Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter PHY-149
September 2016

TO: Physicians Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: Physician *Manual* Revised Regulations (130 CMR 433.000)

This letter transmits revisions to the Physician regulation at 130 CMR 433. The regulation was updated to remove pharmacy requirements covered in 130 CMR 406, replacing requirements with a cross-reference to 130 CMR 406, and to clarify remaining prescribed drug requirements. Conforming changes were made elsewhere in the regulation. These regulations are effective August 12, 2016.

- 130 CMR 433.441 was updated to replace Pharmacy requirements in 130 CMR 406 with a cross-reference and renamed "Drugs Dispensed in Pharmacies."
- 130 CMR 433.442 through 130 CMR 443.446, containing pharmacy requirements covered in 130 CMR 406, were deleted.
- 130 CMR 433.447 was renamed "Drugs Administered in the Office (Physician-Administered Drugs)" and updated to include rules on payment and prior authorization relevant to such drugs.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center 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, iv-a, 4-5, 4-6, 4-13, 4-14, and 4-35 through 4-40

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Physician Manual

Pages 4-5, 4-6, 4-37, and 4-38 — transmitted by Transmittal Letter PHY-142

Pages 4-13 and 4-14 — transmitted by Transmittal Letter PHY-124

Pages iv, iv-a, 4-35, 4-36, 4-39, and 4-40 — transmitted by Transmittal Letter PHY-140

4. Program Regulations

Part 1. General Information

Part 2. Medical Services

4. Program Regulations (cont.)

Part 3. Surgery Services

Part 4. Other Services

Referral – the transfer of the total or specific care of a member from one physician to another. For the purposes of 130 CMR 433.000, a referral is not a consultation.

Respiratory Therapy Equipment – a product that

(1) is fabricated primarily and customarily for use in the domiciliary treatment of pulmonary insufficiencies for its therapeutic and remedial effect;
(2) is of proven quality and dependability; and
(3) conforms to all applicable federal and state product standards.

Routine Study – a set of X rays of an extremity that includes two or more views taken at one sitting.

Separate Procedure – a procedure that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but commands a separate fee when performed as a separate entity not immediately related to other services.

Speech/Language Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of presence of a communication disability), and those that impair comprehension, spoken, written, or other symbol systems used for communication.

Sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Therapeutic Radiology Service – a radiology service used to treat an injury or illness.

Therapy Visit – a personal contact provided as an office visit or outpatient visit for the purpose of providing a covered physical or occupational therapy service by a physician or licensed physical or occupational therapist employed by the physician. Additionally, speech therapy services provided by a physician as an office or outpatient visit is considered a therapy visit.

Unit-Dose Distribution System – a means of packaging or distributing drugs, or both, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken.

433.402: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency pays for physician services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the MassHealth regulations. 130 CMR 450.105: *Coverage Types* specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Recipients of Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

433.403: Provider Eligibility

(A) Participating Providers.

(1) 130 CMR 433.000 applies to medical, radiology, laboratory, anesthesia, and surgery services provided to members by physicians participating in MassHealth as of the date of service.

(2) To be eligible for payment, a physician must be physically present and actively involved in the treatment of the member. Time periods specified in the service descriptions refer to the amount of time the physician personally spends with the member, except in the instances noted where the service can be performed under the direct supervision of the physician. For surgery, the physician must be scrubbed and present in the operating room during the major portion of an operation.

(B) In State. An in-state physician is a physician who is licensed by the Massachusetts Board of Registration in Medicine.

(C) Out of State. An out-of-state physician must be licensed to practice in his or her state. The MassHealth agency pays an out-of-state physician for providing covered services to a MassHealth member only under the following circumstances.

(1) The physician practices in a community of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont that is within 50 miles of the Massachusetts border and provides services to a member who resides in a Massachusetts community near the border of that physician's state.

(2) The physician provides services to a member who is authorized to reside out of state by the Massachusetts Department of Children and Families.

(3) The physician practices outside a 50-mile radius of the Massachusetts border and provides emergency services to a member.

(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.

433.411: Child and Adolescent Needs and Strengths (CANS) Data Reporting

For each Child and Adolescent Needs and Strengths (CANS) conducted as described in 130 CMR 433.429, the physician must report data collected during the assessment to the MassHealth agency, in the manner and format specified by the MassHealth agency.

433.412: 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.

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 433.447 Drugs Administered in the Office (Physician Administered Drugs.)) The MassHealth agency does not pay for the cost of the injectable material if the Massachusetts Department of Public Health distributes the injectable material free of charge.

(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.

(2) the acupuncturist has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine; and
(3) services are provided pursuant to a supervisory arrangement with a physician.

(F) Acupuncture Claims Submissions.

(1) Physicians, independent nurse practitioners licensed in acupuncture, and independent nurse midwives licensed in acupuncture may submit claims for acupuncture services when they provide those services directly to MassHealth members or as an exception to 130 CMR 450.301(A) when a licensed practitioner under the supervision of a physician provides those services directly to MassHealth members. See Subchapter 6 of the *Physician Manual* for service code descriptions and billing requirements.

(2) For MassHealth members receiving services under any of the acupuncture codes on the same date of service as an office visit, the physician, independent nurse practitioner licensed in acupuncture, or independent nurse midwife licensed in acupuncture may bill for either an office visit or the acupuncture code, but may not bill for both an office visit and the acupuncture code for the same member on the same date when the office visit and the acupuncture services are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same provider on the same day of the acupuncture service.

433.441: Pharmacy Services: Drugs Dispensed in Pharmacies

Coverage of drugs and medical supplies dispensed to MassHealth members by MassHealth pharmacy providers, and related prescription requirements for prescribing prescribers, are governed by 130 CMR 406.000: *Pharmacy Services*

(130 CMR 433.442 thorough 446 Reserved)

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433.447: Drugs Administered in the Office (Physician-Administered Drugs)

(A) Payment

(1) Drugs and biologicals dispensed in the office are payable, subject to the exclusions and service limitations at 130 CMR 433.404, 433.406, and 130 CMR 406.413(B) and (C).
(2) 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.
(3) 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.
(4) 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 HCPCS units dispensed, NDC code, NDC units and NDC unit of measurement. In addition, for drugs and/or biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Physician Manual*, a copy of the invoice showing the actual acquisition cost must be attached to the claim. Claims without this information are denied.
(5) 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 EOHHS regulations at 101 CMR 331.00: *Prescribed Drugs*
(6) The MassHealth agency does not pay for a biological if the Massachusetts Department of Public Health distributes the biological free of charge.
(7) Payment for drugs may be claimed in addition to an office visit.

(B) Prior Authorization

Prior authorization requirements for drugs dispensed in the pharmacy are included in the MassHealth Drug List. For prior authorization requirements for drugs administered as part of a medical visit, refer to the Subchapter 6 of the *Physician Manual*. All prior authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Physician Manual*.

(130 CMR 433.448 Reserved)