Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MASSHEALTH
TRANSMITTAL LETTER DEN-75
April 2006

TO: Dental Providers Participating in MassHealth

FROM: Beth Waldman, Medicaid Director

RE: *Dental Manual* (Revision to Regulations About Medicare Part D)

This letter transmits revisions to the dental regulations as a result of federal law enacting Medicare Part D and a new state law providing certain benefits to Medicare Part D-eligible members. The change applies to MassHealth members who have Medicare and who can enroll in a Medicare Part D drug plan.

Effective January 1, 2006, MassHealth provides assistance with Medicare Part D copayments, in accordance with Chapter 175 of the Acts of 2005.

Due to widespread and systemic problems across the Commonwealth with the implementation of Medicare Part D drug coverage, between January 7, 2006, and March 15, 2006, MassHealth provided temporary emergency coverage for outpatient prescription drugs for individuals with both Medicare and MassHealth. This coverage was available if a pharmacy was not able to bill a Medicare Part D plan or the Wellpoint/Anthem point-of-sale contingency plan.

Once the temporary emergency coverage ended, effective March 16, 2006, MassHealth began providing limited supplies of Medicare Part D-covered drugs, in accordance with Chapter 175 of the Acts of 2005.

These emergency regulations were effective January 1, 2006.

In addition, revisions that had been issued in earlier transmittal letters, but had since been inadvertently omitted, have been reinstated.

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.)

Dental Manual

Pages 4-9 through 4-14

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Dental Manual

Pages 4-9 through 4-14 — transmitted by Transmittal Letter DEN-74

420.411: Pretreatment Review

Where the MassHealth agency identifies an unusual pattern of practice of a given provider, the MassHealth agency, at its discretion and pursuant to written notice, may require the provider to submit any proposed treatments identified by the MassHealth agency, including those not otherwise subject to prior authorization, for the MassHealth agency's review and approval before treatment.

420.412: Individual Consideration

(A) Certain services are designated "I.C." (indicating individual consideration) in Subchapter 6 and Appendix E of the *Dental Manual*. This means that a fee could not be established for these services. Service codes for unlisted or unspecified procedures are also designated as "I.C." The MassHealth agency determines appropriate payment for individual-consideration services from the provider's detailed report of services furnished. The report must include a narrative summary or operative report, and laboratory, radiographs, and pathology reports. The MassHealth agency does not pay claims for "I.C." services without a complete report. If the documentation is illegible or incomplete, the MassHealth agency will deny the claim.

(B) Determination of the appropriate payment for an individual-consideration service is 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 extenuating circumstances or complications.

420.413: Separate Procedures

Certain procedures are designated "S.P." in the service descriptions in Subchapter 6 and Appendix E of the Dental Manual. "S.P." is an abbreviation for separate procedure. A separate procedure is one that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but that commands a separate fee when performed as a separate procedure not immediately related to other services. (For example, the MassHealth agency does not pay for a frenulectomy when it is performed as part of a vestibuloplasty, and full-study models are not reimbursable separately when performed as part of orthodontic treatment or diagnosis; however, the MassHealth agency does pay for full-study models separately when they are requested by the MassHealth agency.) The administration of analgesia and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure.

420.414: Recordkeeping Requirements

Federal and state regulations require that all MassHealth providers maintain complete written records of patients who are members. All records, including radiographs, must be kept for a minimum of four years after the date of service. Records for members who are residents of long-term-care facilities must be retained by the dentist as part of the member's dental record and by the nursing facility as part of the member's record at the facility. The fees for all dental services listed in 130 CMR 420.000 include payment for preparation of the member's dental record. Services for which payment is claimed must be substantiated by clear evidence of the nature, extent, and

necessity of care furnished to the member. Evidence must include examination results, diagnostic charting, description of treatment, radiographs, and findings of other diagnostic tests. For all claims under review, the member's medical and dental records determine the appropriateness of services provided to members. The written dental record corresponding to the services claimed must include, but is not limited to, the following:

(A) the member's name, date of birth, and sex;

(B) the member's identification number;

(C) the date of each service;

(D) the name and title of the individual servicing provider furnishing each service, if the dental provider claiming payment is not a solo practitioner;

(E) pertinent findings on examination and in medical history;

(F) a description of any medications administered or prescribed and the dosage given or prescribed;

(G) a description of any anesthetic agent administered, the dosage given, and the anesthesia flowsheet;

(H) a complete identification of treatment, including, when applicable, the arch, quadrant, tooth number, and tooth surface;

(I) dated and mounted radiographs, if applicable; and

(J) copies of all approved prior-authorization requests.

420.415: Report Requirements

(A) General Report. A general written report that includes a diagnosis and a description of the service performed must accompany the claim for payment when the service description in Subchapter 6 or Appendix E of the *Dental Manual* stipulates "with report only," when the service is designated "I.C.," or when a service code for an unlisted procedure is used. This report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of services performed. The report can be on the claim form or on a separate piece of paper with the provider's letterhead. Supporting documentation, including pathology, admission, and operative reports, must be attached.

(B) Operative Report. For surgical procedures designated "I.C." and for any service that is an unlisted or unspecified procedure, an operative report must accompany the provider's claim. An operative report must contain the name of the surgical procedure, the name and date of birth of the member, the date of the service, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and of any assistant, and the technical procedures performed.

420.416: Pharmacy Services: Prescription Requirements

(A) Legal Prescription Requirements. Legend drugs, nonlegend drugs, and those medical supplies listed at 130 CMR 420.417(C) are covered only if the pharmacy has in its possession a prescription that meets all requirements for a legal prescription under all applicable federal and state laws and regulations. Each prescription, regardless of drug schedule, must contain the prescriber's unique DEA number. For Schedule VI drugs, if the practitioner has no DEA registration number, the practitioner must provide the state registration number on the prescription.

(B) Emergencies. When the pharmacist determines that an emergency exists, the MassHealth agency will pay a pharmacy for at least a 72-hour, nonrefillable supply of the drug in compliance with state and federal regulations. Emergency dispensing to a MassHealth member who is enrolled in the Controlled Substance Management Program (CSMP) must comply with 130 CMR 406.442(C)(2).

(C) Refills.
(1) The MassHealth agency does not pay for prescription refills that exceed the specific number authorized by the prescriber.
(2) The MassHealth agency pays for a maximum of 11 monthly refills, except in circumstances described in 130 CMR 420.416(C)(3).
(3) The MassHealth agency pays for more than 11 refills within a 12-month period if such refills are for less than a 30-day supply and have been prescribed and dispensed in accordance with 130 CMR 420.416(D).
(4) The MassHealth agency does not pay for any refill dispensed after one year from the date of the original prescription.
(5) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.
(6) The MassHealth agency does not pay for any refill without an explicit request from a member or caregiver for each filling event. The possession by the provider of a prescription with remaining refills does not in itself constitute a request to refill the prescription.

(D) Quantities.
(1) Days' Supply Limitations. The MassHealth agency requires that all drugs be prescribed in a 30-day supply, unless the drug is available only in a larger minimum package size, except as specified in 130 CMR 420.416(D)(2).
(2) Exceptions to Days' Supply Limitations. The MassHealth agency allows exceptions to the limitations described in 130 CMR 420.416(D)(1) for the following products:
(a) drugs in therapeutic classes that are commonly prescribed for less than a 30-day supply, including but not limited to antibiotics and analgesics;
(b) drugs that, in the prescriber's professional judgment, are not clinically appropriate for the member in a 30-day supply;
(c) drugs that are new to the member, and are being prescribed for a limited trial amount, sufficient to determine if there is an allergic or adverse reaction or lack of effectiveness. The initial trial amount and the member's reaction or lack of effectiveness must be documented in the member's medical record;

(d) drugs packed in such a way that the smallest quantity that may be dispensed is larger than a 30-day supply (for example, inhalers, ampules, vials, eye drops, and other sealed containers not intended by the manufacturer to be opened by any person other than the end user of the product);
(e) drugs in topical dosage forms that do not allow the pharmacist to accurately predict the rate of the product's usage (for example, lotions or ointments);
(f) products generally dispensed in the original manufacturer's packaging (for example, fluoride preparations, prenatal vitamins, and over-the-counter drugs); and
(g) methylphenidate and amphetamine prescribed in 60-day supplies.

(E) Prescription-Splitting. Providers must not split prescriptions by filling them for a period or quantity less than that specified by the prescriber. For example, a prescription written for a single 30-day supply may not be split into three 10-day supplies. The MassHealth agency considers prescription-splitting to be fraudulent. (See 130 CMR 450.238(B)(6).)

(F) Excluded, Suspended, or Terminated Clinicians. The MassHealth agency does not pay for prescriptions written by clinicians who:
(1) have been excluded from participation based on a notice by the U.S. Department of Health and Human Services Office of Inspector General; or
(2) the MassHealth agency has suspended, terminated, or denied admission into its program for any other reason.

420.417: Pharmacy Services: Covered Drugs and Medical Supplies

(A) Drugs. The MassHealth Drug List specifies the drugs that are payable under MassHealth. In addition, the MassHealth agency pays only for legend drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8.

(B) Medical Supplies. The MassHealth agency pays only for the following medical supplies:
(1) blood and urine testing reagent strips used for the management of diabetes;
(2) disposable insulin syringe and needle units;
(3) insulin cartridge delivery devices and needles or other devices for injection of medication (for example, Epipens);
(4) lancets;
(5) drug delivery systems for use with metered dose inhalers (for example, aerochambers); and
(6) alcohol swabs.

420.418: Pharmacy Services: Limitations on Coverage of Drugs

(A) Interchangeable Drug Products. The MassHealth agency pays no more for a brand-name interchangeable drug product than its generic equivalent, unless:
(1) the prescriber has requested and received prior authorization from the MassHealth agency for a nongeneric multiple-source drug (see 130 CMR 420.419); and
(2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(B) Drug Exclusions. The MassHealth agency does not pay for the following types of drugs or drug therapy.

(1) Cosmetic. The MassHealth agency does not pay for legend or nonlegend preparations for cosmetic purposes or for hair growth.

(2) Cough and Cold. The MassHealth agency does not pay for legend or nonlegend drugs used solely for the symptomatic relief of coughs and colds, including but not limited to, those that contain an antitussive or expectorant as a major ingredient unless dispensed to an institutionalized member.

(3) Fertility. The MassHealth agency does not pay for any drug used to promote male or female fertility.

(4) Obesity Management. The MassHealth agency does not pay for any drug used for the treatment of obesity.

(5) Smoking Cessation. The MassHealth agency does not pay for any drug used for smoking cessation.

(6) Less-Than-Effective Drugs. The MassHealth agency does not pay for drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a Notice of Opportunity for Hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications.

(7) Experimental and Investigational Drugs. The MassHealth agency does not pay for any drug that is experimental, medically unproven, or investigational in nature.

(8) Drugs for Sexual Dysfunction. The MassHealth agency does not pay for drugs when used for the treatment of male or female sexual dysfunction.

(C) Service Limitations.

(1) The MassHealth agency covers drugs that are not explicitly excluded under 130 CMR 420.418(B). The limitations and exclusions in 130 CMR 420.418(B)(1) through (5) do not apply to medically necessary drug therapy for MassHealth Standard enrollees under age 21. The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 420.000. The MassHealth Drug List can be viewed online at www.mass.gov/druglist, and copies may be obtained upon request. The MassHealth agency will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List accordingly. (See 130 CMR 450.303.)

(2) The MassHealth agency does not pay for the following types of drugs or drug therapy without prior authorization:

(a) immunizing biologicals and tubercular (TB) drugs that are available free of charge through local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs; and

(c) drugs related to sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. The MassHealth agency, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(3) The MassHealth agency does not pay any additional fees for dispensing drugs in a unit-dose distribution system.
(4) The MassHealth agency does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the MassHealth agency determines to be consistent with current medical evidence.
(5) The MassHealth agency does not pay for drugs that are provided as a component of a more comprehensive service for which a single rate of pay is established in accordance with 130 CMR 450.307.

(D) Insurance Coverage.
(1) Managed Care Organizations. The MassHealth agency does not pay pharmacy claims for services to MassHealth members enrolled in a MassHealth managed care organization (MCO) that provides pharmacy coverage through a pharmacy network or otherwise, except for family planning pharmacy services provided by a non-network provider to a MassHealth Standard MCO enrollee (where such provider otherwise meets all prerequisites for payment for such services). A pharmacy that does not participate in the MassHealth member's MCO must instruct the MassHealth member to take his or her prescription to a pharmacy that does participate in such MCO. To determine whether the MassHealth member belongs to an MCO, pharmacies must verify member eligibility and scope of services through POPS before providing service in accordance with 130 CMR 450.107 and 450.117.
(2) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill the MassHealth agency for the primary insurer's member copayment for the primary carrier's preferred drug without regard to whether the MassHealth agency generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 420.418(C)(2)(a) and (c). In such cases, the prescriber must obtain prior authorization from the MassHealth agency in order for the pharmacy to bill the MassHealth agency for the primary insurer's member copayment. For additional information about third party liability, see 130 CMR 450.101 et seq.
(3) Medicare Part D. Except as otherwise required in 130 CMR 406.414(C)(2) and (3), for MassHealth members who have Medicare, the MassHealth agency does not pay for any Medicare Part D drugs, or for any cost-sharing obligations (including premiums, copayments, and deductibles) for Medicare Part D drugs, whether or not the member has actually enrolled in a Medicare Part D drug plan. Medications excluded from the Medicare Part D drug program continue to be covered for MassHealth members eligible for Medicare, if they are MassHealth-covered medications.

420.419: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from the MassHealth agency for drugs identified by the MassHealth agency in accordance with 130 CMR 450.303. If the limitations on covered drugs specified in 130 CMR 420.417(A) and 420.418(A) and (C) would result in inadequate treatment for a diagnosed medical condition, the prescriber may submit a written request, including written documentation of medical necessity, to the MassHealth agency for prior authorization for an otherwise noncovered drug.

(B) All prior-authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the *Dental Manual*. If the MassHealth agency approves the request, it will notify both the pharmacy and the member.