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

MassHealth
Transmittal Letter ALL-218
February 2017

TO: All Providers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: *All Provider Manuals* (Updates to MassHealth Out-of-State Acute Outpatient Hospital Payment Method in 130 CMR 450.233(D))

This letter transmits amendments to the MassHealth administrative and billing regulations at 130 CMR 450.233(D) to reflect the new out-of-state acute outpatient hospital adjudicated payment per episode of care (APEC) payment methodology (Out-of-State APEC) that was previously described in All-Provider Bulletin 263. As announced in All-Provider Bulletin 263, the new Out-of-State APEC methodology became effective for dates of service on or after December 30, 2016, in order to generally align the out-of-state acute outpatient hospital payment methodology with the corresponding in-state acute outpatient hospital payment methodology. These regulatory updates incorporate those previously-announced changes, and as with the prior methodology, also provide that MassHealth-covered acute outpatient hospital services that are not paid through the Out-of-State APEC are paid in accordance with the applicable fee schedule established by EOHHS.

There are no changes to the payment methods for out-of-state acute inpatient hospital services or for services not available in state (see 130 CMR 450.233(D)(1) and (D)(3), respectively).

Providers are reminded that updates to out-of-state acute hospital rates and rate components will be published on the MassHealth website at www.mass.gov/masshealth. (Click on the links to Other Resources and Publications then Special Notices for Acute Hospitals.) Providers are encouraged to periodically visit this site for further information. Updates generally occur each MassHealth hospital-rate year (HRY) which is typically in effect from October 1 through September 30 of a given year, although certain updates may also occur during the MassHealth HRY.

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 the MassHealth Customer Service Center 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 Manual

Pages ii, iia, and 2-19 through 2-38

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(The pages listed here are no longer in effect.)

All Provider Manual

Pages ii and 2-19 through 2-22 — transmitted by Transmittal Letter ALL-212

Pages iia, 2-27 through 2-30, and 2-33 through 2-38 — transmitted by Transmittal Letter ALL-201

Pages 2-23, 2-24, 2-31, and 2-32 — transmitted by Transmittal Letter ALL-202

Pages 2-25 and 2-26 — transmitted by Transmittal Letter ALL-212

2. Administrative Regulations

2. Administrative Regulations (cont.)

450.226: Provider Contract: Issuance of Provider Numbers

(A) Upon execution of the provider contract, the Division will issue a provider number or numbers to be used to identify the provider that is the subject of the contract.

(B) For every case in which a provider is assigned two or more provider numbers, the provider must use each provider number only in conjunction with the facility or location to which the number is assigned. The Division, however, maintains its right to commence proceedings in accordance with the provisions of 130 CMR 450.234 through 450.248 against any or all of its provider numbers, regardless of the location or facility where the violation has been alleged to have occurred or the overpayment received.

450.227: Provider Contract: Termination or Disapproval

The Division may at its discretion disapprove a provider contract, and may terminate an existing contract, if the provider fails to disclose any information in accordance with the provisions of 130 CMR 450.222, 130 CMR 450.223, or 42 CFR 420.205.

(130 CMR 450.228 through 450.230 Reserved)

450.231: General Conditions of Payments

(A) Except to the extent otherwise permitted by state or federal regulations, no provider is entitled to any payment from MassHealth unless on the date of service the provider was a participating provider and the person receiving the services was a member.

(B) The "date of service" is the date on which a medical service is provided to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers to a member medical goods that had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date before the final delivery of the goods, the Division will pay the provider for the goods only under the following circumstances:

(1) the member must have been eligible for MassHealth on the date of the member's last visit with the provider before the provider orders or fabricates the goods;
(2) the date on which the provider orders or fabricates the goods occurs no later than seven days after the last visit;
(3) the provider has submitted documentation with the claim to the Division that verifies both the date of the member's last visit that occurred before the provider ordered or fabricated the goods and the date on which the goods were actually ordered or fabricated;
(4) the provider must not have accepted any payment from the member for the goods except copayments as provided in 130 CMR 450.130; and
(5) the provider must have attempted to deliver the goods to the member.

(C) For the purposes of 130 CMR 450.231, a provider who directly services the member and who also produces the goods for delivery to the member has "fabricated" an item if the provider has taken the first substantial step necessary to initiate the production process after the conclusion of all necessary member visits.

(D) A provider is responsible for verifying a member's eligibility status on a daily basis, including but not limited to members who are hospitalized or institutionalized. In order to receive MassHealth payment for a covered medical service, the person receiving such service must be eligible for MassHealth coverage on the date of service and the provider must comply with any service authorization requirements and all other conditions of payment. A provider's failure to verify a member's MassHealth status before providing services to the member may result in nonpayment of such services. For payment for services provided before a member's MassHealth eligibility determination, see 130 CMR 450.311. For payment to out-of-state providers providing services on an emergency basis, see 130 CMR 450.312.

(E) Payments to QMB-only providers as defined in 130 CMR 450.212(D) for covered services described in 130 CMR 450.105(D) for MassHealth Senior Buy-in members and 130 CMR 450.105(A) for MassHealth Standard members may be made upon the Division's receipt of a claim for payment within the time limitations set forth in provisions, regulations, or rules under Title XVIII of the Social Security Act. QMB-only providers are not required to be registered as such with the Division as of the date the medical services were delivered, but are required to sign a QMB-only provider contract with the Division or become a participating provider in MassHealth before receiving payment for such claim.

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 by the MassHealth agency is made in accordance with the applicable payment methodology established by EOHHS, 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) and 435.405(B), payment to an out-of-state institutional provider for any medical service payable by the MassHealth agency is the lowest 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 current copy of the applicable rate schedule under its state's Medicaid program.

(C) Payment to an out-of-state noninstitutional provider for any medical service payable by the MassHealth agency is made in accordance with the applicable fee schedule established by EOHHS, 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 by the MassHealth agency is made as set forth in 130 CMR 450.233(D)(1) through (3) below. For purposes of 130 CMR 450.233(D), "High MassHealth Volume Hospital" means any out-of-

state acute hospital provider that had at least 150 MassHealth discharges during the most recent federal fiscal year for which complete data is available as determined by the MassHealth agency at least 90 days prior to the start of each federal fiscal year.

(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).

(a) Payment Amount Per Discharge.

1. Out-of-State APAD: Out-of-state acute hospitals are paid an adjudicated payment amount per discharge ("Out-of-State APAD") for inpatient services. The Out-of-State APAD is calculated using the sum of the statewide operating standard per discharge and the statewide capital standard per discharge both as in effect for in-state acute hospitals on the date of admission, which is then multiplied by the MassHealth DRG Weight assigned to the discharge based on the information contained in a properly submitted inpatient acute hospital claim.

a. "MassHealth DRG Weight" for purposes of 130 CMR 450.233(D) is the MassHealth relative weight determined by the MassHealth agency for each unique combination of APR-DRG and Severity of Illness (SOI).

b. "APR-DRG" or "DRG" for purposes of 130 CMR 450.233(D) refers to the All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned to a claim by the 3M APR-DRG Grouper.

2. Out-of-State Outlier Payment: If the calculated cost of the discharge exceeds the discharge-specific outlier threshold, then the out-of-state acute hospital is also paid an outlier payment for that discharge ("Out-of-State Outlier Payment"). The Out-of-State Outlier Payment is equal to the marginal cost factor in effect for in-state acute hospitals on the date of admission multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold.

a. The "calculated cost of the discharge" for purposes of 130 CMR 450.233(D) shall be determined by the MassHealth agency by multiplying the out-of-state acute hospital's allowed charges for the discharge by the following cost-to-charge ratio:

i. For a High MassHealth Volume Hospital, the hospital's inpatient cost-to-charge ratio, for the most recent complete rate year used for in-state acute hospitals, as determined by the MassHealth agency.

ii. For all other out-of-state acute hospitals, the median in-state acute inpatient hospital cost-to-charge ratio in effect on the date of admission based on MassHealth discharge volume, as determined by the MassHealth agency.

b. The "discharge-specific outlier threshold" for purposes of 130 CMR 450.233(D) is equal to the sum of the Out-of-State APAD corresponding to the discharge, and the fixed outlier threshold in effect for in-state acute hospitals on the date of admission.

(b) Out-of-State 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 transfer per diem rate ("Out-of-State Transfer Per Diem"), capped at the sum of the transferring hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment, that would have otherwise applied for the period that the member was an inpatient at

the transferring hospital as calculated by the MassHealth agency. No other payments specified in 130 CMR 450.233(D)(1) apply.

1. The Out-of-State Transfer Per Diem is equal to the sum of the transferring hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment, that would have otherwise applied for the period that the member was an inpatient at the transferring hospital as calculated by the MassHealth agency, divided by the mean in-state acute hospital all-payer length of stay for the particular DRG assigned, as determined by the MassHealth agency.

(c) Out-of-State Psychiatric Per Diem. If an out-of-state acute hospital admits a MassHealth patient primarily for behavioral health services, including psychiatric and substance abuse services, the out-of-state acute hospital shall be paid an all-inclusive psychiatric per diem equal to the psychiatric per diem in effect for in-state acute hospitals on the date of service ("Out-of-State Psychiatric Per Diem"). No other payments specified in 130 CMR 450.233(D)(1) apply.

(2) Outpatient Services.

(a) Payment for Outpatient Services. Except as provided in 130 CMR 450.233(D)(3), out-of-state acute hospitals are paid for outpatient services utilizing an adjudicated payment per episode of care payment methodology ("Out-of-State APEC") as described in 130 CMR 450.233(D)(2)(b), below, or in accordance with the applicable fee schedule established by EOHHS for outpatient services for which in-state acute hospitals are not paid the APEC. For purposes of 130 CMR 450.233(D), "APEC-covered services" are outpatient services for which in-state acute hospitals are paid an APEC, and "episode" means all APEC-covered services delivered to a MassHealth member on a single calendar day, or if the services extend past midnight in the case of emergency department or observation services, on consecutive days.

(b) Out-of-State APEC. The Out-of-State APEC for each payable episode will equal the sum of the episode-specific total EAPG payment, and the APEC outlier component (see 130 CMR 450.233(D)(2)(b)(1.) and (2.), respectively). For proper payment, out-of-state acute hospitals must include on a single claim all of the APEC-covered services that correspond to the episode, and must otherwise submit properly completed outpatient hospital claims.

1. The "episode-specific total EAPG payment" is equal to the sum of all of the episode's claim detail line EAPG payment amounts, where each claim detail line EAPG payment amount is equal to the product of the APEC outpatient statewide standard in effect for in-state acute hospitals on the date of service, and the claim detail line's adjusted EAPG weight. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the episode's claim detail line MassHealth EAPG weights to produce the claim detail line's adjusted EAPG weight used for this calculation. For purposes of 130 CMR 450.233(D)

a. EAPG stands for Enhanced Ambulatory Patient Group. EAPG(s) are assigned to claim detail lines containing APEC-covered services based on information contained on a properly submitted outpatient claim by the 3M EAPG Grouper, and refer to a group of outpatient services that have been bundled for purposes of categorizing and measuring casemix.

b. 3M EAPG Grouper refers to the 3M Corporation's EAPG grouper that has been configured for the MassHealth APEC payment methodology.

c. MassHealth EAPG weight refers to the MassHealth relative weight developed by the MassHealth agency for each unique EAPG.

2. The "APEC outlier component" is equal to the marginal cost factor in effect for in-state acute hospitals on the date of service multiplied by the difference between the episode-specific case cost and the episode-specific outlier threshold. If the episode-specific case cost is less than the episode-specific outlier threshold, then the APEC outlier component will be $0.

a. The "episode-specific case cost" for purposes of 130 CMR 450.233(D) shall be determined by the MassHealth agency by multiplying the sum of the allowed charges for all of the claim detail lines with APEC-covered services in the episode that adjudicate to pay, by the following cost-to-charge ratio:

i. For a High MassHealth Volume Hospital, the hospital's outpatient cost-to-charge ratio, for the most recent complete rate year used for in-state acute hospitals, as determined by the MassHealth agency.

ii. For all other out-of-state acute hospitals, the median in-state acute outpatient hospital cost-to-charge ratio in effect on the date of service based on MassHealth episode volume, as determined by the MassHealth agency.

b. The "episode -specific outlier threshold" for purposes of 130 CMR 450.233(D) is equal to the sum of the episode-specific total EAPG payment corresponding to the episode, and the fixed outpatient outlier threshold in effect for in-state acute hospitals on the date of service.

c. In no case is an APEC outlier component payable if the episode-specific total EAPG payment is $0.

(3) Services Not Available In-State.

(a) For medical services payable by the MassHealth agency 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 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.

450.234: Rates of Payment to Chronic Disease, Rehabilitation, or Similar Hospitals with Both Out-of-State Inpatient Facilities and In-State Outpatient Facilities.

Payment to a chronic disease, rehabilitation, or similar hospital with both out-of-state inpatient facilities and in-state outpatient facilities, for any medical service payable by the MassHealth agency is made as follows:

(A) Inpatient Services. For inpatient services, payment shall be in accordance with 130 CMR 435.405(B).

(B) Outpatient Services.

(1) For outpatient services provided out-of-state, payment shall be in accordance with 130 CMR 450.233(A) and (B).

(2) For outpatient services provided in-state, payment shall be the median in-state outpatient hospital cost-to-charge ratio for similar hospitals.

450.235: Overpayments

(A) Overpayments include, but are not limited to, payments to a provider

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

(2) 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);

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

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

(5) 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;

(6) 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;

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

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

(B) A provider must report in writing and return any overpayments to the MassHealth agency within 60 days of the provider identifying such overpayment or, for payments subject to reconciliation based on a cost report, by the date any corresponding cost report is due, whichever is later. A provider must include in such written report the reason for the overpayment and use such form and follow such process that may be prescribed by the MassHealth agency.

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), 450.211, 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., including but not limited to 130 CMR 450.235(B), 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)