




Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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MassHealth
Transmittal Letter PHY-165
June 2022

TO: Physicians Participating in MassHealth

FROM: Amanda Cassel Kraft, Assistant Secretary for MassHealth 

RE: *Physician Manual* (Revisions to 130 CMR 433.000 to Clarify Coverage of Abortion Services)

This letter transmits amendments to the physician regulation at 130 CMR 433.000. These amendments clarify MassHealth coverage of abortion services for consistency with M.G.L. c. 112, §§ 12K through 12R, and make certain other technical edits.

These amendments are effective as of June 10, 2022.

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NEW MATERIAL

(The pages listed here contain new or revised language.)

Acute Outpatient Hospital Manual

Pages 4-1, 4-2, 4-15, 4-16, 4-39, and 4-40

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Acute Outpatient Hospital Manual

Pages 4-1, 4-2, 4-15, 4-16, 4-39, and 4-40— transmitted by Transmittal Letter PHY-154

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Part 1. General Information

433.401: Definitions

The following terms used in 130 CMR 433.000 have the meanings given in 130 CMR 433.401 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 433.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 433.000 and in 130 CMR 450.000: *Administrative and Billing Regulations*.

Acupuncture – the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, with or without the application of an electric current, and with or without the application of heat to the needles, skin, or both.

Child and Adolescent Needs and Strengths (CANS) – a tool that provides a standardized way to organize information gathered during behavioral-health clinical assessments. A Massachusetts version of the tool has been developed and is intended to be used as a treatment decision support tool for behavioral-health providers serving MassHealth members younger than 21 years old.

Consultant – a licensed physician whose practice is limited to a specialty and whose written advice or opinion is requested by another physician or agency in the evaluation or treatment of a member's illness or disability.

Consultation – a visit made at the request of another physician.

Controlled Substance – a drug listed in Schedule II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

Cosmetic Surgery – a surgical procedure that is performed for the exclusive purpose of altering appearance and is unrelated to disease or physical defect, or traumatic injury.

Couple Therapy – therapeutic services provided to a couple for whom the disruption of their marriage, family, or relationship is the primary reason for seeking treatment.

Diagnostic Radiology Service – a radiology service intended to identify an injury or illness.

Domiciliary – for use in the member's place of residence, including a long-term-care facility.

Drug – a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

Emergency Medical Condition – a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant individual, as further defined in §1867(e)(1)(B) of the Social Security Act, 42 U.S.C. §1395dd(e)(1)(B).

Emergency Services – medical services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.

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Family Planning – any medically approved means, including diagnosis, treatment, and related counseling, that helps individuals of childbearing age, including sexually active minors, to determine the number and spacing of their children.

Family Therapy – a session for simultaneous treatment of two or more members of a family.

Group Therapy – application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

High-Risk Newborn Care – care of a full-term newborn with a critical medical condition or of a premature newborn requiring intensive care.

Home or Nursing Facility Visit – a visit by a physician to a member at a residence, nursing facility, extended care facility, or convalescent or rest home.

Hospital-Licensed Health Center (HLHC) – a facility that

- (1) operates under a hospital's license but is not physically attached to the hospital;
- (2) is subject to the fiscal, administrative, and clinical management of the hospital;
- (3) provides services to patients solely on an outpatient basis;
- (4) demonstrates CMS provider-based status in accordance with 42 CFR 413.65;
- (5) meets all regulatory requirements for participation in MassHealth as a hospital-licensed health center; and
- (6) is enrolled with the MassHealth agency as a hospital-licensed health center.

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: *Independent Diagnostic Testing Facility*.

Individual Psychotherapy – private therapeutic services provided to a member to lessen or resolve emotional problems, conflicts, and disturbances.

Institutionalized Individual – an individual who is

- (1) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a psychiatric hospital or other facility for the care and treatment of mental illness; or
- (2) confined under a voluntary commitment in a psychiatric 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.

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- (a) tracking and follow-up of the patient's activity to ensure completion of the patient care plan, with the appropriate number of visits;
- (b) coordination of medical management with necessary referral to other medical specialties and dental services; and
- (c) referral to WIC (the Special Supplemental Food Program for Women, Infants, and Children), counseling, and social work as needed.

(4) Health-Care Counseling. In conjunction with providing prenatal care, the primary provider or coverage provider must provide health-care counseling to the woman over the course of the pregnancy. Topics covered must include, but are not limited to, the following:

- (a) EPSDT screening for teenage pregnant individuals;
- (b) smoking and substance abuse;
- (c) hygiene and nutrition during pregnancy;
- (d) care of breasts and plans for infant feeding;
- (e) obstetrical anesthesia and analgesia;
- (f) the physiology of labor and the delivery process, including detection of signs of early labor;
- (g) plans for transportation to the hospital;
- (h) plans for assistance in the home during the postpartum period;
- (i) plans for pediatric care for the infant; and
- (j) family planning.

(5) Obstetrical-Risk Assessment and Monitoring. The primary provider or coverage provider must manage the member's obstetrical-risk assessment and monitoring. Medical management requires monitoring the woman's care and coordinating diagnostic evaluations and services as appropriate. The professional and technical components of these services are paid separately from the global fee and should be billed for by the servicing provider on a fee-for-service basis. Such services may include, but are not limited to, the following:

- (a) counseling specific to high-risk patients (for example, antepartum genetic counseling);
- (b) evaluation and testing (for example, amniocentesis); and
- (c) specialized care (for example, treatment of premature labor).

(C) Multiple Providers. When more than one provider is involved in prenatal, delivery, and postpartum services for the same member, the following conditions apply.

- (1) The global fee may be claimed only by the primary provider and only if the required services (minimum of six prenatal visits, a delivery, and a minimum of one postpartum visit) are provided directly by the primary provider, or a coverage provider. (This constitutes an exception to 130 CMR 450.301(A): *Claims* and 130 CMR 433.451(A).)
- (2) If the primary provider bills for the global fee, no coverage provider may claim payment from the MassHealth agency. Payment of the global fee constitutes payment in full both to the primary provider and to all coverage providers who provided components of the obstetric global service .
- (3) If the primary provider bills for the global fee, any non-coverage provider who performed prenatal visits or postpartum visits for the member may claim payment for such services only on a fee-for-service basis. If the primary provider bills for the global fee, no non-coverage provider may claim payment for the delivery.
- (4) If the primary provider bills on a fee-for-service basis and does not bill a global fee, any other coverage or non-coverage provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services they provided to the same member.

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

(130 CMR 433.422 and 433.423 Reserved)

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- (a) If an anesthesiologist provides medical direction of a CRNA who participates in MassHealth in accordance with 130 CMR 433.454(B)(3) and is not employed by the facility in which the anesthesia services are performed, the anesthesiologist receives fifty percent (50%) of the fee and the CNRA receives fifty percent (50%) of the fee.
- (b) If an anesthesiologist provides medical direction of a CRNA employed by a facility in which the anesthesia service is performed, the anesthesiologist receives fifty percent (50%) of the fee, but no separate payment is made for the CRNA's services.
- (c) Anesthesiologists and CRNAs should refer to subchapter 6 of the *Physician Manual* for appropriate modifiers.

(D) Medical Supervision of Anesthesia Services. The MassHealth agency does not pay a physician for medical supervision of a CRNA. The term medical supervision is used in this section for payment purposes only.

- (1) Medical supervision of anesthesia services occurs when an anesthesiologist is involved in five or more concurrent anesthesia procedures and when the anesthesiologist provides some, but not all of the seven required services under medical direction in 130 CMR 433.454(C)(1)(a) through (1)(g).
- (2) Medical supervision also occurs when the seven required services under medical direction in 130 CMR 433.454(C)(1)(a) through (1)(g) are not performed by an anesthesiologist. This might occur in cases when the anesthesiologist:
 - (a) left the immediate area of the operating suite for more than a short duration;
 - (b) devote extensive time to an emergency case; or
 - (c) was otherwise not available to respond to the immediate needs of the surgical patients.

(E) Acupuncture as an Anesthetic. The MassHealth agency pays for acupuncture as a substitute for conventional surgical anesthesia (see 130 CMR 433.440).

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 law.
- (2) For the purposes of 130 CMR 433.455, a medically necessary abortion is one which, according to the medical judgment of a licensed physician, or, consistent with c. 112, s. 12M and the time limitations established therein a physician assistant, certified nurse practitioner, or certified nurse midwife, is necessary in light of all factors affecting the pregnant individual'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.

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(C) Certification for Payable Abortion Form. All providers (i.e., physicians, physician assistants, nurse practitioners, or nurse midwives) must complete a Certification for Payable Abortion (CPA-2) form and retain the form in the member's record. (Instructions for obtaining the CPA-2 form are in Appendix A of all provider manuals.) To identify those abortions that meet federal reimbursement standards, the MassHealth agency must secure on the CPA-2 form the certifications described in 130 CMR 433.455(C)(1), (2), and (3), when applicable. For all medically necessary abortions not included in 130 CMR 433.455(C)(1), (2), or (3), the certification described in 130 CMR 433.455(C)(4) is required on the CPA-2 form. The provider 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 Pregnant Individual Would Be Endangered. The attending provider must certify that, in their professional judgment, the life of the pregnant individual would be endangered if the pregnancy were carried to term.

(2) Severe and Long-lasting Damage to Pregnant Individual's Physical Health. The attending provider and another provider must each certify that, in their professional judgment, severe and long-lasting damage to the pregnant individual's physical health would result if the pregnancy were carried to term. At least one of the providers must also certify that they are not an "interested provider," 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 provider whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(3) Victim of Rape or Incest. The provider 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 provider must certify that, in their medical judgment, for reasons other than those described in 130 CMR 433.455(C)(1), (2), and (3), the abortion performed was necessary in light of all factors affecting the pregnant individual's health.

433.456: Sterilization Services: Introduction

(A) Covered Services. The MassHealth agency pays for a sterilization service provided to an eligible 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 a mentally incompetent individual or an institutionalized individual.

(B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of sterilization 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 have a sterilization 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