Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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MassHealth
Transmittal Letter PHY-122
August 2008

TO: Physicians Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: Physician Manual (Revised Pharmacy Regulations)

This letter transmits revisions to the pharmacy regulations. These changes

- allow MassHealth to specify refill limitations in the MassHealth Drug List;
- include additional exceptions to the 30-day quantity limit to allow 90-day supplies
  - for all family planning drugs; and
  - when MassHealth is the secondary payer and the primary payer allows a 90-day supply; and
- specify that all medical supplies and devices that are paid through POPS are now listed in the MassHealth Drug List in a section called the MassHealth Non-Drug Product List, instead of in the pharmacy regulations.

These regulations are effective August 15, 2008.

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, 4-3, 4-4, and 4-35 through 4-42

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(The pages listed here are no longer in effect.)

Physician Manual

Pages iv-a, 4-39, and 4-40 — transmitted by Transmittal Letter PHY-117

Pages 4-3, 4-4, 4-37, and 4-38 — transmitted by Transmittal Letter PHY-111

Pages 4-35, 4-36, 4-41, and 4-42 — transmitted by Transmittal Letter PHY-109

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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.

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.

Non-Drug Product List – a section of the MassHealth Drug List comprised of those products not classified as drugs (i.e., blood testing supplies) that are payable by the MassHealth agency through the Pharmacy Program. Payment for these items is in accordance with rates published in Division of Health Care Finance and Policy regulations at 114.3 CMR 22.00: Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment and 114.3 CMR 17.00: Medicine. The MassHealth Non-Drug Product List also specifies which of the included products require prior authorization.

Over-the-Counter Drug – any drug for which no prescription is required by federal or state law. These drugs are sometimes referred to as nonlegend drugs. The MassHealth agency requires a prescription for both prescription drugs and over-the-counter drugs (see 130 CMR 433.441(A)).

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, and 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.

Prescription Drug – any drug for which a prescription is required by applicable federal or state law or regulation, other than MassHealth regulations. These drugs are sometimes referred to as legend drugs.

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.

433.441: Pharmacy Services: Prescription Requirements

(A) Legal Prescription Requirements. The MassHealth agency pays for prescription drugs, over-the-counter drugs, and items listed on the Non-Drug Product List only if the pharmacy has in its possession a prescription that meets all requirements for a legal prescription under all applicable federal and state laws and regulations. Each prescription, for drugs in Schedules II through V must contain the prescriber's unique DEA number. For Schedule VI drugs, if the prescriber has no DEA registration number, the prescriber's Massachusetts Controlled Substance Registration number must appear on the prescription.

(B) Emergencies. When the pharmacist determines that an emergency exists, the MassHealth agency will pay a pharmacy for at least a 72-hour, nonrefillable supply of the drug in compliance with state and federal regulations. Emergency dispensing to a MassHealth member who is enrolled in the Controlled Substance Management Program (CSMP) must comply with 130 CMR 406.442(C)(2).

(C) Refills.
(1) The MassHealth agency does not pay for prescription refills that exceed the specific number authorized by the prescriber.
(2) The MassHealth agency pays for a maximum of 11 monthly refills, except in circumstances described at 130 CMR 433.441(C)(3), or where the MassHealth Drug List specifically limits the number of refills, duration of the prescription, or both.
(3) The MassHealth agency pays for more than 11 refills within a 12-month period if such refills are for less than a 30-day supply and have been prescribed and dispensed in accordance with 130 CMR 433.441(D).
(4) The MassHealth agency does not pay for any refill dispensed after one year from the date of the original prescription.
(5) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.
(6) The MassHealth agency does not pay for any refill without an explicit request from a member or caregiver for each filling event. The possession by a provider of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription.

(D) Quantities.
(1) Days' Supply Limitations. The MassHealth agency requires that all drugs be prescribed in a 30-day supply, unless the drug is available only in a larger minimum package size, except as specified in 130 CMR 433.441(D)(2).
(2) Exceptions to Days' Supply Limitations.
(a) The MassHealth agency allows exceptions to the limitations described in 130 CMR 433.441(D)(1) for the following products:
(i) drugs in therapeutic classes that are commonly prescribed for less than a 30-day supply, including but not limited to antibiotics and analgesics;
(ii) drugs that, in the prescriber's professional judgment, are not clinically appropriate for the member in a 30-day supply;
(iii) drugs that are new to the member, and are being prescribed for a limited trial amount, sufficient to determine if there is an allergic or adverse reaction or lack of effectiveness. The initial trial amount and the member's reaction or lack of effectiveness must be documented in the member's medical record;

(iv) drugs packed in such a way that the smallest quantity that may be dispensed is larger than a 30-day supply (for example, inhalers, ampules, vials, eye drops, and other sealed containers not intended by the manufacturer to be opened by any person other than the end user of the product);
(v) drugs in topical dosage forms that do not allow the pharmacist to accurately predict the rate of the product's usage (for example, lotions or ointments);
(vi) products generally dispensed in the original manufacturer's packaging (for example, fluoride preparations, prenatal vitamins, and over-the-counter drugs); and
(vii) methylphenidate and amphetamine prescribed in 60-day supplies;

(b) Drugs paid for by a member's primary insurance carrier that are dispensed in up to a 90-day supply when the MassHealth agency pays any portion of the claim, including the copayment portion or deductible, may be dispensed in up to a 90-day supply.
(c) Drugs used for family planning may be dispensed in up to a 90-day supply.

(E) Prescription-Splitting. Providers must not split prescriptions by filling them for a period or quantity less than that specified by the provider. For example, a prescription written for a single 30-day supply may not be split into three 10-day supplies. The MassHealth agency considers prescription-splitting to be fraudulent. (See 130 CMR 450.238(B)(6).)

(F) Excluded, Suspended, or Terminated Clinicians. The MassHealth agency does not pay for prescriptions written by clinicians
(1) who have been excluded from participation based on a notice by the U.S. Department of Health and Human Services Office of Inspector General; or
(2) whom the MassHealth agency has suspended, terminated, or denied admission into its program for any other reason.

433.442: Pharmacy Services: Covered Drugs and Medical Supplies

(A) Drugs. The MassHealth Drug List specifies the drugs that are payable under MassHealth. In addition, the following rules apply.
(1) Prescription Drugs. The MassHealth agency pays only for prescription drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8. Payment is calculated in accordance with DHCFP regulations at 114.3 CMR 31.00: Prescribed Drugs.
(2) Over-the-Counter Drugs. Payment by the MassHealth agency for over-the-counter drugs is calculated in accordance with DHCFP regulations at 114.3 CMR 31.00: Prescribed Drugs.

(B) Non-drug Products Paid Through POPS.
(1) The MassHealth agency pays through POPS, only for those products not classified as drugs that are listed on the non-drug product section of the MassHealth Drug List.

(2) Non-drug Product List. Payment for these items is in accordance with rates published in the Division of Health Care Finance and Policy regulations at 114.3 CMR 22.00: Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment and 114.3 CMR 17.00: Medicine. The MassHealth Non-Drug Product List also specifies which of the included products require prior authorization.

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 prescription or over-the-counter drugs or drug therapy.

(1) Cosmetic. The MassHealth agency does not pay for any drug used for cosmetic purposes or for hair growth.

(2) Cough and Cold. The MassHealth agency does not pay for any drug 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 a member who is a resident in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR).

(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 any 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 any drug 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) do not apply to medically necessary drugs 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. (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.

(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. 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. 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. 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, must pay 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 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.

(E) 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 406.000. MassHealth evaluates the prior-authorization status of drugs on an ongoing basis, and updates the MassHealth Drug List accordingly.

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 prescription or over-the-counter) 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.

433.448: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary physician services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 433.000, and with prior authorization.

(130 CMR 433.449 and 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 MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable; and
(6) services billed with 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 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 pays 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.