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Office of Medicaid
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Boston, MA 02111
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MASSHEALTH
TRANSMITTAL LETTER PHY-111
June 2006

TO: Physicians Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: *Physician Manual* (Revised Regulations About New Tobacco Cessation Services and Independent Diagnostic Testing Facility (IDTF) Services)

I. 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 detail 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 institution of higher education and have completed at least eight hours of course instruction. All nonphysicians must provide services under the supervision of a physician. Physicians, independent nurse practitioners, and independent nurse midwives may submit claims to MassHealth for tobacco cessation services they provide directly to MassHealth members.

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. Distinct modifiers are required with the HCPCS code for claims processing. These modifiers vary by the type of service provided and by the provider. Please see the attachment "Tobacco Cessation Coding and Rates Chart" for important coding information. For more 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 *Physician Manual* under tobacco cessation services.

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

These regulations are effective July 1, 2006.

II. Independent Diagnostic Testing Facility (IDTF) Services

This transmittal letter issues changes to the physician regulations to be consistent with new provider regulations for independent diagnostic testing facility (IDTF) services at 130 CMR 431.000. IDTFs perform portable X-ray services, freestanding magnetic resonance imaging (MRI) services, diagnostic imaging services, sleep center services, and services performed by mammography vans.

Revisions to the physician program regulations include adding a definition of the term independent diagnostic testing facility at 130 CMR 433.401. Additional conforming changes have also been made to other sections of these regulations.

Providers who are enrolled as a group practice but meet the IDTF provider eligibility requirements, as stated in 130 CMR 431.404, must reenroll as an IDTF. Potential applicants may contact the MassHealth Provider Enrollment and Credentialing at 1-800-841-2900 or providersupport@mahealth.net for an enrollment application package or enrollment questions.

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.)

Physician Manual

Pages iv, vi, 4-3, 4-4, 4-9, 4-10, 4-29 through 4-34, 4-37, 4-38, 6-15, 6-16, and E-1 through E-4

OBSOLETE MATERIAL

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

Physician Manual

Pages iv, 4-3, 4-4, 4-9, 4-10, 4-29 through 4-34, 4-37, and 4-38 — transmitted by Transmittal Letter PHY-109

Pages vi and 6-15 — transmitted by Transmittal Letter PHY-110

Pages E-1 through E-4 — transmitted by Transmittal Letter PHY-84

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"

Tobacco Cessation Counseling Service Rates

Service Code (modifiers)	**Mid-Level Practitioner Rate (85%)**		**Physician Rate**	
	NFAC Rate($)	**FAC Rate($)**	**NFAC Rate($)**	**FAC Rate($)**
G0376 (SA,SB,HN,TD,U1) Individual Counseling 30 minutes	42.10	41.39	49.53	48.69
GO376 (TF or U2) Individual Counseling Intake 45 minutes	63.20	62.08	74.30	73.04
G0376 (HQ or U3) Group Counseling 60 to 90 minutes	25.26	24.83	29.72	29.21

4. Program Regulations

Part 1. General Information

Part 2. Medical Services

6. Service Codes

Hospital Visit – a bedside visit by a physician to a hospitalized member, except for routine preoperative and postoperative care.

Hysterectomy – a medical procedure or operation for the purpose of removing the uterus.

Independent Diagnostic Testing Facility (IDTF) – a Medicare-certified diagnostic imaging center, freestanding MRI center, portable X-ray provider, sleep center, or mammography van in a fixed location or mobile entity independent of a hospital or physician's office, that performs diagnostic tests and meets the requirements of 130 CMR 431.000.

Individual Psychotherapy – private therapeutic services provided to a member to lessen or resolve emotional problems, conflicts, and disturbances.

Institutionalized Individual – a member who is either:

(1) involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or

(2) confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

Intensive Care Services – the services of a physician other than the attending physician, provided for a continuous period of hours (rather than days), required for the treatment of an unusual aspect or complication of an illness, injury, or pregnancy.

Interchangeable Drug Product – a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A-rated") by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

Legend Drug – any drug for which a prescription is required by applicable federal or state law or regulation.

Maintenance Program – repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment and skill of a licensed physician or licensed therapist for safety and effectiveness.

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by the MassHealth agency. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 433.443(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 433.000.

Mentally Incompetent Individual – a member who has been declared mentally incompetent for any purpose by a federal, state, or local court of jurisdiction, unless the individual has been declared competent to consent to sterilization.

Multiple-Source Drug – a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Nonlegend Drug – any drug for which no prescription is required by federal or state law.

Not Otherwise Classified – a term used for service codes that should be used when no other service code is appropriate for the service provided.

Occupational Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence, preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

Oxygen – gaseous or liquid medical-grade oxygen that conforms to United States Pharmacopoeia Standards.

Pediatric Office Visit – a medical visit by a member under 21 years of age to a physician's office or to a hospital outpatient department.

Pharmacy Online Processing System (POPS) – the online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

Physical Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

Prolonged Detention – constant attendance to a member in critical condition by the attending physician.

Reconstructive Surgery – a surgical procedure performed to correct, repair, or ameliorate the physical effects of physical disease or defect (for example, correction of cleft palate), or traumatic injury.

(B) The MassHealth agency determines the appropriate payment for a service requiring individual consideration 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;
(5) any complications or other circumstances that the MassHealth agency deems relevant;
(6) the policies, procedures, and practices of other third-party insurers;
(7) the payment rate for drugs as set forth in the MassHealth pharmacy regulations at 130 CMR 406.000; and
(8) for drugs or supplies, a copy of the invoice from the supplier showing the actual acquisition cost.

433.407: Service Limitations: Professional and Technical Components of Services and Procedures

Additional limitations are set forth in 130 CMR 433.413 and 433.437.

(A) Definitions.

(1) Mobile Site – any site other than the physician's office, but not including community health centers, hospital outpatient departments, or hospital-licensed health centers.
(2) Professional Component – the component of a service or procedure representing the physician's work interpreting or performing the service or procedure.
(3) Technical Component – the component of a service or procedure representing the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses of the service or procedure, excluding the physician's professional component.

(B) Payment. A physician may bill for the professional component of a service or procedure or, subject to the conditions of payment set forth in 130 CMR 433.407(C), both the professional and technical components of the service or procedure. The MassHealth agency does not pay a physician for providing the technical component only of a service or procedure.

(C) Conditions of Payment for the Provision of Both the Professional and Technical Components of a Service or Procedure. Only the physician providing the professional component of the service or procedure may bill for both the professional and technical components. This constitutes a limited exception to 130 CMR 450.301. A physician may bill for providing both the professional and technical components of a service or procedure in the physician's office when the physician owns or leases the equipment used to perform the service or procedure, provides the technical component (either directly or by employing a technician), and provides the professional component.

433.408: Prior Authorization

(A) Introduction.

(1) Subchapter 6 of the *Physician Manual* lists codes that require prior authorization as a prerequisite for payment. The MassHealth agency does not pay for services if billed under any of these codes, unless the provider has obtained prior authorization from the MassHealth agency before providing the service.

(2) A prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as member eligibility or resort to health insurance payment.

(B) Requesting Prior Authorization. All prior-authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Physician Manual*.

(C) Physician Services Requiring Prior Authorization. Services requiring prior authorization include, but are not limited to, the following:

(1) certain surgery services, including reconstructive surgery;

(2) nonemergency services provided to a member by an out-of-state physician who practices outside a 50-mile radius of the Massachusetts border;

(3) certain vision care services; and

(4) certain psychiatry services.

(D) Mental Health and Substance Abuse Services Requiring Prior Authorization. Members enrolled with the MassHealth behavioral health contractor require service authorization before certain mental health and substance abuse services are provided. For more information, see 130 CMR 450.124.

(C) Supervisory Arrangement Requirements.

(1) The services of a physician assistant must be performed under the supervision of a physician. For purposes of 130 CMR 433.434, "supervision" or "supervise" means that the supervising physician is principally responsible for all medical decisions relating to physician assistant services and is either:

(a) immediately available to the physician assistant in person or by means of a communication device; or

(b) in actual physical attendance at and during the provision of those physician assistant services identified in written guidelines as requiring the physician's physical presence. (See 130 CMR 433.434(C)(3).)

(2) The physician assistant's supervising physician must be a MassHealth provider who engages in the same type of clinical practice as the physician assistant. Such supervising physician must be the physician assistant's employer or a physician member of the physician assistant's employer group. (See 130 CMR 433.434(E).)

(3) The physician assistant must practice in accordance with written guidelines developed in conjunction with the supervising physician as set forth in 263 CMR 5.04. The guidelines must specify:

(a) what services the physician assistant can perform;

(b) the established procedures for common medical problems; and

(c) those services for which the supervising physician must be physically present.

(4) The physician assistant's supervising physician must designate another licensed physician to provide temporary supervision in circumstances where the supervising physician is unavailable. Such designated physician must be a MassHealth provider who engages in the same type of clinical practice as the supervising physician. The name of such physician must be documented in the member's records.

(5) The physician assistant's supervising physician is, in all cases, responsible for ensuring that each task performed by a physician assistant is properly supervised, even under circumstances involving temporary supervision by another physician pursuant to 130 CMR 433.434(C)(2).

(6) A supervising physician may not supervise more than the number of physician assistants allowed in 263 CMR 5.00.

(D) Nonpayable Services.

(1) Physician supervision of or consultation with a physician assistant is not payable as a separate service.

(2) The MassHealth agency does not pay for surgical assistance provided by a physician assistant.

(E) Submitting Claims for Physician Assistants. A physician assistant is not eligible to enroll as a MassHealth provider. As an exception to 130 CMR 450.301(A), a physician or group practice who is an employer of a physician assistant may submit claims for services provided by a physician assistant employee but only if such services are provided in accordance with 130 CMR 433.434, and payment is claimed in accordance with 130 CMR 450.301(B).

433.435: Tobacco Cessation Services

(A) Introduction. MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 433.435(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 433.435(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:

(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 institution of higher education with a minimum of eight hours of instruction.

(2) Supervision of Tobacco Cessation Counseling Services. A physician must supervise all nonphysician providers of tobacco cessation counseling services for whom the physician will submit claims.

(D) Tobacco Cessation Services: Claims Submission.

(1) Physicians, independent nurse practitioners, and independent nurse midwives may submit claims for tobacco cessation services when they provide those services directly to MassHealth members. These are the only MassHealth provider types who may bill for this service independently. A physician may submit claims for tobacco cessation counseling services that are provided by physicians, nurse practitioners, registered nurses, nurse midwives, physician assistants, and MassHealth-qualified tobacco cessation counselors according to 130 CMR 433.435(B) and (C). See Subchapter 6 of the *Physician Manual* for service code descriptions.

(2) As an exception to 130 CMR 450.301(A), a physician that is an employer of a nonphysician provider of tobacco cessation counseling may submit claims for services provided by a nonphysician employee, but only if such services are provided in accordance with 130 CMR 433.435(B) and (C) and payment is claimed in accordance with 130 CMR 450.301(B).

433.436: Radiology Services: Introduction

The MassHealth agency pays for radiology services only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Services Provided by an Independent Diagnostic Testing Facility (IDTF). The MassHealth agency pays an IDTF as defined in 130 CMR 433.401 for applicable diagnostic tests in accordance with the independent diagnostic testing facility regulations at 130 CMR 431.000.

(B) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (see 130 CMR 433.409), the physician must keep suitable records of radiology services performed. All X rays must be labeled adequately with the following:

(1) the member's name;
(2) the date of the examination;
(3) the nature of the examination; and
(4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

See also the general limitations described at 130 CMR 433.407.

(A) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays physicians in accordance with the DHCFP fee schedule. The MassHealth agency does not pay for the interpretation of an X ray that was previously read and taken in the same hospital. However, the MassHealth agency does pay a physician for interpreting an X ray that was previously read and taken in a different hospital.

(B) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays the physician in accordance with the DHCFP fee schedule.

(C) Surgical Introductions and Interpretations. The MassHealth agency pays a physician for performing surgical introductions and interpretations of films performed in a hospital inpatient or outpatient setting, with the following restrictions.

(1) Only one surgical introduction per operative session is payable in accordance with the DHCFP fee schedule.
(2) In a single operative session:
    (a) no more than three additional surgical introductions using the same puncture site are payable, each in accordance with the DHCFP fee schedule; and
    (b) no more than three additional selective vascular studies using the same puncture site are payable, each at the maximum allowable fee.
(3) Interpretations are payable in accordance with the DHCFP fee schedule, up to a maximum of three.

(D) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a member by one or more physicians are payable only if sufficient documentation for each is shown in the member's medical record.

(E) Interventional Radiology. If interventional radiology services are performed by two providers, the professional component is divided equally into surgical and interpretative components.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a member are payable under MassHealth.

(A) Provider Eligibility. The MassHealth agency pays for laboratory tests only when they are performed on a member by a physician or by an independent clinical laboratory certified by Medicare.

(B) Payment.

(1) Except for the circumstance described in 130 CMR 433.438(B)(2), the MassHealth agency pays a physician only for laboratory tests performed in the physician's office. If a physician uses the services of an independent clinical laboratory, the MassHealth agency pays only the laboratory for services provided for a member.

(2) A physician may bill the MassHealth agency for laboratory services provided on a fee-for-service basis by the state laboratory of the Massachusetts Department of Public Health.

(C) Information with Specimen. A physician who sends a specimen to an independent clinical laboratory participating in MassHealth must also send the following:

(1) a signed request for the laboratory services to be performed;
(2) the member's MassHealth identification number; and
(3) the physician's name, address, and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The MassHealth agency does not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). However, the MassHealth agency will pay a physician who collects, centrifuges, and mails a specimen to a laboratory for analysis once per member specimen, regardless of the number of tests to be performed on that specimen.

(B) Professional Component of Laboratory Services. The MassHealth agency does not pay a physician for the professional component of a clinical laboratory service. The MassHealth agency pays a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The MassHealth agency does not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. Payment for laboratory services includes payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests.

(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the physician performing the tests.

(b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.

(2) In no event may a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

(E) Forensic Services. The MassHealth agency does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438, including but not limited to:

(1) tests performed to establish paternity;

(2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and

(3) post-mortem examinations.

(130 CMR 433.440 Reserved)

433.443: 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 433.444); 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) 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 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; 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 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) 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.

604 HCPCS Level II Service Codes (cont.)

Service Code	Service Description
R0070	Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen
S0020	Injection, bupivicaine HCl, 30 ml
S0021	Injection, ceftoperazone sodium, 1 gram (IC)
S0023	Injection, cimetidine HCl, 300 mg (IC)
S0028	Injection, famotidine, 20 mg (IC)
S0077	Injection, clindamycin phosphate, 300 mg (IC)
S0162	Injection, efalizumab, 125 mg (IC), (PA)
S0302	Completed early periodic screening diagnosis and treatment (EPSDT) service (List in addition to code for appropriate evaluation and management services.)
S2260	Induced abortion, 17 to 24 weeks, any surgical method (CPA-2) (second trimester, third trimester in hospital only)
S4989	Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies (IC)
S4993	Contraceptive pills for birth control
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter

605 Modifiers

The following service code modifiers are allowed for billing under MassHealth. See Subchapter 5 of the *Physician Manual* for billing instructions related to the use of modifiers.

26 Professional component
50 Bilateral procedure
51 Multiple procedures
54 Surgical care only
62 Two surgeons
66 Surgical team
80 Assistant surgeon
82 Assistant surgeon (when qualified resident surgeon not available)
99 Multiple modifiers
FP Services provided as part of Medicaid Family Planning Program
HN Bachelor's degree level (Use to indicate physician assistant.) (This modifier is to be applied to service codes billed by a physician that were performed by a physician assistant employed by the physician or group practice.)
RP Replacement and repair (This modifier should only be used with 92340, 92341, and 92342 to bill for the displacement of replacement lenses.)
SA Nurse practitioner rendering service in collaboration with a physician (This modifier is to be applied to service codes billed by a physician which were performed by a non-independent nurse practitioner employed by the physician or group practice.) (An independent nurse practitioner billing under his/her own individual provider number should not use this modifer.)

605 Modifiers (cont.)

SB Nurse midwife (This modifier is to be applied to service codes billed by a physician which were performed by a non-independent nurse midwife employed by the physician or group practice.) (An independent nurse midwife billing under his/her own individual provider number should not use this modifier.)

SL State supplied vaccine (This modifier should only be applied to Service codes 90465, 90467, 90471 and 90473 to identify vaccines administered under the Vaccine for Children Program (VFC) for individuals age 18 and under.)

TC Technical component (The component of a service or procedure representing the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses of the service or procedures, excluding the physician's professional component. When the technical component is reported separately the addition of modifier '-TC' to the service code will let the technical component allowable fee contained in 114.3 CMR 17.04 be paid.)

606 Tobacco Cessation Services

Service Code	Service Description
G0376	Tobacco cessation individual counseling provided by a physician, an independent nurse practitioner (NP), or an independent nurse midwife.

Service Code-Modifier	Service Description
G0376-HN	Tobacco cessation individual counseling provided by a physician's assistant
G0376-HQ	Tobacco cessation group counseling, at least 60 to 90 minutes in duration, provided by a physician
G0376-SA	Tobacco cessation individual counseling provided by a nurse practitioner
G0376-SB	Tobacco cessation individual counseling provided by a nurse midwife
G0376-TD	Tobacco cessation individual counseling provided by a registered nurse
G0376-TF	Tobacco cessation individual counseling, intermediate level of care (intake/assessment) provided by a physician
G0376-U1	Tobacco cessation individual counseling provided by a tobacco cessation counselor
G0376-U2	Tobacco cessation individual intake/assessment counseling, at least 45 minutes in duration, provided by a nurse practitioner, nurse midwife, physician's assistant, registered nurse, or a tobacco cessation counselor, under the supervision of a physician
G0376-U3	Tobacco cessation group counseling, at least 60 to 90 minutes in duration, provided by a nurse practitioner, nurse midwife, physician's assistant, registered nurse, or a tobacco cessation counselor, under the supervision of a physician

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.

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