


Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Office of Medicaid  
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MassHealth  
Transmittal Letter PHY-137  
September 2012

**TO:** Physicians Participating in MassHealth  
**FROM:** Julian J. Harris, M.D., Medicaid Director   
**RE:** *Physician Manual* (Certified Registered Nurse Anesthetists)

This letter transmits revisions to the anesthesia services section of the physician regulations to expand the conditions of payment for services provided by certified registered nurse anesthetists (CRNAs). The nurse practitioner, nurse midwife, and physician assistant sections of the regulations have also been amended to allow these mid-level providers to have a supervisory and/or collaborative relationship with a MassHealth provider or a salaried employee of a MassHealth provider.

These regulations are effective September 28, 2012.

### **MassHealth Website**

This transmittal letter and attached pages are available on the MassHealth website at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### **Questions**

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](mailto: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 4-15, 4-16, 4-27 through 4-30, and 4-43 through 4-46

### OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

#### Physician Manual

Pages 4-15 and 4-16 — transmitted by Transmittal Letter PHY-124

Pages 4-27, 4-28, 4-45, and 4-46 — transmitted by Transmittal Letter PHY-109

Pages 4-29 and 4-30 — transmitted by Transmittal Letter PHY-111

Pages 4-43 and 4-44 — transmitted by Transmittal Letter PHY-133

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(B) 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.)

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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 the regulations of the Massachusetts Board of Registration in Nursing);
- (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 the regulations of the Massachusetts Board of Registration in Nursing 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, or a salaried employee of 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 the regulations of the Massachusetts Board of Registration in Nursing. 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.

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(C) Pulmonary Procedures. Fees for pulmonary procedures include payment for laboratory procedures, interpretations, and physician's services. These services may be billed in addition to an office visit.

(D) Dermatological Special Procedures. These services may be billed in addition to an office visit.

(E) Unlisted Procedures. Providers may bill for unlisted procedures only if there is no "Not otherwise classified" code.

433.433: Nurse Practitioner Services

(A) General. 130 CMR 433.433 applies specifically to nurse practitioners. 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 practitioners, such as service limitations, recordkeeping, report requirements, and prior-authorization requirements.

(B) Conditions of Payment. The MassHealth agency pays either an independent nurse practitioner (in accordance with 130 CMR 433.433(C)) or the physician employer of a nonindependent nurse practitioner (in accordance with 130 CMR 433.433(D)) for nurse practitioner services provided by a nurse practitioner when:

- (1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to the regulations of the Massachusetts Board of Registration in Nursing);
- (2) the nurse practitioner has a current license to practice as a nurse practitioner in Massachusetts from the Massachusetts Board of Registration in Nursing; and
- (3) the nurse practitioner has a current collaborative arrangement with a physician or group of physicians, as required by state law or regulation (including but not limited to the regulations of the Massachusetts Board of Registration in Nursing and 130 CMR 433.433(C)(2)). The MassHealth agency deems this requirement to be met for nonindependent nurse practitioners employed by a physician.

(C) Independent Nurse Practitioner Provider Eligibility.

- (1) Submission Requirements. Only an independent nurse practitioner may enroll as a MassHealth provider. Any nurse practitioner 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 practitioners; or
  - (c) in a solo private practice.

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

- (a) the services the nurse practitioner is authorized to perform under the collaborative arrangement; and
- (b) the established procedures for common medical problems.

(3) Consultation Between Independent Nurse Practitioner and Collaborating Physician. The MassHealth agency does not pay for a consultation between an independent nurse practitioner and a collaborating physician as a separate service.

(D) Submitting Claims for Nonindependent Nurse Practitioners. Any nurse practitioner who does not meet the requirements of 130 CMR 433.433(C) is a nonindependent nurse practitioner and is not eligible to enroll as a MassHealth provider. As an exception to 130 CMR 450.301, an individual physician (who is neither practicing as a professional corporation nor a member of a group practice) who employs a nonindependent nurse practitioner may submit claims for services provided by a nonindependent nurse practitioner employee, but only if such services are provided in accordance with 130 CMR 433.433(B), and payment is claimed in accordance with 130 CMR 450.301(B).

#### 433.434: Physician Assistant Services

(A) General. 130 CMR 433.434 applies specifically to physician assistants. 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 physician assistants, such as service limitations, recordkeeping, report requirements, and prior-authorization requirements. Services provided by a physician assistant must be limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR 5.00).

(B) Conditions of Payment. The MassHealth agency pays the physician employer of a physician assistant (in accordance with 130 CMR 433.434(E)) for services provided by a physician assistant when the:

- (1) services are limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR 5.05);
- (2) physician assistant has a current license or certificate of registration from the Massachusetts Board of Registration of Physician Assistants. Services provided by a physician assistant who possesses only a temporary license to practice, who has failed the certifying examination, or whose license has expired or is suspended are not payable; and
- (3) services are provided pursuant to a formal supervisory arrangement with a physician, as further described under 130 CMR 433.434(C).

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(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, or a salaried employee of 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, or a salaried employee of 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).

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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.

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(H) 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.

(I) 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. Payment includes all surgical assistant fees.

(130 CMR 433.453 Reserved)



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433.454: Anesthesia Services

(A) Payment.

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

(2) Calculation.

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

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

(c) Reporting Time Units. A provider's claim must report only payable time units. It must not include base anesthesia units or units that exceed the criteria described in 130 CMR 433.454(A)(2)(b) in the number of units field on the claim. Time units are measured in minutes. One unit equals one minute.

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

(B) Services Provided by a Certified Registered Nurse-Anesthetist (CRNA).

(1) General. 130 CMR 433.454 applies specifically to physicians and CRNAs. 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 CRNAs, such as service limitations, recordkeeping, report requirements, and prior-authorization requirements.

(2) Conditions of Payment. The MassHealth agency pays the physician or group practice employer or contractor of a CRNA for services provided by the CRNA when

(a) the services are limited to the scope of practice authorized by state law or regulation (including, but not limited to regulations of the Massachusetts Board of Registration in Nursing);

(b) the CRNA has a current license to practice as a certified registered nurse anesthetist in Massachusetts from the Massachusetts Board of Registration in Nursing;

(c) the CRNA is not a salaried employee of the hospital in which the CRNA services were performed; and

(d) the services of the CRNA are provided under the supervision of a physician such that the operating physician or an anesthesiologist is immediately available if needed.

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(3) Submitting Claims for Certified Registered Nurse-Anesthetists. As an exception to 130 CMR 450.301(A), a physician or group practice who is an employer of or who contracts with a CRNA, may submit claims for services provided by a CRNA, but only if such services are provided in accordance with 130 CMR 450.301(B). Only one provider may claim payment for the services provided by the CRNA.

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

433.455: Abortion Services

(A) Payable Services.

(1) The MassHealth agency pays for an abortion service if both of the following conditions are met:

- (a) the abortion is a medically necessary abortion, or the abortion is performed upon a victim of rape or incest when such rape or incest has been reported to a law enforcement agency or public health service within 60 days of the incident; and
- (b) the abortion is performed in accordance with M.G.L. c. 112, §§12K through 12U, except as provided under 130 CMR 433.455(C)(2).

(2) For the purposes of 130 CMR 433.455, a medically necessary abortion is one that, according to the medical judgment of a licensed physician, is necessary in light of all factors affecting the woman's health.

(3) Unless otherwise indicated, all abortions referred to in 130 CMR 433.455 are payable abortions as defined in 130 CMR 433.455(A)(1) and (2).

(B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of abortion services. The MassHealth agency, any provider, or any agent or employee of a provider must not mislead any member into believing that a decision to have or not to have an abortion will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of member records for abortion services as well as for all other medical services covered by MassHealth.

(C) Locations in Which Abortions May Be Performed. Abortions must be performed in compliance with the following.

(1) First-Trimester Abortion. A first-trimester abortion must be performed by a licensed and qualified physician in a clinic licensed by the Department of Public Health to perform surgical services, or in a hospital licensed by the Department of Public Health to perform medical and surgical services.

(2) Second-Trimester Abortion. A second-trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform medical and surgical services; provided, however, that up to and including the 18<sup>th</sup> week of pregnancy, a second-trimester abortion may be performed in a clinic that meets the requirements of 130 CMR 433.455(C)(1) where the attending physician certifies in the medical record that, in his or her professional judgment, a nonhospital setting is medically appropriate in the specific case.

(3) Third-Trimester Abortion. A third-trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform abortions and to provide facilities for obstetric services.

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(C) Certification for Payable Abortion Form. All physicians must complete a Certification for Payable Abortion (CPA-2) form and retain the form in the member's record. (Instructions for obtaining the Certification for Payable Abortion form are in Appendix A of all provider manuals.) To identify those abortions that meet federal reimbursement standards, specified in 42 CFR 449.100 through 449.109, the MassHealth agency must secure on the CPA-2 form the certifications described in 130 CMR 433.455(D)(1), (2), and (3), when applicable. For all medically necessary abortions not included in 130 CMR 433.455(D)(1), (2), or (3), the certification described in 130 CMR 433.455(D)(4) is required on the CPA-2 form. The physician must indicate on the CPA-2 form which of the following circumstances is applicable, and must complete that portion of the form with the appropriate signatures.

(1) Life of the Mother Would Be Endangered. The attending physician must certify that, in the physician's professional judgment, the life of the mother would be endangered if the pregnancy were carried to term.

(2) Severe and Long-Lasting Damage to Mother's Physical Health. The attending physician and another physician must each certify that, in his or her professional judgment, severe and long-lasting damage to the mother's physical health would result if the pregnancy were carried to term. At least one of the physicians must also certify that he or she is not an "interested physician," defined herein as one whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(3) Victim of Rape or Incest. The physician is responsible for submitting with the claim form signed documentation from a law enforcement agency or public health service certifying that the person upon whom the procedure was performed was a victim of rape or incest that was reported to the agency or service within 60 days of the incident. (A public health service is defined as either an agency of the federal, state, or local government that provides health or medical services, or a rural health clinic, provided that the agency's principal function is not the performance of abortions.) The documentation must include the date of the incident, the date the report was made, the name and address of the victim and of the person who made the report (if different from the victim), and a statement that the report included the signature of the person who made the report.

(4) Other Medically Necessary Abortions. The attending physician must certify that, in his or her medical judgment, for reasons other than those described in 130 CMR 433.455(D)(1), (2), and (3), the abortion performed was necessary in light of all factors affecting the mother's health.

#### 433.456: Sterilization Services: Introduction

(A) Covered Services. The MassHealth agency pays for a sterilization service provided to a member only if all of the following conditions are met.

- (1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 433.457, and such consent is documented in the manner described in 130 CMR 433.458.
- (2) The member is at least 18 years old at the time consent is obtained.
- (3) The member is not mentally incompetent or institutionalized.