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

MASSHEALTH
TRANSMITTAL LETTER PHY-104
May 2005

TO: Physicians Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: *Physician Manual* (Revision to Service Limitations)

This letter transmits revisions to the physician regulations about topical acne products. The revision removes language about service limitations for topical acne products. Service limitations to this type of drug therapy will be in the MassHealth Drug List.

In addition, this letter transmits revisions to the regulations about oral drugs. The change adds oral radiopharmaceuticals to the oral drugs MassHealth pays for that can be dispensed in the physician's office without prior authorization.

The revisions also clarify service limitations and exclusions.

These regulations are effective May 15, 2005.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Physician Manual

Pages iv-a and 4-31 through 4-36

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Physician Manual

Page iv-a — transmitted by Transmittal Letter PHY-95

Pages 4-31 and 4-32 — transmitted by Transmittal Letter PHY-103

Pages 4-33 through 4-36 — transmitted by Transmittal Letter PHY-92

4. PROGRAM REGULATIONS (cont.)

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.

(C) Service Limitations.

(1) MassHealth covers drugs that are not explicitly excluded under 130 CMR 433.443(B). The limitations and exclusions in 130 CMR 433.443(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 433.000. 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;

(c) drugs used for the treatment of male or female sexual dysfunction; and

(d) 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 any 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.

433.444: Pharmacy Services: Insurance Coverage

(A) 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.

(B) 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 433.443(C)(2)(a), (c), and (d). 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.

433.445: 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 433.442(A) and 433.443(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 *Physician Manual*. If the MassHealth agency approves the request, it will notify the pharmacy and the member.

(C) The MassHealth agency will authorize at least a 72-hour emergency supply of a prescription drug to the extent required by federal law. (See 42 U.S.C. 1396r-8(d)(5).) The MassHealth agency acts on requests for prior authorization for a prescribed drug within a time period consistent with federal regulations.

(D) Prior authorization does not waive any other prerequisites to payment such as, but not limited to, member eligibility or requirements of other health insurers.

433.446: Pharmacy Services: Member Copayments

Under certain conditions, the MassHealth agency requires that members make a copayment to the dispensing pharmacy for each original prescription and for each refill for all drugs (whether legend or nonlegend) covered by MassHealth. The copayment requirements are detailed in 130 CMR 450.130.

433.447: Pharmacy Services: Payment

Drugs and biologicals dispensed in the office are payable, subject to the service limitations at 130 CMR 433.404, 433.406, and 433.443. The MassHealth agency does not pay a physician separately for drugs that are considered routine and integral to the delivery of a physician's professional services in the course of diagnosis or treatment. Such drugs are commonly provided without charge or are included in the physician's fee for the service. The MassHealth agency does not pay separately for any oral drugs dispensed in the office for which the physician has not requested and received prior authorization from the MassHealth agency, with the exception of oral vaccines and oral radiopharmaceuticals, which do not require prior authorization. Claims for drugs and biologicals that are listed in Subchapter 6 of the *Physician Manual* must include the name of the drug or biological, strength, dosage, and number of units dispensed. A copy of the invoice showing the actual acquisition cost must be attached to the claim form for drugs and/or biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Physician Manual*, and must include the National Drug Code (NDC). Claims without this information are denied. The MassHealth agency does not pay for a biological if the Massachusetts Department of Public Health distributes the biological free of charge. Payment for drugs may be claimed in addition to an office visit.

(130 CMR 433.448 through 433.450 Reserved)

PART 3. SURGERY SERVICES

433.451: Surgery Services: Introduction

(A) Provider Eligibility. The MassHealth agency will pay a physician for surgery only if the physician is scrubbed and present in the operating room during the major portion of the operation. (See 130 CMR 433.421(D)(1) for the single exception to this requirement.)

(B) Nonpayable Services. The MassHealth agency does not pay for:

(1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment. This specifically includes, but is not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries.

(2) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).

(3) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the physical effects of physical disease or defect, or traumatic injury.

(4) services billed under codes listed in Subchapter 6 of the *Physician Manual* as not payable.

(5) services otherwise identified in the MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable.

(6) otherwise covered service codes when such codes are used to bill for nonpayable circumstances as described in 130 CMR 433.404.

433.452: Surgery Services: Payment

The maximum allowable fees for the surgery services apply to surgery procedures performed in any setting. The MassHealth agency pays a physician for either a visit or a treatment/procedure, whichever commands a higher fee. The MassHealth agency does not pay for both a visit and a treatment/procedure provided to a member on the same day when they are performed in the same location. All maximum allowable fees for surgery procedures include payment for the initial application of casts, traction devices, or similar appliances.

(A) Obstetrics. Obstetric fees include payment for procedures performed and care given to a member in a hospital or at home. However, the MassHealth agency will give individual consideration to a claim for extended obstetric preoperative or postoperative care due to unusual circumstances, if the physician requests it and attaches adequate medical documentation to the claim form.

(B) Inpatient Services.

(1) For surgery procedures performed on an inpatient in a licensed hospital, the fees include payment for preoperative diagnosis and postoperative care during the period of hospitalization.

(2) The MassHealth agency will give individual consideration to a claim for extended preoperative or postoperative care due to unusual circumstances if the physician requests it and attaches adequate medical documentation to the claim form.

(3) A physician who performs an inpatient surgery procedure but does not provide the postoperative care will be paid 85 percent of the maximum allowable fee. The physician providing the postoperative care will be paid according to the applicable office, hospital, or home visit fee.

(C) Surgical Assistants. The MassHealth agency pays a surgical assistant at 15 percent of the allowable fee for the surgical procedure. The MassHealth agency will not pay for a surgical assistant if a surgical assistant is used in less than five percent of the cases for that procedure nationally. In addition, the MassHealth agency will not pay for a surgical assistant if:

(1) any component of the surgery is billed using a team surgery modifier pursuant to 130 CMR 433.452(D) or a two-surgeon modifier pursuant to 130 CMR 433.452(E); or

(2) the surgery services were provided in a teaching hospital that has an approved training program related to the medical specialty required for the surgical procedure(s) and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the MassHealth agency will pay for a surgical assistant if the member's medical record documents that a qualified resident was unavailable at the time of the surgery.

(D) Team Surgery. Under some circumstances, the MassHealth agency pays for highly complex surgical procedures requiring the concomitant services of more than two surgeons as "team surgery." The MassHealth agency pays a single consolidated payment for team surgery to the director of the surgical team. To receive payment, the director of the team must use the team surgery modifier. Payment includes all surgical assistant fees. The director of the surgical team is expected to distribute the MassHealth payment to the other physician members of the surgical team.

(E) Two Surgeons (Co-Surgery). The MassHealth agency pays for co-surgery when two surgeons work together as primary surgeons performing distinct parts of a reportable procedure. To receive payment, each surgeon must use the two surgeons modifier. The MassHealth agency pays 57.5 percent of the allowable fee to each of the two surgeons. Payment includes all surgical assistant fees.

(F) Multiple Procedures. In most circumstances, the MassHealth agency will pay for only one operative procedure in a single operative session. For example, it is inappropriate to request payment for both an exploratory laparotomy and an appendectomy, or for both an arthrotomy and a meniscectomy. When two definitive procedures are performed during the same operative session, and neither procedure is designated "I.P." (for independent procedure) (see 130 CMR 433.452(G)), the full maximum allowable fee will be paid for one procedure, and 50 percent of the maximum allowable fee will be paid for each additional procedure.

(G) Independent Procedures. A number of surgery procedures are designated "I.P." in Subchapter 6 of the *Physician Manual*. I.P. is an abbreviation for independent procedure. An independent procedure is reimbursable only when no other procedure is performed during the same operative session, unless one of the exceptions in 130 CMR 433.452(G)(1) through (3) applies.

(1) When during the same operative session an additional surgery procedure performed by the same physician is designated "I.P." and requires an unrelated operative incision, the full maximum allowable fee will be paid for the procedure with the largest fee, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein. In the event that two or more procedures are scheduled at the largest amount, the full maximum allowable fee will be paid for only one of the procedures, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein.

(2) When during the same operative session one or more of the surgery procedures performed by the same physician is designated "I.P." and does not require an unrelated operative incision, the maximum allowable fee will be paid for the procedure commanding the largest fee, and no payment will be made for any other procedure.

(3) When during the same operative session all of the surgery procedures performed by the same physician are designated "I.P." and one or more requires an unrelated operative incision, payment is determined on the basis of individual consideration.

(130 CMR 433.453 Reserved)

433.454: Anesthesia Services

(A) Payment.

(1) Payment Determination. Payment for anesthesia services is determined using base anesthesia units and time units. To determine payment, the MassHealth agency multiplies the anesthesia unit fee established by DHCFP by the time units reported on the claim pursuant to 130 CMR 433.454(A)(2)(c), plus the number of base units, if any have been set by DHCFP. The number of base units is the same for a surgical procedure, regardless of the type of anesthesia administered, including acupuncture (see 130 CMR 433.454(C)).

(2) Calculation.

(a) Anesthesia Units. The MassHealth agency pays for anesthesia services by multiplying the time units plus any base anesthesia units by the unit fee established by DHCFP. If DHCFP has not established base anesthesia units for a service, the MassHealth agency pays using time units only.

(b) Determining Payable Anesthesia Time. Payable anesthesia time starts when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or equivalent area. Payable anesthesia time ends when the patient may be safely placed under postoperative supervision.

(c) Reporting Time Units. A provider's claim must report only payable time units. It must not include base anesthesia units or units that exceed the criteria described in 130 CMR 433.454(A)(1)(b) in the number of units field on the claim. To calculate the correct number of time units, the provider must determine the number of 15-minute intervals of payable anesthesia time plus any remaining fraction, provided such fraction equals or exceeds five minutes.

(3) Multiple Surgery Procedures. When anesthesia is administered for multiple surgery procedures, the MassHealth agency applies only the base anesthesia units for the procedure with the largest number of units to determine the maximum allowable fee.

(B) Services Provided by a Nurse-Anesthetist.

(1) Anesthesia services provided by a nurse-anesthetist are payable only if the nurse-anesthetist

(a) is authorized by law to perform the services;

(b) is a full-time employee of the physician and is not a salaried employee of the hospital; and

(c) performs the services under the direct and continuous supervision of the physician.

(2) The supervising physician must be in the operating suite and responsible for no more than four operating rooms. Availability of the physician by telephone does not constitute direct and continuous supervision.

(C) Acupuncture as an Anesthetic. The MassHealth agency pays for acupuncture only as a substitute for conventional surgical anesthesia.