealth, suspension or termination will not be stayed. A timely claim will not stay any withholding of payments under 130 CMR 450.249.

450.243: Hearings: Consideration of a Claim for an Adjudicatory Hearing

(A) A timely claim must specifically identify each issue and fact in dispute and state the provider's position, the pertinent facts to be adduced at the hearing, and the reasons supporting that position.

(B) If a matter has been referred to or is under investigation by, the Attorney General's Medicaid Fraud Control Unit or other criminal investigation agency, or if a question of quality of care has been referred to a professional licensing board for investigation, the Board of Hearings, upon notice from the MassHealth agency, will postpone the hearing until the conclusion of such investigation and the final disposition of any criminal complaint, indictment, or order to show cause that ensues, or until the MassHealth agency notifies the Board to schedule the hearing. A provider may not request a postponement of the hearing under 130 CMR 450.243(B).

(C) The Board of Hearings will grant a hearing only if the claimant demonstrates all of the following.

(1) The claim was filed within the time limits set forth in 130 CMR 450.241.
(2) There is a genuine and material issue of adjudicative fact for resolution.
(3) The factual issues can be resolved by available and specifically identified reliable evidence as set forth in M.G.L. c. 30A, §11(2). A hearing will not be granted on the basis of general allegations or denials or general descriptions of positions and contentions.
(4) The allegations of the provider, if established, would be sufficient to resolve a factual dispute in the manner urged by the provider. A hearing will not be granted if the provider's submissions are insufficient to justify the factual determination urged, even if accurate.
(5) Resolution of the factual dispute in the way sought by the provider is relevant to and would support the relief sought.

(D) Failure to comply with the conditions set forth in 130 CMR 450.243(C) will result in dismissal of the claim. Dismissal of a claim is a final agency action reviewable pursuant to M.G.L. c. 30A.

(E) Notwithstanding 130 CMR 450.243(C) and (D), if there is no issue of adjudicative fact, but the provider has challenged the MassHealth agency's interpretation or application of regulations or laws, argument concerning such challenges will be presented in memoranda and briefs.

450.244: Hearings: Authority of the Hearing Officer

The hearing officer does not render a decision about the legality of federal or state laws, including, but not limited to MassHealth regulations. If the legality of such law or regulation is raised by the provider, the hearing officer renders a decision based on the applicable law as interpreted by the MassHealth agency. Such decision includes a statement that the hearing officer cannot rule on the legality of such law or regulation and is subject to judicial review in accordance with M.G.L. c. 30A.

450.245: Hearings: Burden of Proof

The provider has the burden of establishing by a preponderance of the evidence that the provider has complied with the MassHealth requirements cited in the MassHealth agency's final determination or otherwise has correctly received, or is entitled to receive, any amounts in dispute.

450.246: Hearings: Procedure

The hearing is conducted in accordance with M.G.L. c. 30A, §§ 9, 10, and 11, and the formal rules of the Standard Rules of Practice and Procedure found at 801 CMR 1.00, 1.01, and 1.03, as modified or supplemented by 130 CMR 450.000.

450.247: Hearings: Hearing Officer's Decision

The hearing officer's decision is in the form of a proposed decision to the commissioner. The proposed decision may affirm, modify, or overturn the actions proposed in the MassHealth agency's final determination. The proposed decision includes a determination of the amount of overpayments, if overpayments have been alleged, and a statement of reasons for the decision, including determination of each issue of fact or law necessary to the decision. If the provider makes a written request for the proposed decision prior to its issuance, the Board of Hearings notifies the provider by mail of the proposed decision. The decision of the hearing officer is effective when and to the extent it is adopted by the commissioner.

450.248: Commissioner's Decision

If the provider has made a written request for a copy of the proposed decision prior to its issuance, the provider has seven calendar days from its receipt of the proposed decision to file written objections with the commissioner. The commissioner may adopt or modify the proposed decision, or return the matter to the hearing officer for further consideration, based on evidence already in the record or, if necessary, additional evidence to be included in the reopened record. The hearing officer will resubmit the proposed decision to the commissioner, as modified pursuant to 130 CMR 450.247 and 450.248. The provider is notified of the commissioner's action. When the commissioner has adopted or modified the proposed decision, the commissioner's decision is a final agency action reviewable pursuant to M.G.L. c. 30A.

450.249: Withholding of Payments

(A) Introduction. The term "withholding of payments" or "withholding payments" as used in 130 CMR 450.249 means the withholding of all or a portion of payments payable to a provider. While withholding payments, the MassHealth agency continues to process the provider's claims. To avoid rejection of otherwise proper claims because of late submission, a provider whose payments are being withheld must continue to submit timely claims.

(B) Withholding Payments from Providers for Overpayments or Other Violations. Upon written notice to the provider, the MassHealth agency may withhold payments to a provider, or any provider under common ownership (defined the same as "provider under common ownership" in 130 CMR 450.101), if the MassHealth agency believes that the provider has received any overpayments or committed any violations. The notice states the effective date of the withholding, the amount being withheld, and the reason for the withholding. A provider subject to a withhold may submit written evidence for consideration by the MassHealth agency as to why payments in whole or in part should not be withheld. The withholding of payments expires 90 calendar days after the date withholding begins unless the MassHealth agency has sent the provider an overpayment or sanction notice pursuant to 130 CMR 450.237 or 450.240. The withholding of payments continues until the entitlement to the withheld funds and the amount of overpayment or

administrative fines has been finally adjudicated and all due amounts have been recovered.

(C) Withholding Payments for Credible Allegation of Fraud. Upon written notice to the provider, or without notice as provided for under 42 CFR 455.23(b), the MassHealth agency may withhold payments to a provider, or to any provider under common ownership (defined the same as "provider under common ownership" in 130 CMR 450.101), where there is a credible allegation of fraud under 42 CFR 455.23. The notice complies with 42 CFR 455.23(b) and informs the provider of the right to submit written evidence for consideration by the MassHealth agency as to why payments in whole or in part should not be withheld. The withholding of payments continues until such time as any investigation and associated enforcement proceedings are completed, and all due amounts have been recovered. If the Attorney General's Medicaid Fraud Division or other law enforcement agency declines to accept any fraud referral, any payments withheld under 130 CMR 450.249(C) are released and no further payments are withheld, unless within 10 business days of the MassHealth agency receiving such notice from the Attorney General's Medicaid Fraud Division or other law enforcement agency, the MassHealth agency sends written notice to the provider in accordance with 130 CMR 450.249(B) that the MassHealth agency believes that the provider has received any overpayments or committed any violations.

(D) Withholding Payments to Providers Withdrawing from MassHealth.

(1) The MassHealth agency may withhold payments to a provider, or to any providers under common ownership, at any time following receipt by the MassHealth agency of notification of the provider's intention to close or to withdraw from MassHealth. The MassHealth agency may withhold such payments whenever the MassHealth agency reasonably believes that there may be an outstanding issue, claim, or adjustment in connection with or incident to any payment to the provider. Such payment may be withheld regardless of whether the outstanding issue, claim, or adjustment is related to that payment. Circumstances in which there may be an outstanding issue, claim, or adjustment include, without limitation:

(a) an outstanding provider cost report;
(b) an anticipated or pending audit or utilization review;
(c) a rate decrease or other payment adjustment; or
(d) an outstanding or incomplete payment reconciliation.

(2) The MassHealth agency notifies the provider in writing of the date of the withholding, the amount withheld, and the reason for the withholding. The withholding of payments under 130 CMR 450.249(D) continue until the provider's entitlement to the withheld funds, and all outstanding issues, claims, or adjustments in connection with or incident to the payments to the provider, have been finally adjudicated or otherwise finally resolved. During the period the MassHealth agency withholds payments under 130 CMR 450.249(D), the MassHealth agency may recoup or offset all or part of the withheld funds for repayment by the provider of any liability incurred due to a rate decrease, any recoupment account balance owed, or any other debt, liability, or account balance owed by the provider.

(E) Federal Orders to Withhold Payments. If the MassHealth agency receives notice from the U.S. Department of Health and Human Services of an order for suspension of payments to a provider under 42 U.S.C. § 1396m or any other section of the Social Security Act, the MassHealth agency withholds payments otherwise due the provider in accordance with the terms of the notice. The MassHealth agency promptly notifies the provider of such action and the reason for it. The MassHealth agency takes such other action as may be necessary or appropriate to ameliorate the effect of actions taken under 130 CMR 450.249(E) on members and on MassHealth, including action similar to that described in 130 CMR 450.216. The withholding of payments continues until the underlying Department of Health and Human Services order is rescinded, or becomes final and unappealable, at which time apportionment of the withheld amounts between the MassHealth agency and the provider are made.

(F) Continued Provider Participation in the MassHealth Program.

(1) A provider subject to a withhold under 130 CMR 450.249(B),(C), and (E) must continue to provide services to MassHealth members as long as the provider continues to participate in MassHealth. Any provider terminating its participation in MassHealth must do so in accordance with 130 CMR 450.223(D) and such other statutory, regulatory, or contractual requirements as may be applicable to the particular provider or provider type.

(2) Any provider that terminates or otherwise discontinues its business operations will be deemed to be terminating its participation in MassHealth and accordingly must comply with the requirements stated in 130 CMR 450.249(F)(1).

(130 CMR 450.250 through 450.258 Reserved)

450.259: Overpayments Attributable to Rate Adjustments

(A) Whenever an overpayment occurs due to a rate adjustment that is certified by DHCFP or otherwise established by the MassHealth agency in accordance with applicable law, the MassHealth agency notifies the provider in writing by issuing a remittance advice identifying the impact of the rate adjustment on all previously paid claims and stating the amount of the overpayment.

(B) A provider must pay to the MassHealth agency the full amount of any overpayment attributable to a rate adjustment within 30 calendar days after the date of issuance of a remittance advice under 130 CMR 450.259(A), unless the provider enters into a payment arrangement with the MassHealth agency under 130 CMR 450.260(H).

(C) If a provider disputes the MassHealth agency's computation of an overpayment attributable to a rate adjustment, the provider must submit proposed corrections, including a detailed explanation, in writing to the MassHealth agency within 30 calendar days after the date of issuance of the remittance advice under 130 CMR 450.259(A). The fact that any rate adjustment certified by DHCFP is under appeal is not considered a factor in determining the amount of liability. The fact that a provider has submitted proposed corrections to the MassHealth agency does not delay or suspend the provider's payment obligations set forth under 130 CMR 450.259(B).

(D) If proposed corrections are timely submitted in accordance with 130 CMR 450.259(C), the MassHealth agency reviews the proposed corrections and notifies the provider of its decision within 30 calendar days of receipt of the provider's corrections. If the MassHealth agency determines that corrections are required, the MassHealth agency makes any appropriate payment adjustments reflecting the corrections.

(E) A provider must pay the MassHealth agency the full amount of the overpayment stated in a remittance advice under 130 CMR 450.259(A), regardless of any pending appeal, action, or other proceeding contesting the overpayment, including but not limited to, any appeal, action, or other proceeding contesting any rate on which the overpayment is computed. If required by a final disposition of any such appeal, action, or proceeding, the MassHealth agency issues a revised remittance advice and makes any appropriate payment adjustments to effect the final disposition.

450.260: Monies Owed by Providers

(A) Provider Liability. A provider is liable for the prompt payment to the MassHealth agency of the full amount of any overpayments, or other monies owed under 130 CMR 450.000 et seq., or under any other applicable law or regulation. A provider that is a group practice is 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.

(B) Ownership Liability. Any owner of an institutional provider is liable for the monetary liability of the institutional provider under 130 CMR 450.260(A) to the extent of the owner's ownership interest. For purposes of 130 CMR 450.260, an "owner" is a person or entity having an ownership interest in an institutional provider, as such interest is defined in 130 CMR 450.221(A)(9)(a), (b), (c), or (f). An "institutional provider" is any provider that provides nursing facility services, or acute, chronic, or rehabilitation hospital services.

(C) Common Ownership Liability. Any two or more providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or

otherwise, are jointly and severally liable for each of their obligations to pay the full amount of any monies owed under 130 CMR 450.260(A).

(D) Successor Liability. Any successor owner of a provider is liable for the obligation of any prior owner to pay the full amount of any monies owed by the prior owner under 130 CMR 450.260(A). For purposes of 130 CMR 450.260, a "successor owner" is any successor owner, operator, or holder of any right to operate all or a part of the prior owner's health-care business, which includes, but is not limited to, the business management, personnel, physical location, assets, or general business operations. A successor owner of a nursing facility, or acute, chronic, psychiatric, or rehabilitation hospital includes any successor owner or holder of a license to operate all or some of the beds of a nursing facility, or acute, chronic, psychiatric, or rehabilitation hospital.

(E) Group Practice Liability. The individual practitioner who provided the service and the group practice will be jointly and severally liable for each of their obligations to pay the full amount of any monies owed under 130 CMR 450.260.

(F) Recoupment. If a provider fails to pay the full amount of any monies owed under 130 CMR 450.260(A), the Division may recoup up to 100 percent of any and all payments to the provider, without further notice or demand, until such time as the full amount of any monies owed under 130 CMR 450.260(A) is paid in full.

(G) Set-Off. The Division may apply a set-off against payments to a provider in the following circumstances.

(1) Providers Under Common Ownership. Whenever any monies are owed by a provider under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to any providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or otherwise, without further notice or demand, until such time as the full amount of the monies owed under 130 CMR 450.260(A) is repaid in full.

(2) Successors. Upon the sale or transfer of all or part of a provider, the Division may set off up to 100 percent of any and all payments to any successor owner, without further notice or demand, until such time as the full amount of any monies owed by any prior owner under 130 CMR 450.260(A) is repaid in full.

(3) Group Practices. Whenever monies are owed by a group practice under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to the individual practitioner who provided the service, without further notice or demand, until such time as the full amount of any monies owed by the group practice under 130 CMR 450.260(A) is repaid in full. Whenever monies are owed by an individual practitioner who is a member of a group practice under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to the group practice, without further notice or demand, until such time as the full amount of any monies owed by the individual practitioner under 130 CMR 450.260(A) is repaid in full.

(H) Payment Arrangements. At its discretion, the Division may enter into a written arrangement with a provider, its owner, any provider under common ownership, or any successor owner to establish a schedule to pay to the Division the full amount of any monies owed, on such terms as are acceptable to the Division. The arrangement may provide for such guarantees or collateral as may be acceptable to the Division to secure the payment schedule.

(I) Court Action. The Division may recover the full amount of any monies owed to the

Division under 130 CMR 450.260(A) by commencing an action in any court of competent jurisdiction. Such action may be commenced against any parties described under 130 CMR 450.260.

(J) Joint and Several Obligations. All obligations of any parties described under 130 CMR 450.260, are joint and several.

450.261: Member and Provider Fraud

All members and providers must comply with all federal and state laws and regulations prohibiting fraudulent acts and false reporting, specifically including but not limited to 42 U.S.C. 1320a-7b.

(130 CMR 450.262 through 450.270 Reserved)

450.271: Individual Consideration

(A) The Division may identify certain services as requiring individual consideration (I.C.) in program regulations, associated lists of service codes and service descriptions, billing instructions, provider bulletins, and other written issuances from the Division. For services requiring individual consideration, the Division will establish the appropriate amount of payment based on the standards and criteria set forth in 130 CMR 450.271(B). Providers claiming payment for any I.C.-designated service must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that shall minimally include where applicable, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The Division does not pay claims for "I.C." services unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim.

(B) The Division determines the appropriate payment for an I.C. service in accordance with the following standards and criteria:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the member's disease, disorder, or disability;
(4) any applicable relative-value studies; and
(5) any complications or other circumstances that the Division deems relevant.

(130 CMR 450.272 through 450.274 Reserved)

450.275: Teaching Physicians: Documentation Requirements

In order to be paid for physician services provided in a teaching setting, physicians must comply with the following documentation requirements.

(A) Definitions. Whenever one of the following terms is used in 130 CMR 450.275, it will have the meaning given in the definition, unless the context clearly requires a different meaning.

(1) Resident — an individual who participates in an approved Graduate Medical Education (GME) program, including interns and fellows. A medical student is never considered a resident.

(2) Teaching Physician — a physician (not a resident) who involves residents in the care of his or her patients. Where applicable and appropriate, the use of the phrase "teaching physician" will be construed to include teaching podiatrists and teaching dentists.

(3) Teaching Setting — a setting in which there is an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

(B) General Requirements.

(1) Under MassHealth, the Division will pay for physician services (which are otherwise payable) furnished in teaching settings only if documentation in the patient's medical record clearly substantiates that the key portions of the services are personally provided by a teaching physician, or the key portions of the services, which include decision-making processes, are provided jointly by a teaching physician and resident, or by a resident in the presence of a teaching physician. (The teaching physician must determine which portions of the service or procedure are to be considered key and require his or her presence.) Any contribution of a medical student to the performance of a service or procedure must be performed in the physical presence of a teaching physician, or jointly with a resident.

(2) The teaching physician may not bill for the supervision of residents. The Division reimburses for this through its GME reimbursement.

(3) The teaching physician may not bill for services provided solely by residents.

(C) Documentation.

(1) The teaching physician and resident are each responsible for documenting in the medical record his or her own level of involvement in the services. Documentation by the resident alone is not acceptable. In all cases, the teaching physician must personally document his or her presence and participation in the services in the medical record. This documentation by the teaching physician may either be in writing or via a dictated note, and may include references to notes entered by the resident.

(2) If the teaching physician would be repeating key elements of the service components previously documented by the resident (for example, the patient's complete history and physical examination), the teaching physician need not repeat the documentation of these components in detail. In these circumstances, the teaching physician's documentation may be brief, summary comments that reflect the resident's entry and that confirm or revise the key elements identified.

(D) Covered Services. Division pays for medical services (including, but not limited to, evaluation and management services, surgery services, anesthesia services, and radiology services) performed in a teaching setting if the following requirements are met, in addition to the general requirements in 130 CMR 450.275(A) through (C):

(1) Exceptions to Physical-Presence Requirement. For certain services (general/internal medicine, pediatric, obstetric/gynecologic, and psychiatric), the teaching physician does not have to be physically present for the key portions of the service. (Refer to Appendix K of the

Physician Manual for a listing of the service codes for which this exception to the physical presence requirement applies.)

(2) Services Paid on the Basis of Time. For services paid on the basis of time (excluding anesthesia and those psychiatric services listed in Appendix K of the *Physician Manual*), the teaching physician must be present for the period of time for which the claim is made. Time spent by the resident in the absence of the teaching physician may not be added to time spent by the resident and teaching physician with the member, or time spent by the teaching physician alone with the member. For example, the Division will pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is present for 20 to 30 minutes.

(3) Medical Services. For medical services (including, but not limited to, evaluation and management services), the teaching physician may supervise up to four residents at any given time, and he or she must direct the care from such proximity as to constitute immediate physical availability.

(4) Surgery Services. For surgery services, the teaching physician is responsible for the preoperative, intra-operative, and postoperative care of the member. The teaching physician must be scrubbed and physically present during the key portion of the surgical procedure. During the intra-operative period in which the teaching physician is not physically present, he or she must remain immediately available to return to the procedure, if necessary. He or she must not be involved in another procedure from which he or she cannot return. If the teaching physician leaves the operating room after the key portion(s) of the surgical procedure or during the closing of the surgical site to become involved in another surgical procedure, he or she must arrange for another teaching physician to be immediately available to intervene as needed. The designee must be a physician (excluding a resident) who is not involved in or immediately available for any other surgical procedure. The following guidelines apply to specific types of surgery and related services:

(a) Concurrent Surgeries. To be paid for concurrent surgeries, the teaching physician must be present during the key portions of both operations. Therefore, the key portions must not occur simultaneously. When all of the key portions of the first procedure have been completed, the teaching physician may initiate his or her involvement in a second procedure. The teaching physician must personally document the key portions of both procedures in his or her notes to demonstrate that he or she was immediately available to return to either procedure as needed.

(b) Straightforward or Low-complexity Procedures. The teaching physician must be present for the decision-making portions of straightforward or low-complexity procedures.

(c) Endoscopy Procedures. For procedures performed through an endoscope (other than endoscopic operations, when the endoscopy performed is not the key portion of the surgical procedure), the teaching physician must be present during the entire viewing. The entire viewing includes the period of insertion through removal of the device. Viewing of the entire procedure through a monitor in another room does not meet the teaching-physician-presence requirement.

(d) Obstetrics. To be paid for the procedure, the teaching physician must be present for the delivery. In situations in which the teaching physician's only involvement was at the time of delivery, he or she may bill for the delivery only. To be paid for the global procedures, the teaching physician must be physically present, in accordance with the general requirements above and applicable program requirements.

(5) Anesthesia Services. If a teaching anesthesiologist is involved in a procedure with a resident, or with a resident and a non-physician anesthetist, the teaching physician must be present for induction and emergence. For any other portion of the anesthesia service, the

teaching physician must be immediately, physically available to return to the procedure, as needed. The documentation in the medical records must indicate the teaching anesthesiologist's presence and participation in the administration of the anesthesia.

(6) Radiology Services. The interpretation of diagnostic tests must be performed or reviewed by a teaching physician. If the teaching physician's signature is the only signature on the interpretation, this indicates that he or she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed both the image and the resident's interpretation and either agrees with or edits the findings. The teaching physician's countersignature alone is not acceptable documentation.

(130 CMR 450.276 through 450.300 Reserved)

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