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 OPD-59
June 2006

TO: Outpatient Hospitals Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: *Outpatient Hospital Manual* (Revised Regulations About Tobacco Cessation Services)

Beginning July 1, 2006, MassHealth will cover individual and group tobacco cessation counseling and pharmacotherapy through the MassHealth tobacco cessation benefit. Those members eligible to receive physician services, community health center services, acute outpatient hospital services, and pharmacy services are covered for tobacco cessation services, based on their MassHealth coverage type as described at 130 CMR 450.105.

Cessation Counseling Benefit

Since stopping tobacco use may require multiple attempts, this benefit is designed to allow members and providers as much flexibility as possible. Members may use up to 16 counseling sessions in any combination of group or individual face-to-face sessions per 12-month cycle, including two intake/assessment sessions. Prior authorization is required for counseling sessions beyond these limits. For further details please see the attachment "MassHealth Tobacco Cessation Counseling Benefit."

Pharmacotherapy Benefit

MassHealth will cover medically necessary drugs used for tobacco cessation, subject to all other provisions of 130 CMR 406.000. Members may obtain a 90-day supply of the nicotine patch, gum, or lozenge, per cessation attempt. The nicotine inhaler and nasal spray require prior authorization. A maximum of two 90-day treatment regimens are covered per member per 12-month cycle. Additional nicotine replacement therapy (NRT) requires prior authorization. The pharmacotherapy benefit also covers other medically necessary drugs for tobacco cessation, such as bupropion (the generic form of Zyban). Please see the MassHealth Drug List for further details about the pharmacotherapy benefit for tobacco cessation. The MassHealth Drug List can be found at www.mass.gov/druglist. It can also be accessed from the MassHealth Pharmacy Program home page at www.mass.gov/masshealth/pharmacy.

Cessation Counseling Provider Qualifications

Physicians, as well as certain mid-level providers (registered nurses, physician assistants, nurse practitioners, and nurse midwives) may provide tobacco cessation counseling to MassHealth members. Other health care providers with specific training in the provision of tobacco cessation counseling may also qualify to provide counseling, and physicians who supervise those providers must ensure that they are trained by a degree-granting institute of higher education and have completed at least eight hours of course instruction. All nonphysicians must provide services under the supervision of a physician.

Coding and Billing for Tobacco Cessation Services

Claims for tobacco cessation counseling must be submitted using Healthcare Common Procedure Coding System (HCPCS) Service Code G0376 and revenue code 942 (education and training). Distinct modifiers are required with the HCPCS code for claims processing. These modifiers vary by the type of service provided and by the type of provider. While mid-level providers can provide tobacco cessation services under the supervision of a physician, acute outpatient hospitals cannot bill separately for services delivered by mid-level providers. Please see the attachment "Tobacco Cessation Coding Chart" for important coding information. For information about the reimbursement rates for the tobacco cessation counseling services, please see the Division of Health Care Finance and Policy Web site at www.mass.gov/dhcfp.

Service Code G0376 and relevant modifiers are in Subchapter 6 of the *Acute Outpatient Hospital Manual* under tobacco cessation services.

This transmittal letter also transmits a revised Appendix G, Acute Inpatient Hospital Admission Guidelines. This revision updates terminology.

These regulations are effective July 1, 2006.

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 iv, 4-7, 4-8, 4-15 through 4-18, 4-39, 4-40, and G-1 through G-4

OBSOLETE MATERIAL

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

Outpatient Hospital Manual

Page iv — transmitted by Transmittal Letter OPD-52

Pages 4-7 and 4-8 — transmitted by Transmittal Letter OPD-56

Pages 4-15, 4-16, and G-1 through G-4 — transmitted by Transmittal Letter OPD-46

Pages 4-17 and 4-18 — transmitted by Transmittal Letter OPD-38

Pages 4-39 and 4-40 — transmitted by Transmittal Letter OPD-58

MassHealth Tobacco Cessation Counseling Benefit (Attachment 1)

MassHealth strongly encourages providers to inquire about all members' smoking status and recommend that they try to quit by referring them to the best available resource for tobacco cessation counseling. Clinical evidence indicates that the best treatment outcomes are achieved when members receive a combination of tobacco cessation counseling and pharmacotherapy.

Component	Duration	Limits
Intake/Assessment/Planning Face-to-face intake, assessment, and treatment planning as a component of treatment	At least 45 minutes	Maximum of one intake, assessment and treatment planning per course of treatment. Two such sessions are permitted per 12-month cycle*
In-Depth – Individual Face-to-face behavioral counseling for tobacco cessation	At least 30 minutes	Maximum 16 sessions per 12-month cycle*
In-Depth – Group Face-to-face group behavioral counseling for tobacco cessation	Minimum 60 to 90 minutes per group sessions, minimum of 5, maximum of 12 members per group session	Maximum 16 sessions per 12-month cycle*

* A total of 16 face-to-face counseling sessions, using any combination of intake/assessment/planning, in-depth individual or in-depth group counseling sessions are permitted for each member per 12-month cycle without prior authorization.

MassHealth Tobacco Cessation HCPCS Code and Modifiers (Attachment 2)

	Tobacco Cessation Counseling Services		
	Individual tobacco cessation counseling visit, at least 30 minutes	Individual tobacco cessation intake/assessment counseling visit, at least 45 minutes	Group tobacco cessation counseling visit, at least 60 to 90 minutes
Servicing Provider	**Service Code + Modifier**	**Service Code + Modifier**	**Service Code + Modifier**
Physician, Independent Nurse Practitioner, Independent Nurse Midwife, Community Health Center (CHC), Outpatient Hospital Department (OPD)*	**G0376**	**G0376 TF**	**G0376 HQ**
Nurse Practitioner (employed by physician or CHC, CHC or physician billing)	**G0376 SA**	**G0376 U2**	**G0376 U3**
Nurse Midwife (employed by physician or CHC, CHC or physician billing)	**G0376 SB**	**G0376 U2**	**G0376 U3**
Physician's Assistant (employed by physician or CHC, CHC or physician billing)	**G0376 HN**	**G0376 U2**	**G0376 U3**
Registered Nurse (employed by physician or CHC, CHC or physician billing)	**G0376 TD**	**G0376 U2**	**G0376 U3**
Tobacco Cessation Counselor (employed by physician or CHC, CHC or physician billing)	**G0376 U1**	**G0376 U2**	**G0376 U3**

*OPDs will receive the PAPE (clinic visit rate/ facility rate) for this service. OPDs cannot bill separately for services provided by mid-level providers, this will be included in the facility rate. This means they will use only Service Code G0376 code with TF and HQ modifiers.

Modifiers:
TF = intermediate level of care
HQ = group setting
SA = nurse practitioner
SB = nurse midwife
HN = bachelor's degree level (used for physician assistant)
TD = RN
U1 = defined for use by "tobacco cessation counselor"
U2 = defined for use as "intake assessment, non-physician provider employed by physician"
U3 = defined for use as "group visit, non-physician provider employed by physician"

4. Program Regulations

(B) The MassHealth agency does not pay for mental health services such as, but not limited to, the following (see 130 CMR 410.472):

(1) vocational rehabilitation services;
(2) sheltered workshops;
(3) recreational services;
(4) life-enrichment services; and
(5) alcohol or drug drop-in centers.

(C) The MassHealth agency does not pay for pharmacy services such as, but not limited to, the following (see 130 CMR 410.462 through 410.465):

(1) any drug used for the treatment of obesity;
(2) cough and cold preparations;
(3) less-than-effective drugs;
(4) hormone therapy related to sex-reassignment surgery; and
(5) drugs related to the treatment of male or female infertility.

(D) The MassHealth agency does not pay for vision care services such as, but not limited to, the following (see 130 CMR 410.481 through 410.489):

(1) absorptive lenses of greater than 25 percent absorption;
(2) photochromatic lenses, sunglasses, or fashion tints;
(3) treatment of congenital dyslexia;
(4) extended-wear contact lenses;
(5) invisible bifocals; and
(6) the Welsh 4-Drop Lens.

(E) The MassHealth agency does not pay an independent practitioner for services provided to members in an outpatient department except when that practitioner has an active provider number issued by the MassHealth agency and meets one of the following criteria.

(1) The practitioner serves in an attending, visiting, or supervisory role at the hospital where the services are provided, is legally responsible for the management of the member's care, is physically present and actively involved in the treatment for which payment is claimed, and provides a service for which the MassHealth agency pays an independent practitioner when provided in an outpatient hospital setting. Supervisory surgeons must be scrubbed and physically present during the major portion of an operation.

(2) The independent practitioner, if serving as a salaried intern, resident, fellow, or house officer, provides services during off-duty hours at an institution that does not pay his or her salary.

(3) The independent practitioner receives a salary from an institution for administrative or teaching services, but not for delivery of care, and provides direct medical care to a member that meets the conditions set forth in 130 CMR 410.405(E)(1).

410.406: Payment

(A) Hospital outpatient departments and hospital-licensed health centers in Massachusetts are paid for services provided to eligible members according to the rate for services established in the signed MassHealth provider agreement, subject to the limitations set forth in 130 CMR 410.406.

(B) For purposes of making payments to hospital outpatient departments and hospital-licensed health centers in Massachusetts, the following limitations apply.

(1) The MassHealth agency does not pay for outpatient services provided to a member who is an inpatient at the same or a different hospital on the same day.

(2) The MassHealth agency pays only for emergency outpatient services provided to a member on the day that the member is discharged from the hospital, whether from the same or a different facility.

(3) If a member receives outpatient services at one facility and, later on the same day, is admitted as an inpatient to another facility, the MassHealth agency pays both hospitals for services.

(4) When a member is admitted to inpatient status through the emergency department or outpatient department, the hospital must bill for only the inpatient stay. The MassHealth agency does not pay for services furnished in the emergency department or outpatient department on the admitting day.

(C) Nonacute hospital outpatient departments in Massachusetts are paid for services provided to eligible members according to the rate of payment established for each hospital in the signed MassHealth provider agreement, subject to the limitations set forth in 130 CMR 410.406(C)(1) and (2).

(1) Charges.

(a) The MassHealth agency pays only those charges contained in the charge book that the hospital has currently filed with DHCFP and no more than those charges.

(b) For changes in charges, the appropriate regulations of the DHCFP apply.

(c) In those cases where a specific rate has been established by DHCFP for a specific service or program (such as for adult day health services), the MassHealth agency pays no more than that rate.

(2) Payments. For purposes of making payments to nonacute outpatient hospitals, the following limitations apply.

(a) The MassHealth agency does not pay for outpatient services provided to a member who is an inpatient at the same or a different hospital on the same day.

(b) The MassHealth agency pays only for emergency outpatient services provided to a member on the day that he or she is discharged from the hospital, whether from the same or a different facility.

(c) If a member receives outpatient services at one facility and, later on the same day, is admitted as an inpatient to another facility, the MassHealth agency pays both hospitals for services.

(d) When a member is admitted to inpatient status through the emergency department or outpatient department, the hospital must bill for only the all-inclusive per diem rate for that day. The MassHealth agency does not pay for services furnished in the emergency department or outpatient department on the admitting day.

(D) The MassHealth agency pays for laboratory services in accordance with 130 CMR 410.456.

410.407: Certification

(A) Hospital outpatient departments must receive certification from the MassHealth agency before providing the following services:

(1) adult day health services (for requirements, see 130 CMR 410.443);

(2) adult foster care services (for requirements, see 130 CMR 410.444); and

(3) psychiatric day treatment program services (for requirements, see 130 CMR 410.445).

410.413: Medical Services Required on Site at a Hospital-Licensed Health Center

In order to be reimbursed at the rates established for hospital-licensed health centers (HLHCs), an HLHC must provide on site the medical services specified in 130 CMR 410.413(D), (E), and (F), and at least two of the medical services described in 130 CMR 410.413(A), (B), and (C). It is not necessary that all of these services be available during all hours of the HLHC's operation, but all services must be available to members on a regularly scheduled basis with sufficient frequency to ensure access to care and continuity of care.

(A) Pediatric Services. The HLHC must provide pediatric services.

(B) Internal Medicine. The HLHC must provide internal medicine services.

(C) Obstetrics/Gynecology. The HLHC must provide obstetrical and gynecological services. When a family practitioner is employed in place of a medical specialist in obstetrics/gynecology, the family practitioner must have admitting privileges to a hospital for delivery and obstetrical and gynecological backup.

(D) Health Education. The HLHC must provide health education designed to prepare members for their participation in and reaction to specific medical procedures, and to instruct members in self-management of medical problems and in disease prevention. Health education may be provided by any health practitioner or by any other individual approved by the HLHC's professional services director as possessing the qualifications and training necessary to provide health education to members.

(E) Medical Social Services. The HLHC must provide medical social services designed to assist members in their adjustment to and management of social problems resulting from medical treatment, specific disease episodes, or chronic illness. Medical social services must be provided by a clinical social worker who is licensed by the Massachusetts Board of Registration. This individual must be on site sufficient hours and with sufficient frequency to provide medical social services to members.

(F) Nutrition Services. The HLHC must provide counseling in the purchase, preparation, and consumption of proper nutrients to members who have been determined to require such counseling because of their health problems or because they have a high potential for developing health problems that might be avoided or made less severe through proper nutrition. Each HLHC must employ either a nutrition professional with a bachelor's or master's degree in public health nutrition, community nutrition, or human nutrition, or a dietitian who is currently registered by the American Dietetic Association. This individual is responsible for planning, directing, and evaluating the nutrition services provided at the HLHC; for educating the HLHC's staff about nutrition; for supervising any nutrition aides; for consulting with practitioners and other staff members of the HLHC; and for counseling members referred for nutrition information. The nutrition professional or registered dietitian must be on site at least one day per calendar month.

410.414: Observation Services

(A) Reimbursable Services. MassHealth covers medically necessary observation services provided by acute inpatient hospitals. Reimbursable observation services may exceed 24 hours, and do not need to be provided in a distinct observation unit. To qualify for reimbursement of observation services, the medical record must specifically document when those services began and ended, the purpose of observation, and the name of the physician who ordered it. Acute inpatient hospitals will be reimbursed for these observation services on an outpatient basis in accordance with the signed provider agreement with the MassHealth agency.

(B) Nonreimbursable Services.

(1) Nonreimbursable observation services include but are not limited to:

(a) services that are not reasonable or necessary for the diagnosis or treatment of the member; and

(b) routine preparation and recovery services associated with diagnostic testing or outpatient surgery.

(2) The following services are not reimbursable as a separate service:

(a) postoperative monitoring during a standard recovery period that should be characterized as recovery-room services; and

(b) observation services provided concurrently with therapeutic services such as chemotherapy.

(130 CMR 410.415 through 410.419 Reserved)

410.420: Tobacco Cessation Services

(A) Introduction. MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 410.420(B) and pharmacotherapy treatment, including nicotine replacement therapy (NRT), in accordance with 130 CMR 406.000.

(B) Tobacco Cessation Counseling Services.

(1) MassHealth covers a total of 16 group and individual counseling sessions per member per 12-month cycle, without prior authorization. These sessions may be any combination of group and individual counseling. All individual counseling sessions must be at least 30 minutes, except for intake sessions, which must be at least 45 minutes. Intake sessions are limited to two per member per 12-month cycle, without prior authorization.

(a) Individual counseling consists of face-to-face tobacco cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobacco cessation services as set forth in 130 CMR 410.420(B) and (C).

(b) Group tobacco treatment counseling consists of a scheduled professional counseling session with a minimum of three and a maximum of 12 members and has a duration of at least 60 to 90 minutes.

(c) Individual and group counseling also includes collaboration with and facilitating referrals to other health care providers to coordinate the appropriate use of medications, especially in the presence of medical or psychiatric comorbidities.

(2) The individual and group tobacco cessation counseling services must include the following:

(a) education on proven methods for stopping the use of tobacco, including a:

(i) a review of the health consequences of tobacco use and the benefits of quitting;

(ii) a description of how tobacco dependence develops and an explanation of the biological, psychological, and social causes of tobacco dependence; and

(iii) a review of evidence-based treatment strategies and the advantages and disadvantages of each strategy;

(b) collaborative development of a treatment plan that uses evidence-based strategies to assist the member to attempt to quit, to continue to abstain from tobacco, and to prevent relapse, including:

(i) identification of personal risk factors for relapse and incorporation into the treatment plan;

(ii) strategies and coping skills to reduce relapse risk; and

(iii) a plan for continued aftercare following initial treatment; and

(c) information and advice on the benefits of nicotine replacement therapy or other proven pharmaceutical or behavioral adjuncts to quitting smoking, including:

(i) the correct use, efficacy, adverse events, contraindications, known side effects, and exclusions for all tobacco dependence medications; and

(ii) the possible adverse reactions and complications related to the use of pharmacotherapy for tobacco dependence.

(C) Provider Qualifications for Tobacco Cessation Counseling Services

(1) Qualified Providers.

(a) Physicians, registered nurses, nurse practitioners, nurse midwives, and physician assistants may provide tobacco cessation counseling services without additional experience or training in tobacco cessation counseling services.

(b) All other providers of tobacco cessation counseling services must be under the supervision of a physician, and must complete a course of training in tobacco

cessation counseling by a degree granting institute of higher education with a minimum of eight hours of instruction.

(2) Supervision of Tobacco Cessation Counseling Services. A physician must supervise all non-physician providers of tobacco cessation counseling services.

(D) Tobacco Cessation Services: Claims Submission. An acute outpatient hospital may submit claims for tobacco cessation counseling services that are provided by physicians, or by mid-level providers under the supervision of a physician (i.e. nurse practitioner, registered nurse, nurse midwife, physician assistant, and MassHealth-qualified tobacco cessation counselor), according to 130 CMR 410.420(B) and (C). Acute outpatient hospital departments cannot bill separately for services provided by mid-level providers. See Subchapter 6 of the *Acute Outpatient Hospital Manual* for service codes and descriptions.

(130 CMR 410.421 through 410.430 Reserved)

(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) 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.

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

(7) 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 hospital's Request for Applications and Contract, if applicable.

(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.

Acute Inpatient Hospital Admission Guidelines

A. Introduction

This appendix is intended to help providers make appropriate decisions about the medical necessity of acute inpatient hospital admissions. These guidelines have been approved by physicians from several medical specialties who have active practices in Massachusetts. Providers making decisions on whether to admit a member as an inpatient should use their medical judgment and these guidelines. Services that meet the medical-necessity criteria at 130 CMR 450.204 and the rules governing reimbursement of inpatient, outpatient, and observation services in 130 CMR 410.414 (see section E of this appendix) or 415.414 (see section C of this appendix) are reimbursable by MassHealth.

B. Definitions

The reimbursability of services defined below is not determined by these definitions, but by application of MassHealth regulations referenced in 130 CMR 450.000 and in section A above.

Inpatient Services — medical services provided to a member admitted to an acute inpatient hospital.

Observation Services — outpatient hospital services provided anywhere in an acute inpatient hospital, to evaluate a member's condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Outpatient Hospital Services — medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, day-surgery services, and recovery-room services.

Outpatient Services — medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home.

C. Medical Determination

[excerpted from MassHealth acute inpatient hospital regulations at 130 CMR 415.414]

To support the medical necessity of an inpatient admission, the provider must adequately document in the member's medical record that a provider with applicable expertise expressly determined that the member required services involving a greater intensity of care than could be provided safely and effectively in an outpatient setting. Such a determination may take into account the amount of time the member is expected to require inpatient services, but must not be based solely on this factor. The decision to admit is a medical determination that is based on factors, including but not limited to the:

(1) member's medical history;
(2) member's current medical needs;
(3) severity of the signs and symptoms exhibited by the member;
(4) medical predictability of an adverse clinical event occurring with the member;
(5) results of outpatient diagnostic studies;
(6) types of facilities available to inpatients and outpatients; and
(7) MassHealth Acute Inpatient Hospital Admission Guidelines (in section D of this appendix).

D. Acute Inpatient Hospital Admission Guidelines

The following guidelines describe admissions that generally are not medically necessary. This is not an all-inclusive list. MassHealth or its agent may also determine that other admissions not characterized in this list are medically unnecessary and nonreimbursable on an inpatient basis.

1. The admission occurs following observation services, and the admitting provider has not documented at least one of the following in the medical record at the time the decision to admit is made:
   - Failure to respond to outpatient treatment and a clear deterioration of the patient's clinical status;
   - a significant probability that the treatment plan will continue to need frequent clinical modifications and what specific modifications are necessary;
   - instability of the patient that is a deviation from either normal clinical parameters or the patient's baseline; or
   - a requirement for more intensive services than were already being delivered while the patient was on observation status, and a physician's order for each specific new service.

2. The admission occurs when the member's condition had improved significantly in response to outpatient treatment with a progression toward either normal clinical parameters or the member's baseline.

3. The admission is for further monitoring or observing for potential complications when the member undergoes a procedure that is appropriately performed in an outpatient setting according to the current standards of care, the procedure is performed without complications, and the member's clinical status is approaching either normal clinical parameters or his or her baseline.

4. The admission is primarily for providing or monitoring the services and treatment of a member with multiple or complex medical needs whose needs were adequately being met in a setting other than an acute inpatient hospital prior to that admission.

5. The admission of a member whose baseline clinical status is outside of the normal clinical parameters and whose condition has been managed successfully on an outpatient basis, when the admission is based primarily on the member's abnormal status, unless that status has significantly deteriorated.

6. The admission is primarily to observe for the possible progression of labor when examination and monitoring does not indicate definite progression of active labor leading to delivery.

7. The admission is primarily for education, teaching, minor medication changes and/or monitoring, or adjustment of therapies associated with a medically stable condition(s).

8. The admission is primarily because the member requires sedation or anesthesia in order to conduct diagnostic tests that are appropriately performed in an outpatient setting according to the current standards of care, when there are no serious complications requiring inpatient services.

9. The admission of a member whose baseline condition requires the use of complex medical technology, when the admission is primarily due to the need for such technology or other maintenance services related to the pre-existing medical condition(s), unless the member's condition is significantly deteriorating.

10. The admission is primarily for a continuation of treatment or monitoring that has already been delivered effectively in the home, hospital outpatient department, or other institutional setting.

11. The admission of a member who is a patient or resident in another institutional setting, and is admitted primarily for diagnostic or treatment services that could have been provided in the member's current institutional setting or by using outpatient services.

12. The admission of a member who has simple, uncomplicated, outpatient surgery and is being admitted primarily because of the time of day or the need for postoperative observation.

13. The admission is primarily due to the:
    - amount of time a member has spent as an outpatient in a hospital or other outpatient setting;
    - time of day a member recovers from outpatient surgery;
    - need for education of the member, parent, or primary caretaker;
    - need for diagnostic testing or obtaining consultations;
    - need to obtain medical devices or equipment or arrange home care or other noninstitutional services;
    - age of the member;
    - convenience of the physician, hospital, member, family, or other medical provider;
    - type of unit within the hospital in which the member is placed; or
    - need for respite care.

E. Observation Services

[excerpted from MassHealth outpatient hospital regulations at 130 CMR 410.414]

Reimbursable Services. MassHealth covers medically necessary observation services provided by acute inpatient hospitals. Reimbursable observation services may exceed 24 hours, and do not need to be provided in a distinct observation unit. To qualify for reimbursement of observation services, the medical record must specifically document when those services began and ended, the purpose of observation, and the name of the physician who ordered it. Acute inpatient hospitals will be reimbursed for these observation services on an outpatient basis in accordance with the signed provider agreement with the MassHealth agency.

Nonreimbursable Services.

(1) Nonreimbursable observation services include but are not limited to:
    (a) services that are not reasonable or necessary for the diagnosis or treatment of the member; and
    (b) routine preparation and recovery services associated with diagnostic testing or outpatient surgery.

(2) The following services are not reimbursable as a separate service:
    (a) postoperative monitoring during a standard recovery period that should be characterized as recovery-room services; and
    (b) observation services provided concurrently with therapeutic services such as chemotherapy.

This page is reserved.