Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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MASSHEALTH
TRANSMITTAL LETTER PHY-117
May 2007

TO: Physicians Participating in MassHealth

FROM: Tom Dehner, Acting Medicaid Director TD

RE: *Physician Manual* (Revisions to Regulations about Medicare Part D)

This letter transmits revisions to the physician regulations about Medicare Part D, as provided in the Massachusetts state budget for fiscal year 2007. The provision extends and expands the state pharmacy assistance available to MassHealth members who have Medicare.

The fiscal year 2007 budget extended the availability of one-time 30-day supplies of prescribed medications for members with Medicare for dates of pharmacy service from July 1, 2006, until December 31, 2006. After this supply, MassHealth paid for a one-time 72-hour supply of the prescribed medication, without a copayment. Effective July 1, 2006, payment for these one-time supplies will be available when a pharmacist is unable to bill a Medicare Part D plan or the point-of-sale facilitator (currently WellPoint/Anthem). Effective January 1, 2007, the one-time 30-day supplies will no longer be available, but MassHealth will still pay for a one-time 72-hour supply of prescribed medications.

Effective July 1, 2006, for cost-sharing assistance for MassHealth members who are enrolled in a Medicare Part D prescription drug plan, if the Medicare Part D copayment or deductible is in excess of the member's applicable MassHealth copayment, the MassHealth member will pay the applicable MassHealth copayment and MassHealth will pay the difference between the applicable MassHealth copayment and the amount charged by the Medicare Part D prescription drug plan.

These regulations are being issued as emergency regulations and are effective July 1, 2006.

MassHealth is reissuing pages 4-13 through 4-16 of the *Physician Manual* to correct a pagination error in the banners. There are no changes to the regulations on those pages.

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-a, 4-13 through 4-16, 4-39, and 4-40

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Physician Manual

Pages iv-a, 4-13, 4-16, 4-39, and 4-40 — transmitted by Transmittal Letter PHY-109

Pages 4-14 and 4-15 — transmitted by Transmittal Letter PHY-112

4. Program Regulations (cont.)

(G) Compliance with the medical record requirements set forth in, referred to in, or deemed applicable to 130 CMR 433.000 will be determined by a peer-review group designated by the MassHealth agency as set forth in 130 CMR 450.206. The MassHealth agency will refuse to pay or, if payment has been made, will consider such payment to be an overpayment as defined in 130 CMR 450.234 subject to recovery, for any claim that does not comply with the medical record requirements established or referred to in 130 CMR 433.000. Such medical record requirements constitute the standard against which the adequacy of records will be measured for physician services, as set forth in 130 CMR 450.205(B).

433.410: Report Requirements

(A) General Report. A general written report or a discharge summary must accompany the physician's claim for payment for any service that is listed in Subchapter 6 of the *Physician Manual* as requiring a report or individual consideration (I.C.), or if the code is for an unlisted service. This report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of the service.

(B) Operative Report. For surgery procedures designated in Subchapter 6 of the *Physician Manual* as requiring individual consideration, the provider must attach operative notes to the claim. An operative report must state the operation performed, the name of the member, the date of the operation, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and surgical assistants, and the technical procedures performed.

(130 CMR 433.411 and 433.412 Reserved)

Part 2. Medical Services

433.413: Office Visits: Service Limitations

(A) Time Limit. Payment for office visits is limited to one visit per day per member per physician.

(B) Office Visit and Treatment/Procedure. The physician may bill for either an office visit or a treatment/procedure, but may not bill for both an office visit and a treatment/procedure for the same member on the same date when the office visit and the treatment/procedure are performed in the same location. This limitation does not apply to tobacco cessation counseling services provided by a physician or a qualified staff member under the supervision of a physician on the same day as a visit. This limitation does not apply to a treatment/procedure that is performed as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit (see 130 CMR 450.140 et seq.); in such a case, the physician may bill for both an EPSDT visit and a treatment/procedure. Examples of treatment/procedures are suturing, suture removal, aspiration of a joint, and cast application or removal. X rays, laboratory tests, and certain diagnostic tests may be billed in addition to an office visit.

(C) Immunization or Injection. When an immunization or injection is the primary purpose of an office or other outpatient visit, the physician may bill only for the injectable material and its administration. However, when the immunization or injection is not the primary purpose of the office or other outpatient visit, a physician may bill for both the visit and the injectable material, but not for its administration. (See 130 CMR 433.440 on drugs dispensed in a physician's office.) The MassHealth agency does not pay for the cost of the injectable material if:

(1) the Massachusetts Department of Public Health distributes the injectable material free of charge; or

(2) its cost to the physician is $1.00 or less.

(D) Family Planning Office Visits. The MassHealth agency pays for office visits provided for the purposes of family planning. The MassHealth agency pays for any family planning supplies and medications dispensed by the physician at the physician’s acquisition cost. To receive payment for the supplies and medications, the provider must attach to the claim a copy of the actual invoice from the supplier.

433.414: Hospital Emergency Department and Outpatient Department Visits

(A) Emergency Department Treatment. The MassHealth agency pays a physician for medical care provided in a hospital emergency department only when the hospital's claim does not include a charge for the physician's services.

(B) Emergency Department Screening Fee. For a member enrolled in the PCC Plan for whom no emergency services were provided, The MassHealth agency pays the hospital-emergency-department physician a screening fee for assessing the level of care required by the member's condition when:

(1) the level of care is determined to be primary care; or

(2) the level of care is determined to be urgent and the member's PCC denies a referral between the hours of 8:00 A.M. and 9:59 P.M.

(C) Outpatient Department Visits. The MassHealth agency pays either a physician or a hospital outpatient department, but not both, for physician services provided in an outpatient department.

433.415: Hospital Services: Service Limitations and Screening Requirements

(A) Hospital inpatient visit fees apply to visits by physicians to members hospitalized in acute, chronic, or rehabilitation hospitals. Payment is limited to one visit per day per member for the length of the member's hospitalization.

(B) The MassHealth agency does not routinely pay for visits to members who have undergone or who are expected to undergo surgery, since the allowable surgical fees include payment for the provision of routine inpatient preoperative and postoperative care. In unusual circumstances, however, the MassHealth agency does pay for such visits.

(C) The MassHealth agency pays only the attending physician for hospital visits, with the following exceptions.

(1) The MassHealth agency pays for consultations by a physician other than the attending physician. (See 130 CMR 433.418 for regulations about consultations.)

(2) If it is necessary for a physician other than the attending physician to treat a hospitalized member, the other physician's services are payable. An explanation of the necessity of such visits must be attached to the claim. The MassHealth agency will review the claim and determine appropriate payment to the other physician.

433.416: Nursing Facility Visits: Service Limitations

(A) Requirement for Approval of Admission. The MassHealth agency seeks to ensure that a MassHealth member receives nursing facility services only when available alternatives (see 130 CMR 433.476 through 433.483) do not meet the member's need, and that every member receiving nursing facility services is placed appropriately according to the medical eligibility criteria, in accordance with 130 CMR 456.409 through 456.411.

(B) Service Limitations. Payment for a visit by a physician to members in nursing facilities or rest homes is limited to one visit per member per month, except in an emergency. Any medically necessary care required for the follow-up of a condition during the month must be billed as subsequent nursing facility care.

433.417: Home Visits: Service Limitations

Payment for a visit by a physician to a member's home is limited to one visit per member per day. (For information on additional home health services covered by MassHealth, see 130 CMR 433.478.)

433.418: Consultations: Service Limitations

The MassHealth agency pays for only one initial consultation per member per case episode. Additional consultation visits per episode are payable as follow-up consultations.

433.419: Nurse Midwife Services

(A) General. 130 CMR 433.419 applies specifically to nurse midwives. In general, however, subject to the limitations of state law, the requirements elsewhere in 130 CMR 433.000 that apply to physicians also apply to nurse midwives, such as service limitations, recordkeeping, report requirements, and prior-authorization requirements.

(B) Conditions of Payment. The MassHealth agency pays either an independent nurse midwife (in accordance with 130 CMR 433.419(C)) or the physician employer of a nonindependent nurse midwife (in accordance with 130 CMR 433.419(D)) for nurse midwife services provided by a nurse midwife when:

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR 4.00);

(2) the nurse midwife has a current license to practice as a nurse midwife in Massachusetts from the Massachusetts Board of Registration in Nursing; and

(3) the nurse midwife has a current collaborative arrangement with a physician or group of physicians, as required by state law or regulation (including but not limited to 244 CMR 4.00 and 130 CMR 433.419(C)(2)). The MassHealth agency deems this requirement to be met for nonindependent nurse midwives employed by a physician.

(C) Independent Nurse Midwife Provider Eligibility.

(1) Submission Requirements. Only an independent nurse midwife may enroll in MassHealth as a provider. Any nurse midwife applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she is:

(a) a member of a group practice comprising physicians and other practitioners and is compensated by the group practice in the same manner as the physicians and other practitioners in the group practice;

(b) a member of a group practice that solely comprises nurse midwives; or

(c) in a solo private practice.

(2) Collaborative Arrangement Requirements. The independent nurse midwife's collaborating physician must be a MassHealth provider who engages in the same type of clinical practice as the nurse midwife. The nurse midwife must practice in accordance with written guidelines developed in conjunction with the collaborating physician as set forth in 244 CMR 4.00. The nurse midwife must submit to the MassHealth agency thorough documentation of the collaborative arrangement, including guidelines and any written agreement signed by the nurse midwife and the collaborating physician or physicians. The guidelines must specify:

(a) the services the nurse midwife is authorized to perform under the collaborative arrangement; and

(b) the established procedures for common medical problems.

(C) Medicare Part D.

(1) Overview. 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.

(2) Medicare Part D One-Time Supplies. The MassHealth agency pays for one-time supplies of prescribed medications, as described in 130 CMR 406.414(C)(2)(a) and (b), if the medication is a MassHealth-covered medication and the MassHealth member would otherwise be entitled to MassHealth pharmacy benefits but for being eligible for Medicare prescription drug coverage. MassHealth prior authorization does not apply to such one-time supplies. Between January 1 and June 30, 2006, the MassHealth agency pays for the one-time supplies only if the MassHealth member's Medicare Part D prescription drug plan will not cover the prescribed medication at the time the prescription is presented. Effective July 1, 2006, the MassHealth agency pays for the one-time supplies in all instances in which the pharmacist cannot bill a Medicare Part D prescription drug plan at the time the prescription is presented.

(a) Between January 1 and December 31, 2006, the MassHealth agency pays for a one-time 30-day supply of prescribed medications. Any copayment that would have been charged to the member under MassHealth will apply to a one-time 30-day supply. After this supply of the prescribed medication, the MassHealth agency pays for a one-time 72-hour supply of the same prescribed medication.

(b) Effective January 1, 2007, the MassHealth agency pays for a one-time 72-hour supply of prescribed medications.

(3) Cost-Sharing Assistance for MassHealth Members Enrolled in a Medicare Part D Prescription Drug Plan. For the purpose of 130 CMR 433.444(C)(3)(a) and (b), the "applicable MassHealth copayment" is the copayment the MassHealth member would pay for prescription drugs if the drugs were covered by MassHealth and not covered by Medicare Part D.

(a) Between January 1 and June 30, 2006, for MassHealth members who are enrolled in a Medicare Part D prescription drug plan and are charged a copayment in excess of the member's applicable MassHealth copayment for a drug that MassHealth would otherwise cover, the member pays the applicable MassHealth copayment and the MassHealth agency pays the difference to the pharmacy, up to the amount that the Medicare Part D prescription drug plan is permitted to charge an eligible enrollee who has both MassHealth and Medicare.

(b) Effective July 1, 2006, for MassHealth members who are enrolled in a Medicare Part D prescription drug plan and are charged a copayment or deductible in excess of the member's applicable MassHealth copayment for a drug that MassHealth would otherwise cover, the member pays the applicable MassHealth copayment and the MassHealth agency pays the difference between the applicable MassHealth copayment and the amount charged by the Medicare Part D prescription drug plan.

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)