Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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Boston, MA 02111
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MASSHEALTH
TRANSMITTAL LETTER OPD-58
April 2006

TO: Outpatient Hospitals Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

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

This letter transmits revisions to the outpatient hospital 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.

MassHealth is deleting Appendix E, MH/SA Program, as it has become obsolete.

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.)

Outpatient Hospital Manual

Pages vi, 4-13, 4-14, 4-39, and 4-40

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Outpatient Hospital Manual

Page vi — transmitted by Transmittal Letter OPD-54

Pages 4-13 and 4-14 — transmitted by Transmittal Letter OPD-43

Pages 4-39, 4-40, E-1, and E-2 — transmitted by Transmittal Letter OPD-57

(a) visual acuity;
(b) distance vision and near vision;
(c) cover test;
(d) visual skills;
(e) tonometry; and
(f) biomicroscopy.

(J) For laboratory services, in addition to the applicable information required in 130 CMR 410.409(D) above, the recipient's medical record must contain a suitable record of each specimen and laboratory test result for at least six years from the date on which the results were reported to the prescriber (see 130 CMR 410.458):

(1) the name and any other means of identification of the person from whom the specimen was taken;
(2) the name of the prescriber or laboratory that submitted the specimen;
(3) the authorized requisition or order, or both;
(4) the location where the specimen was taken, if other than the hospital outpatient department;
(5) the date on which the specimen was collected by the prescriber or laboratory;
(6) the date on which the specimen was received in the laboratory;
(7) the condition of unsatisfactory specimens when received (for example, broken, leaked, hemolyzed, turbid, or insufficient sample size);
(8) the date on which the test was performed;
(9) the test name and the results of the test, or the cross-reference to results and the date of reporting; and
(10) the name and address of the laboratory to which the specimen was referred, if applicable.

410.410: Assurance of Recipient Rights

No provider shall use any form of coercion in the provision of any services (for example, abortion, sterilization, and family planning). Neither the MassHealth agency nor any provider, nor any agent or employee of a provider, shall mislead any recipient into believing that a decision to receive any services reimbursable under these regulations will adversely affect the recipient's entitlement to benefits or services for which the recipient would otherwise be eligible. The MassHealth agency has strict requirements for the confidentiality of patient records for all medical services reimbursable under the Medical Assistance Program.

410.411: Emergency Services

(A) The MassHealth agency will pay for emergency services provided in a hospital emergency room only when such services are medically necessary and the necessity is fully documented in the recipient's medical record.

(B) For services provided in the emergency department, handwritten or time-stamped documentation of the length of the recipient's stay in the emergency room must be kept in the recipient's record or on an easily accessible hospital log.

(C) For recipients participating in MassHealth Managed Care who are enrolled in the PCC Plan (see 130 CMR 450.101), the MassHealth agency pays for urgent care and for emergency care in accordance with 130 CMR 450.118(I).

(D) The MassHealth agency requires under certain conditions that recipients make a copayment to the hospital for nonemergency services provided in an emergency room. The copayment requirements are detailed in the MassHealth agency's administrative and billing regulations at 130 CMR 450.130.

410.412: Utilization Management Program and Mental Health and Substance Abuse Admission Screening Requirements

(A) Utilization Management Program. The MassHealth agency will pay for procedures and hospital stays that are subject to the Utilization Management Program only if the applicable requirements of the program as described in 130 CMR 450.207 through 450.211 are satisfied. Appendix H of the Outpatient Hospital Manual contains the name, address, and telephone number of the contact organization for the Utilization Management Program and describes the information that must be provided during the review process.

(B) Mental Health and Substance Abuse Admissions. The MassHealth agency will pay for mental health and substance abuse services provided in an acute or nonacute inpatient setting only if the admitting provider has satisfied the screening requirements at 130 CMR 450.125.

(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 cough or 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) MassHealth covers drugs that are not explicitly excluded under 130 CMR 410.463(B). The limitations and exclusions in 130 CMR 410.463(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 410.000. 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 410.463(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. and the MassHealth Acute Hospital Request for Applications and Contract.

(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.