Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
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MASSHEALTH
TRANSMITTAL LETTER PHY-116
February 2007

TO: Physicians Participating in MassHealth

FROM: Tom Dehner, Acting Medicaid Director TD

RE: *Physician Manual* (Vision Care Services)

Effective July 1, 2006, MassHealth expanded vision care services to eligible members aged 21 years or older. At that time, MassHealth revised the vision care regulations at 130 CMR 402.000 to support this expansion.

Transmittal Letter PHY-114 transmitted a revision to the physician regulations at 130 CMR 433.425. The revision removed the age restrictions, effective July 1, 2006, and referred providers directly to the vision care regulations at 130 CMR 402.000 for additional coverage information.

This transmittal letter restores some of the language at 130 CMR 433.425 inadvertently deleted by Transmittal Letter PHY-114. The purpose of the restoration is to make clear that, consistent with its longstanding practice, MassHealth continues to cover eye examinations provided by ophthalmologists as described in the physician regulations at 130 CMR 433.425.

These regulations are effective retroactive to July 2, 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 and 4-19 through 4-22

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(The pages listed here are no longer in effect.)

Physician Manual

Pages iv and 4-19 through 4-22 — transmitted by Transmittal Letter PHY-114

4. Program Regulations

Part 1. General Information

Part 2. Medical Services

(2) If the primary provider bills for the global fee, no referred provider may claim payment from the MassHealth agency. Payment of the global fee constitutes payment in full both to the primary provider and each referred provider.
(3) If the primary provider bills for the global fee, any provider who is not a referred provider but who performed prenatal visits or postpartum visits for the member may claim payment for such services only on a fee-for-service basis. If the primary provider bills for the global fee, no other provider may claim payment for the delivery.
(4) If the primary provider bills on a fee-for-service basis, any other provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services provided to the same member.

(D) Recordkeeping for Global Fee. The primary provider is responsible for documenting, in accordance with 130 CMR 433.409, all the service components of a global fee. This includes services performed by referred providers or employees of the primary provider. All hospital and ambulatory services, including risk assessment and medical visits, must be clearly documented in each member's record in a way that allows for easy review of her obstetrical history.

(130 CMR 433.422 and 433.423 Reserved)

433.424: Obstetric Services: Fee-for-Service Method of Payment

The fee-for-service method of payment is always available to a provider for obstetric services covered by the MassHealth agency. If the global-fee requirements in 130 CMR 433.421 are not met, the provider or providers may claim payment from the MassHealth agency only on a fee-for-service basis, as specified below.

(A) When there is no primary provider for the obstetric services performed for the member, each provider may claim payment only on a fee-for-service basis.

(B) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the member may claim payment only on a fee-for-service basis.

(C) When an independent nurse midwife is the primary provider and the collaborating physician performs a cesarean section, the independent nurse midwife may claim payment for the prenatal visits only on a fee-for-service basis. The collaborating physician may claim payment for the cesarean section only on a fee-for-service basis.

(D) When additional services (for example, ultrasound or special tests) are performed, the provider may claim payment for these only on a fee-for-service basis.

433.425: Ophthalmology Services

The MassHealth agency pays for ophthalmic materials in accordance with the vision care regulations at 130 CMR 402.000. The MassHealth agency pays for eye examinations subject to the following limitations.

(A) Comprehensive Eye Examinations.
(1) The MassHealth agency does not pay for a comprehensive eye examination if the service has been provided
  (a) within the preceding 12 months, for a member under 21 years of age; or
  (b) within the preceding 24 months, for a member 21 years of age or older.
(2) The restrictions at 130 CMR 433.425(A)(1) do not apply if one of the following complaints or conditions is documented in the member's medical record:
  (a) blurred vision;
  (b) evidence of headaches;
  (c) systemic diseases, such as diabetes, hyperthyroidism, or HIV;
  (d) cataracts;
  (e) pain;
  (f) redness; or
  (g) infection.

(B) Consultation Service. The MassHealth agency pays for a consultation service only if it is provided independently of a comprehensive eye examination.

(C) Screening Services. The MassHealth agency does not pay for a screening service if two screening services have been furnished to the member within the preceding 12 months.

(D) Comprehensive Eye Examinations and Screening Services. A comprehensive eye examination includes a screening service. If the provider performs both a screening service and a comprehensive eye examination for the same member, the MassHealth agency pays for only the comprehensive eye exam.

(E) Tonometry. The MassHealth agency does not pay for a tonometry as a separate service when it is performed as part of a comprehensive eye examination, consultation, or screening service. When a tonometry is performed as a separate service to monitor a member who has glaucoma, the provider must use the appropriate service code.

433.426: Audiology Services: Service Limitations

The MassHealth agency pays for audiology services only when they are provided either by a physician, or by an audiologist licensed or certified in accordance with 130 CMR 426.404 who is employed by a physician. This limitation does not apply to an audiometric hearing test, pure-tone, air only.

433.427: Allergy Testing: Service Limitations

(A) The MassHealth agency pays for allergy testing only when performed by a physician or under a physician's direct supervision. All fees include payment for physician observation and interpretation of the tests in relation to the member's history and physical examination. A physician may bill for an initial consultation in addition to allergy testing.

(B) The MassHealth agency does not pay for more than three blood tests and pulmonary function tests (such as spirometry and expirogram) used only for diagnosis and periodic evaluation per member per year.

(C) Immunotherapy and desensitization (extracts) are covered services. The provider must indicate the amount and anticipated duration of the supply for immunotherapy and desensitization (extracts) on the claim form.

(D) The MassHealth agency pays for follow-up office visits for injections and reevaluation as office visits.

(E) The MassHealth agency pays for sensitivity tests only once per member per year regardless of the type of tests performed or the number of visits required.

433.428: Psychiatry Services: Introduction

(A) Covered Services. The MassHealth agency pays for the psychiatry services described in 130 CMR 433.429.

(B) Noncovered Services.

(1) Nonphysician Services. The MassHealth agency does not pay a physician for services provided by a social worker, psychologist, or other nonphysician mental health professional employed or supervised by the physician.

(2) Research and Experimental Treatment. The MassHealth agency does not pay for research or experimental treatment. This includes, but is not limited to, any method not generally accepted or widely used in the field, or any session conducted for research rather than for a member's clinical need.

(3) Nonmedical Services. The MassHealth agency does not pay a physician for nonmedical services, including, but not limited to, the following:

(a) vocational rehabilitation services;

(b) educational services;

(c) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is payable);

(d) street-worker services (information, referral, and advocacy to certain age populations; liaison with other agencies; role modeling; and community organization);

(e) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and

(f) biofeedback.

(4) Nonmedical Programs. The MassHealth agency does not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other noncovered services. Such programs include freestanding alcohol or drug detoxification programs, freestanding methadone maintenance programs, residential programs, day activity programs, drop-in centers, and educational programs.

(5) Psychological Testing. The MassHealth agency does not pay for psychological testing provided by a physician.

(C) Recordkeeping (Medical Records) Requirements. In addition to the provisions in 130 CMR 433.409, the following specific information must be included in the medical record for each member receiving psychiatric services:

(1) the condition or reason for which psychiatric services are provided;

(2) the member’s diagnosis;

(3) the member’s medical history;