Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER PHY-92
July 2002

TO: Physicians Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: *Physician Manual* (Revised Regulations and Restructured Subchapter 6 (Service Codes))

Updated Physician Regulations

This letter transmits revised physician regulations. The revisions allow an anesthesiologist to supervise as many as four operating rooms—an increase from two. The revisions also reflect only one obstetrical global method of payment and contain updated terminology, editorial revisions, and clarifications of the Division's policy on surgical assists, team surgery, and cosurgery.

Revised Subchapter 6 (Service Codes)

This letter also transmits a revised Subchapter 6 for the *Physician Manual*. Providers should use this revised Subchapter 6 in conjunction with the American Medical Association Current Procedural Terminology (CPT) 2002 code book. Because the Division pays for most of the Centers for Medicare and Medicaid Services Common Procedure Coding System (HCPCS) codes, we have restructured Subchapter 6 of the *Physician Manual* to list only those codes that:

- are not payable under MassHealth;
- have special limitations or requirements, such as prior authorization, individual consideration, or attachment requirements;
- are categorized as Level II HCPCS codes that are payable under MassHealth; or
- are locally assigned codes for use exclusively for MassHealth services.

In addition, a physician may request prior authorization for any medically necessary service for a member under 21 years of age.

We have restructured Subchapter 6 because we recognize that most providers use their CPT code books for codes and service descriptions, and refer to the Division's Subchapter 6 only to determine what limitations or restrictions might apply to a specific code for MassHealth. In addition, we have moved the list of payable modifiers from the physician billing instructions into Subchapter 6. We hope that this restructured Subchapter 6 will be easier to use and more manageable.

Billing Instructions

This letter also transmits revisions to the physician billing instructions (Subchapter 5 of the *Physician Manual*). The revisions remove the list of modifiers, which are now located in Subchapter 6, and update language to reflect the new structure of Subchapter 6. In addition, some of the claim form examples have been updated.

How to Obtain a Physician Fee Schedule

Providers who want to obtain a fee schedule may purchase Division of Health Care Finance and Policy regulations from either the Massachusetts State Bookstore or from the Division of Health Care Finance and Policy (see addresses and telephone numbers below). Providers must contact them first to find out the price of the publication. The Division of Health Care Finance and Policy also has the regulations available on disk. The regulation title for medicine is 114.3 CMR 17.00: Medicine. The regulation title for surgery and anesthesia is 114.3 CMR 16.00: Surgery and Related Anesthesia Care. The regulation title for radiology is 114.3 CMR 18.00: Radiology. The regulation title for laboratory is 114.3 CMR 20.00: Laboratory.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.gov/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcfp

Effective Date

The revised regulations, Subchapter 6, and billing instructions are effective for dates of service on or after April 30, 2002. The new codes introduced under the 2002 HCPCS code book are effective for dates of service on or after April 30, 2002. We will accept either the new or the old codes for dates of service through July 28, 2002. For dates of service on or after July 29, 2002, providers must use the new codes to receive payment.

Miscellaneous

The remainder of this transmittal letter contains information, clarifications, and instructions relating to MassHealth billing.

I. General Information

A. Use of Modifier 59: Distinct Procedural Service

The Division will no longer accept modifier 59, effective for dates of service on or after July 29, 2002.

B. Topical Acne Medications

The Division no longer requires prior authorization for topical acne preparations for members with moderate-to-severe cases of acne who are aged 25 years or younger. Physicians should not hesitate to prescribe this treatment for such members if it is medically necessary.

C. New and Emerging Technology Services and CPT Category III Codes

Category III CPT codes are temporary codes that have been developed and listed in *CPT 2002* to describe emerging technology, services, and procedures. Category III codes are **not payable** under MassHealth. In addition, the services described by these codes are not payable even when they are billed under unlisted service codes or otherwise payable service codes.

D. Billing with Incorrect Service Codes

The Division may deny a claim if a provider used an incorrect service code or could have billed with a more specific service code. If it is necessary to bill using an unlisted service code, the provider must indicate on the claim form in Item 24C the specific service or procedure performed, and attach supporting documentation.

E. Facility and Non-facility Rates

Effective for dates of service beginning April 30, 2002, DHCFP has established facility and non-facility physician rates for certain service codes. The Division pays the facility rate to the physician when the service is provided in a hospital, skilled nursing facility, or freestanding ambulatory surgical center. The Division pays the non-facility rate to the physician when the service is not provided in such a facility.

Payment of the facility or non-facility rate to a physician is based on the place of service code on the physician claim form. Incorrectly coding the place of service may result in an inappropriate payment. Any overpayment may subject the provider to administrative penalties as described in 130 CMR 450.234 through 450.240.

As a consequence of the adoption of facility and non-facility rates by DHCFP, the Division has deleted Appendix G (Site-of-Service List) of the *Physician Manual.*

F. Name and Address of Where Services Are Provided

When completing claim form no. 5, be sure to complete Item 21 (name and address where services are rendered) when services are provided at a location other than a physician's office or the member's home. Failure to provide this information may delay the processing of the claim.

II. Medicine Services

A. NICU Service Codes

Use of NICU (Neonatal Intensive Care Unit) CPT codes (99295, 99296, 99297, and 99298) are restricted to infants in Level III neonatal intensive care units, and are limited to admissions within the first month of life.

Effective for dates of service beginning April 30, 2002, the CPT codes for NICU admissions (99295) and subsequent neonatal intensive care (99298) will no longer be subject to individual consideration, and will not require that documentation be attached to the claim. The two remaining NICU codes will continue to be paid on an individual-consideration basis, and will require appropriate documentation, such as a progress note, for each date of service submitted. CPT code 99295 is limited to infants admitted to the NICU for continuing critical care. It should not be used for transient admissions (for example, transient tachypnea of the newborn, rule-out sepsis evaluations, or observation).

Progress notes should be complete enough to determine the level of acuity, and include such factors as the infant's weight, gestational age at birth, corrected gestational age, ventilator settings, oxygen requirement, feeding status, medications, and thermo-regulation. If the attending physician documents agreement with a nurse practitioner's assessment and plan, the nurse practitioner's progress note may be included instead of a detailed note by the physician. The progress note must be written and signed by the attending physician billing for the service.

Effective for dates of service beginning July 29, 2002, the local code for NICU patients on CPAP (X5570) will be eliminated. Providers should bill claims for NICU patients on CPAP should using the most appropriate CPT code available.

B. Attendance at Delivery and Initial Stabilization of Newborn (CPT Code 99436)

CPT code 99436 (attendance at delivery) is restricted to those deliveries when an obstetrician requests that a pediatrician/neonatologist be present at a high-risk or complicated delivery for stabilization of the infant. Use of CPT code 99436 requires documentation by the servicing provider indicating the reason for attendance and interventions performed. Providers should not use CPT code 99436 for a newborn examination in the delivery room after a normal delivery without neonatal complications.

C. Immunizations

As defined in 130 CMR 433.443, 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 are not payable under MassHealth.

Providers who provide immunizing biologicals or tubercular (TB) drugs to their MassHealth patients and who are not yet enrolled in the Massachusetts Immunization Program (MIP) are encouraged to do so. To learn more about what vaccines MIP provides and how to enroll in the program, providers should contact MIP at 617-983-6800 or 1-888-658-2850, or visit their Web site at www.mass.gov/dph/cdc/epii/imm/imm.htm.

D. Routine Drugs Dispensed in a Physician's Office (99070)

The Division does not pay for routine supplies separately when they are integral to the physician's professional services in the course of diagnosis and treatment. Such supplies are commonly provided by the physician without charge, and payment for such supplies is included in the MassHealth payment of the physician's fee for the service.

The Division considers certain drugs, including but not limited to those listed below to be routine supplies.

- Decadron
- Demerol
- Insulin
- Vistaril
- Vitamin B
- Xylocaine

E. Casts, Splints, and Strapping

Supplies that are part of a dressing or a dressing change, including casting supplies, are included in the payment for the dressing or dressing change, and are not reimbursed separately.

F. Urgent Care Provided in the Office after Hours

Effective for dates of service beginning July 29, 2002, Massachusetts local service code X0310 *(*urgent care provided in the office on Monday through Friday from 5:00 P.M. to 6:59 A.M and on Saturday from 7:00 A.M. to 4:00 P.M., in addition to basic service) and Massachusetts local service code X0320 (urgent care provided in the office from 4:01 P.M. Saturday through 6:59 A.M. on Monday, in addition to basic service) will be replaced by CPT codes. For dates of service between April 30, 2002, and July 28, 2002, providers may use either the Massachusetts local code or one of the following CPT codes: 99050, 99052, or 99054.

Physicians must use these codes for urgent care only. Physicians must not use 99050, 99052, or 99054 for scheduled office hours that occur Monday through Saturday. The Division pays for these services to encourage physicians to provide urgent, after-hour care in their office instead of in the hospital emergency department.

G. Centrifuging and Mailing of a Specimen

Effective for dates of service beginning July 29, 2002, the Massachusetts local code for centrifuging and mailing a specimen (X8012) will be replaced by CPT code 99000. For dates of service between April 30, 2002, and July 28, 2002, providers may use either the Massachusetts local code or 99000. The Division does not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis. However, the Division will pay a physician who collects, centrifuges, and mails a specimen to a laboratory for analysis once per specimen, regardless of the number of tests to be performed on that specimen (see 130 CMR 433.439).

H. Titmus Vision Testing

Effective for dates of service beginning July 29, 2002, the Massachusetts local code for titmus vision testing (X9335) will be replaced by CPT code 99173. For dates of service between April 30, 2002, and July 28, 2002, providers may use either the Massachusetts local code or 99173.

I. Physical Medicine Services

Prior authorization is required for more than 20 physical medicine visits per member in a 12-month period. Providers may bill the first 20 visits without requesting prior authorization. Please note that the initial evaluation counts as part of the 20 visits. The Division will act on requests for prior authorization within 21 calendar days of receipt of the request for prior authorization. Therefore, to avoid an interruption of services, providers should allow sufficient time for the Division to process the prior-authorization request.

J. Osteopathic Manipulative Treatment Services

Prior authorization is required for more than 20 osteopathic manipulative treatment visits per member in a 12-month period. Providers may bill the first 20 visits without requesting prior authorization. The Division will act on requests for prior authorization within 21 calendar days of receipt of the request for prior authorization. Therefore, to avoid an interruption of services, providers should allow sufficient time for the Division to process the prior-authorization request.

III. Surgery and Anesthesia Services

A. Reporting Anesthesia Services during Surgical Procedures

1. Report services involving administration of anesthesia during surgical procedures by using anesthesia CPT codes (CPT codes 00100 through 01999). Do not use surgery CPT codes when reporting anesthesia services.
2. An anesthesiologist may supervise up to four operating rooms. The anesthesiologist must be in the operating suite. Availability of the anesthesiologist by telephone does not constitute direct and continuous supervision.
3. Anesthesia time starts when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or equivalent area. Anesthesia time ends when the anesthesiologist is no longer in personal attendance; that is, when the patient may be safely placed under post-operative supervision.

B. Assist at Surgery: Clarification of Policy and Adoption of Modifier 82

The Division pays a surgical assistant 15 percent of the allowable fee for the surgical procedure. The Division 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 Division 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(s) and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the Division 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.

Effective for dates of service beginning July 29, 2002, surgical-assistant services provided at a teaching hospital when no qualified resident is available must be identified by adding the modifier 82 to the end of the service code for the procedure.

C. Co-Surgery Modifier 62

When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon should report his or her distinct operative work by adding the modifier 62 to the service code and any associated add-on codes for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedures other than add-on procedures are performed as co-surgery during the same surgical session, use modifier 99 (multiple modifiers) to report modifiers 51 and 62.

D. Multiple Surgery Claims Submission

All multiple surgery claims must be submitted on a paper claim form no. 5. When two or more surgical procedure codes are billed electronically for the same member on the same date of service, the claims will be denied with error 282 (multiple surgery under review – requires paper claim).

The status column on the remittance advice will indicate whether the claim is paid, suspended, or denied. When a claim is submitted on paper and is suspended with this error code (282), no action is required. The suspended claim will appear on a later remittance advice as paid or denied.

For additional information on rebilling claims, refer to the billing instructions in Subchapter 5 of the *Physician Manual*.

E. Enhanced Global Obstetric Services

Effective for dates of service beginning July 29, 2002, the Massachusetts local codes for the enhanced global delivery (X5555 and X5556) will be replaced by CPT codes. For dates of service between April 30, 2002, and July 28, 2002, providers may use either the Massachusetts local codes or one of the following CPT codes when billing for global obstetrical services: 59400, 59510, 59610, or 59618. See 130 CMR 433.121 for specific conditions of payment for these services.

F. Labor Management Services Provided by a Nurse Midwife

Effective for dates of service beginning July 29, 2002, the Massachusetts local service codes for labor management (X5554 and X5557) will be replaced by CPT code 59899. For dates of service between April 30, 2002, and July 28, 2002, providers may use either the Massachusetts local codes or 59899 when billing for this service.

G. Unlisted Emergency Oral Surgery Procedure

Effective for dates of service beginning July 29, 2002, the Massachusetts local service code for unlisted emergency oral surgery services (X9900) will be replaced by CPT codes. For dates of service between April 30, 2002, and July 28, 2002, providers may use either the Massachusetts local code or one of the following CPT codes when billing for this service: 21299, 21499, 40899, or 41899.

H. Trigger Point Injections (20552 and 20553)

CPT codes 20552 and 20553 can represent single or multiple injections, but must always be billed with only one unit of service. These codes may not be used in combination to report multiple muscle groups or injections performed during the same session. Only one service code may be reported. Modifier 50, used to report bilateral procedures, is not applicable for these CPT codes.

IV. Radiology Services

Modifiers 50 and 51

Providers submitting claims for radiology services for MassHealth members should not use modifier 50 to identify bilateral procedures. When billing for a bilateral procedure, enter the appropriate radiology CPT code in Item 24C of the MassHealth claim form no. 5, and enter two units of service in Item 24F. Similarly, providers should not use modifier 51 for multiple radiology procedures, unless they are using CPT code 78306, 78320, 78802, 78803, 78806, or 78807 to identify the second or subsequent procedure performed on the same day. All other multiple radiology CPT codes should be listed on the claim form (multiple lines) without modifier 51.

V. Laboratory Services

HIV Testing (Phenotype/Genotype) and PA Requirement

Effective January 1, 2002, the Division began providing coverage for HIV genotype and phenotype resistance tests. Physicians who want to order these specialized tests to help them manage their HIV patients' treatment must request prior authorization from the Division. If the Division authorizes the service, the physician must provide the laboratory with a copy of the letter from the Division approving the test along with the order for testing. Please refer to Physician Bulletin 76, dated January 2002, for additional information. The Division will pay for these laboratory services only when provided by independent clinical laboratories that are certified to perform such testing by the Centers for Medicare and Medicaid Services, under the Clinical Laboratory Improvement Act (CLIA).

Obsolete Appendices

The following provider manual appendices are obsolete. Providers should remove them from their copies of the *Physician Manual*.

- Appendix D. Mental Health/Substance Abuse Program Contract
- Appendix F. Guidelines
- Appendix G. Site of Service List
- Appendix J. Clinical Criteria for Extended Prior Authorization for Mental Health Services

Questions

Providers with questions about the information in this transmittal letter may contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

NEW MATERIAL

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

Physician Manual

Pages iv, iv-a, vi, 4-1 through 4-52, 5.3-9 through 5.3-12, 5.3-15, 5.3-16, 5.3-21 through 5.3-24, 5.3A-5, 5.3A-6, 5.3A-9 through 5.3A-12, and 6-1 through 6-14

OBSOLETE MATERIAL

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

Physician Manual

Pages iv, iv-a, vi-e, 4-1 through 4-6, 4-29 through 4-40, and 4-53 through 4-60 — transmitted by Transmittal Letter PHY-90

Pages vi, vi-a, vi-b, vi-c, vi-d, 6.1-1 through 6.1-40, 6.2-1 through 6.2-10, 6.3-1 through 6.3-192, 6.4-1 through 6.4-22, and 6.5-1 through 6.5-36 — transmitted by Transmittal Letter PHY-87

Pages 4-7, 4-8, 4-13, 4-14, G-1, and G-2 — transmitted by Transmittal Letter PHY-74

Pages 4-9 and 4-10 — transmitted by Transmittal Letter PHY-62

Pages 4-11, 4-12, 4-69, and 4-70 — transmitted by Transmittal Letter PHY-65

Pages 4-15 through 4-18 — transmitted by Transmittal Letter PHY-86

Pages 4-19 through 4-22 — transmitted by Transmittal Letter PHY-41

Pages 4-23, 4-24, and 4-63 through 4-68 — transmitted by Transmittal Letter PHY-52

Pages 4-25 and 4-26 — transmitted by Transmittal Letter PHY-54

Pages 4-27 and 4-28 — transmitted by Transmittal Letter PHY-84

Pages 4-41 and 4-42 — transmitted by Transmittal Letter PHY-68

Pages 4-43 and 4-44 — transmitted by Transmittal Letter PHY-57

Pages 4-45 and 4-46 — transmitted by Transmittal Letter PHY-61

Pages 4-47 through 4-52 — transmitted by Transmittal Letter PHY-76

Pages 4-61 and 4-62 — transmitted by Transmittal Letter PHY-81

Pages 5.3-9 through 5.3-12, 5.3-15, 5.3-16, 5.3-21 through 5.3-24, 5.3A-5, 5.3A-6, and 5.3A-9 through 5.3A-12 — transmitted by Transmittal Letter PHY-89

Pages D-1 and D-2 — transmitted by Transmittal Letter PHY-73

Pages F-1 through F-6 — transmitted by Transmittal Letter PHY-5

Pages J-1 through J-3 — transmitted by Transmittal Letter PHY-35

4. PROGRAM REGULATIONS

Part 1. General Information

Part 2. Medical Services

4. PROGRAM REGULATIONS (cont.)

6. SERVICE CODES

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.

Adult Office Visit — a medical visit by a member 21 years of age or older to a physician's office or to a hospital outpatient department.

Community-Based Physician — any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician.

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 physical disease or 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 Admission Service — a complete history and physical examination by a physician of a member admitted to a hospital to treat an emergency medical condition, when definitive care of the member is assumed subsequently by another physician on the day of admission.

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 woman, 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.

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.

Federal Upper-Limit Price (FULP) — a price established by the federal Centers for Medicare and Medicaid Services (CMS) pursuant to 42 CFR 447.332 and USC §1396r-8(e). The FULP is equal to 150 percent of the published price for the least costly therapeutic equivalent (using all available national compendia of cost information on drugs) that can be purchased by pharmacists in quantities of 100 tablets or capsules (or, if the drug is not commonly available in quantities of 100, the package size most commonly listed) or, in the case of liquids, the most commonly listed size.

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-Based Entity — any entity that contracts with a hospital to provide medical services to members on the same site as the hospital's inpatient facility or hospital-licensed health center.

Hospital-Based Physician — any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital to provide services to members on the same site as the hospital's inpatient facility or hospital-licensed health center.

Hospital-Licensed Health Center — a facility that:

(1) operates under a hospital's license but is not physically attached to the hospital;
(2) operates within the fiscal, administrative, and clinical management of the hospital;
(3) provides services to patients solely on an outpatient basis;
(4) meets all regulatory requirements for participation in MassHealth as a hospital-licensed health center; and
(5) is enrolled with the Division as a hospital-licensed health center with a separate hospital-licensed health center MassHealth provider number.

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.

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, as listed in the current edition of the *Massachusetts List of Interchangeable Drug Products* (105 CMR 720.000) or any supplement thereof.

Legend Drug — any drug for which a prescription is required by applicable federal or state law or regulation.

Massachusetts Upper-Limit Price (MULP) — for multiple-source drugs that do not appear on the federal upper-limit price (FULP) list, an amount equal to 150 percent of the published price for the least costly therapeutic equivalent as listed in national price compendia such as the Red Book and First Data Bank for the most frequently purchased package size.

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.

Most Frequently Purchased Package Size — the package size of a drug most frequently purchased by pharmacy providers based on utilization data compiled by the Division. The National Drug Code (NDC) that is most often paid by the Division and verified by audit, if determined necessary by the Division, is considered the most frequently purchased package size.

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.

Nonlegend Drug — any drug for which no prescription is required by federal or state law.

Not Otherwise Classified — a term used for service codes that should be used when no other service code is appropriate for the service provided.

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 On-Line Processing System (POPS) — the on-line, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

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.

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.

Sterilization — any medical procedure, treatment, or operation performed to make an individual permanently incapable of reproducing.

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

Trimester — one of three three-month terms in a normal pregnancy. If the pregnancy has existed for less than 12 weeks, the pregnancy is in its first trimester. If the pregnancy has existed for 12 or more weeks but less than 24 weeks, the pregnancy is in its second trimester. If the pregnancy has existed for 24 or more weeks, the pregnancy is in its third trimester.

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 Division pays for physician services provided to MassHealth members, subject to the restrictions and limitations described in the Division's regulations. 130 CMR 450.105 describes the services covered and the members covered under each coverage type.

(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.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

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 and acute hospitals 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 Division 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 Social Services.

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

(4) The physician practices outside a 50-mile radius of the Massachusetts border and obtains prior authorization from the Division before providing a nonemergency service. Prior authorization will be granted only for services that are not available from comparable resources in Massachusetts, that are generally accepted medical practice, and that can be expected to benefit the member significantly. To request prior authorization, the out-of-state physician or the referring physician must send the Division a written request detailing the proposed treatment and naming the treatment facility (see the instructions for requesting prior

authorization in Subchapter 5 of the *Physician Manual*). The Division will notify the member, the physician, and the proposed treatment facility of its decision. If the request is approved, the Division will assist in any arrangements needed for transportation.

433.404: Nonpayable Circumstances

(A) The Division does not pay a physician for services provided under any of the following circumstances.

(1) The services were provided by a physician who individually or through a group practice has contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution that involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to member care.

(2) The services were provided by a physician who is an attending, visiting, or supervising physician in an acute, chronic, or rehabilitation hospital but who is not legally responsible for the management of the member's case with respect to medical, surgery, anesthesia, laboratory, or radiology services.

(3) The services were provided by a physician who is a salaried intern, resident, fellow, or house officer. 130 CMR 433.404 does not apply to a salaried physician when the physician supplements his or her income by providing services during off-duty hours on premises other than those of the institution that pays the physician a salary, or through which the physician rotates as part of his or her training.

(4) The services were provided in a state institution by a state-employed physician or physician consultant.

(5) Under comparable circumstances, the physician does not customarily bill private patients who do not have health insurance.

(B) The Division does not pay a physician for performing, administering, or dispensing any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, the Division will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(C) The Division does not pay a physician for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).

(D) The Division does not pay a physician for otherwise payable service codes when those codes are used to bill for circumstances that are not payable pursuant to 130 CMR 433.404.

433.405: Maximum Allowable Fees

(A) The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for physician services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 433.000, and is made at the lowest of the following:

(1) the physician's usual and customary fee;
(2) the physician's actual charge submitted; or
(3) the maximum allowable fee listed in the applicable DHCFP fee schedule, subject to any fee reductions enacted into law.

(B) The DHCFP fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations:

(1) 114.3 CMR 16.00: Surgery and Related Anesthesia Care
(2) 114.3 CMR 17.00: Medical and Related Anesthesia Care
(3) 114.3 CMR 18.00: Radiology
(4) 114.3 CMR 20.00: Clinical Laboratory Services

433.406: Individual Consideration

(A) The Division has designated certain services in Subchapter 6 of the *Physician Manual* as requiring individual consideration. This means that the Division will establish the appropriate rate for these services based on the standards and criteria set forth in 130 CMR 433.406(B). Providers claiming payment for any service requiring individual consideration must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that may include, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The Division does not pay claims for services requiring individual consideration unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim. See 130 CMR 433.410 for report requirements.

(B) The Division determines the appropriate payment for a service requiring individual consideration in accordance with the following standards and criteria:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the member's disease, disorder, or disability;
(4) any applicable relative-value studies;
(5) any complications or other circumstances that the Division deems relevant; and
(6) the policies, procedures, and practices of other third-party insurers.

433.407: Service Limitations: Medical and Radiology Services

Additional limitations are set forth in 130 CMR 433.413 and 433.437.

(A) Definitions.

(1) Global Fee – the rate of payment for the two components of a medical or radiology service: the professional component and the technical component. (For information on the global fee as it relates specifically to obstetrics, see 130 CMR 433.421.)
(2) Mobile Site – any site other than the physician's office, but not including community health centers, hospital outpatient departments, or hospital-licensed health centers.
(3) Professional Component – the component of a medical or radiology service for interpreting a diagnostic test or image or for performing a procedure.

(4) Technical Component – the component of a medical or radiology service for the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses, excluding the physician's professional component.

(B) Payment of the Global Fee. The Division pays a physician a global fee for performing a medical or radiology service in the physician's office when one of the following conditions is met.

(1) The physician owns or leases the equipment for providing the technical component of the service, provides the technical component of the service (either directly or by employing a technician), and provides the professional component of the service.

(2) The physician provides the professional component of the service and subcontracts with a licensed Medicare-certified entity to provide the technical component of the service either in the physician's office or at a mobile site. Only the physician providing the professional component of the service may bill for the global fee. This constitutes a limited exception to 130 CMR 450.301.

(C) Payment for the Professional Component Only. The Division pays a physician the applicable fee for providing the professional component of a medical or radiology service in the physician's office.

433.408: Prior Authorization

(A) Introduction.

(1) Subchapter 6 of the *Physician Manual* lists codes that require prior authorization as a prerequisite for payment. The Division will not pay for services if billed under any of these codes, unless the provider has obtained prior authorization from the Division before providing the service.

(2) A prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as member eligibility or resort to health insurance payment.

(B) Requesting Prior Authorization. All prior-authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*.

(C) Physician Services Requiring Prior Authorization. Services requiring prior authorization include, but are not limited to, the following:

(1) certain surgery services, including reconstructive surgery;

(2) nonemergency services provided to a member by an out-of-state physician who practices outside a 50-mile radius of the Massachusetts border;

(3) certain vision care services; and

(4) certain psychiatry services.

(D) Mental Health and Substance Abuse Services Requiring Prior Authorization. Members enrolled with the Division's behavioral health contractor require service authorization before certain mental health and substance abuse services are provided. For more information, see 130 CMR 450.124.

(E) Nonphysician Services Requiring Prior Authorization. Many nonphysician services require prior authorization, and must first be ordered, or have their need substantiated, by a physician before the Division grants such authorization. These services include, but are not limited to, the following:

(1) transportation;
(2) selected drugs;
(3) home health services;
(4) nursing facility services;
(5) durable medical equipment; and
(6) therapy services.

433.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any service listed in 130 CMR 433.000 is conditioned upon its full and complete documentation in the member's medical record. Payment for maintaining the member's medical record is included in the fee for the service.

(B) In order for a medical record to document completely a service or services to a member, that record must set forth the nature, extent, quality, and necessity of care furnished to the member. When the information contained in a member's medical record is not sufficient to document the service for which payment is claimed by the provider, the Division will disallow payment for the claimed service.

(C) The Division may at its discretion request, and upon such request the physician must furnish, any and all medical records of members corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, §38, and 130 CMR 450.205. The Division may produce, or at its option may require the physician to produce, photocopies of medical records instead of actual records when compliance with 130 CMR 433.409(C) would otherwise result in removal of medical records from the physician's office or other place of practice.

(D) (1) Medical records corresponding to office, home, nursing facility, hospital outpatient department, and emergency department services provided to members must include the reason for the visit and the data upon which the diagnostic impression or statement of the member's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, these medical records must include, but may not be limited to, the following:

(a) the member's name and date of birth;
(b) the date of each service;
(c) the name and title of the person performing the service, if the service is performed by someone other than the physician claiming payment for the service;
(d) the member's medical history;
(e) the diagnosis or chief complaint;
(f) clear indication of all findings, whether positive or negative, on examination;
(g) any medications administered or prescribed, including strength, dosage, and regimen;
(h) a description of any treatment given;
(i) recommendations for additional treatments or consultations, when applicable;
(j) any medical goods or supplies dispensed or prescribed; and
(k) any tests administered and their results.

(2) When additional information is necessary to document the reason for the visit, the basis for diagnosis, or the justification for future diagnostic procedures, treatments, or recommendations for return visits or materials, such information must also be contained in the medical record. Basic data collected during previous visits (for example, identifying data, chief complaint, or history) need not be repeated in the member's medical record for subsequent visits. However, data that fully document the nature, extent, quality, and necessity of care provided to a member must be included for each date of service or service code claimed for payment, along with any data that update the member's medical course.

(E) For inpatient visit services provided in acute, chronic, or rehabilitation hospitals, there must be an entry in the hospital medical record corresponding to and substantiating each hospital visit claimed for payment. An inpatient medical record will be deemed to document services provided to members and billed to the Division if it conforms to and satisfies the medical record requirements set forth in 105 CMR 130.000. The physician claiming payment for any hospital inpatient visit service is responsible for the adequacy of the medical record documenting such service. The physician claiming payment for an initial hospital visit must sign the entry in the hospital medical record that documents the findings of the comprehensive history and physical examination.

(F) Additional medical record requirements for radiology, psychiatry, and other services can be found in the applicable sections of 130 CMR 433.000.

(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 Division as set forth in 130 CMR 450.206. The Division 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 Division to assess the extent and nature of the service.

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

(130 CMR 433.411 and 433.412 Reserved)

PART 2. MEDICAL SERVICES

433.413: Office Visits: Service Limitations

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

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

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

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

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

(D) Family Planning Office Visits. The Division pays for office visits provided for the purposes of family planning. The Division 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 Division will pay a physician for medical care provided in a hospital emergency department only when the hospital's claim does not include a charge for the physician's services.

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

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

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

(C) Outpatient Department Visits. The Division will pay 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 Division 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 Division will pay for such visits.

(C) The Division pays only the attending physician for hospital vists, with the following exceptions.

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

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

433.417: Home Visits: Service Limitations

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

433.418: Consultations: Service Limitations

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

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

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

(3) the nurse midwife has a current collaborative arrangement with a physician or group of physicians, as required by state law or regulation (including but not limited to 244 CMR 4.00 and 130 CMR 433.419(C)(2)). The Division 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 Division, that he or she is:

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

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

(c) in a solo private practice.

(2) Collaborative Arrangement Requirements. The independent nurse midwife's collaborating physician must be a MassHealth provider who engages in the same type of clinical practice as the nurse midwife. The nurse midwife must practice in accordance with written guidelines developed in conjunction with the collaborating physician as set forth in 244 CMR 4.00. The nurse midwife must submit to the Division 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.

(3) Consultation Between Independent Nurse Midwife and Collaborating Physician. The Division does not pay for a consultation between an independent nurse midwife and a collaborating physician as a separate service.

(D) Submitting Claims for Nonindependent Nurse Midwives. Any nurse midwife who does not meet the requirements of 130 CMR 433.419(C) is a nonindependent nurse midwife 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 is a member of a group practice) who employs a nonindependent nurse midwife may submit claims for services provided by a nonindependent nurse midwife employee, but only if such services are provided in accordance with 130 CMR 433.419(B), and payment is claimed in accordance with 130 CMR 450.301(B).

433.420: Obstetric Services: Introduction

The Division offers two methods of payment for obstetric services: the fee-for-service method and the global-fee method. Fee for service requires submission of claims for services as they are performed and is available to a provider for all covered obstetric services. The global fee is available only when the conditions specified in 130 CMR 433.421 are met.

433.421: Obstetric Services: Global-Fee Method of Payment

(A) Definition of Global Fee. The global fee is a single inclusive fee for all prenatal visits, the delivery, and one postpartum visit. The global fee is available only when the conditions in 130 CMR 433.421 are met.

(B) Conditions for Global Fee

(1) Primary Provider. A physician or independent nurse midwife who assumes responsibility for performing or coordinating a minimum of six prenatal visits, the delivery, and postpartum care for the member is the primary provider. In a group practice or when a back-up physician is involved, the primary provider is not required to perform all the components of a global delivery directly. Another member of the practice or a back-up physician can perform services; he or she is a referred provider. Only providers in the same group practice or back-up physicians are considered referred providers.

(2) Payment to Primary Provider. Only the primary provider may claim payment of the global fee. A physician who is a primary provider may claim payment of the global fee for the obstetric services provided by a nurse, nurse practitioner, nurse midwife, or physician assistant employed by the physician. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).) All global-fee claims must use the delivery date as the date of service.

(3) Standards of Practice. All of the components of a global fee must be provided at a level of quality consistent with the standards of practice of the American College of Obstetrics and Gynecology.

(4) Coordinated Medical Management. The physician and nurse, nurse practitioner, nurse midwife, or physician assistant employed by the physician, or an independent nurse midwife must provide referral to and coordination of the medical and support services necessary for a healthy pregnancy and delivery. This includes the following:

(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.

(5) Health-Care Counseling. In conjunction with providing prenatal care, the physician and nurse, nurse practitioner, physician assistant, or nurse midwife employed by the physician, or the independent nurse midwife 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 women;
(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.

(6) Obstetrical-Risk Assessment and Monitoring. The physician and nurse, nurse practitioner, physician assistant, or nurse midwife employed by the physician, or the independent nurse midwife 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 and should be billed for 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 postpartum care) are provided directly by the primary provider, by a nurse, nurse practitioner, nurse midwife, or physician assistant employed by the physician, or by a referred provider, that is, a member of the same group practice or a back-up physician. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).)

(2) If the primary provider bills for the global fee, no referred provider may claim payment from the Division. Payment of the global fee constitutes payment in full both to the primary provider and each referred provider.

(3) If the primary provider bills for the global fee, any provider who is not a referred provider but 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 other provider may claim payment for the delivery.

(4) If the primary provider bills on a fee-for-service basis, any other provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services provided to the same member.

(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 referred providers or employees of the primary provider. 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)

433.424: Obstetric Services: Fee-for-Service Method of Payment

The fee-for-service method of payment is always available to a provider for obstetric services covered by MassHealth. If the global-fee requirements in 130 CMR 433.421 are not met, the provider or providers may claim payment from the Division only on a fee-for-service basis, as specified below.

(A) When there is no primary provider for the obstetric services performed for the member, each provider may claim payment only on a fee-for-service basis.

(B) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the member may claim payment only on a fee-for-service basis.

(C) When an independent nurse midwife is the primary provider and the collaborating physician performs a cesarean section, the independent nurse midwife may claim payment for the prenatal visits only on a fee-for-service basis. The collaborating physician may claim payment for the cesarean section only on a fee-for-service basis.

(D) When additional services (for example, ultrasound or special tests) are performed, the provider may claim payment for these only on a fee-for-service basis.

433.425: Ophthalmology Services: Service Limitations

The Division pays for eye examinations, subject to the following limitations.

(A) The Division requires prior authorization for a comprehensive eye examination if the service has been provided:
(1) within the preceding 12 months, for a member under 21 years of age; or
(2) within the preceding 24 months, for a member 21 years of age or older.

(B) The Division pays for ophthalmology services designated as separate procedures only if they are provided independently of a comprehensive eye examination.

(C) The Division pays for a titmus vision test or similar screening device only once per year per member.

(D) The Division pays for eyeglasses and other ophthalmic materials, except over-the-counter items such as magnifiers, only upon prescription, even if the prescriber dispensed the materials. The prescription must be based upon the results of a vision examination performed by the prescriber. The prescription must include all information that is necessary to enable a dispensing practitioner to fill the prescription. The prescriber must give the member a signed copy of the prescription without extra charge. The date or dates upon which the prescription is filled or refilled must be recorded on the member's copy of the prescription. (For further regulations about ophthalmic materials, see the Division’s regulations governing vision care services at 130 CMR 402.000.)

433.426: Audiology Services: Service Limitations

The Division pays for audiology services only when they are provided by a physician or by an audiologist certified by the American Speech and Hearing Association and employed by a physician. This limitation does not apply to an audiometric hearing test, pure-tone, air only.

433.427: Allergy Testing: Service Limitations

(A) The Division pays for allergy testing only when performed by a physician or under a physician's direct supervision. All fees include payment for physician observation and interpretation of the tests in relation to the member's history and physical examination. A physician may bill for an initial consultation in addition to allergy testing.

(B) The Division does not pay for more than three blood tests and pulmonary function tests (such as spirometry and expirogram) used only for diagnosis and periodic evaluation per member per year.

(C) Immunotherapy and desensitization (extracts) are covered services. The provider must indicate the amount and anticipated duration of the supply for immunotherapy and desensitization (extracts) on the claim form.

(D) The Division pays for follow-up office visits for injections and reevaluation as office visits.

(E) The Division pays for sensitivity tests only once per member per year regardless of the type of tests performed or the number of visits required.

433.428: Psychiatry Services: Introduction

(A) Covered Services. The Division pays for the psychiatry services described in 130 CMR 433.429.

(B) Noncovered Services.

(1) Nonphysician Services. The Division does not pay a physician for services provided by a social worker, psychologist, or other nonphysician mental health professional employed or supervised by the physician.

(2) Research and Experimental Treatment. The Division does not pay for research or experimental treatment. This includes, but is not limited to, any method not generally accepted or widely used in the field, or any session conducted for research rather than for a member's clinical need.

(3) Nonmedical Services. The Division does not pay a physician for nonmedical services, including, but not limited to, the following:

(a) vocational rehabilitation services;

(b) educational services;

(c) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is payable);

(d) street-worker services (information, referral, and advocacy to certain age populations; liaison with other agencies; role modeling; and community organization);

(e) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and

(f) biofeedback.

(4) Nonmedical Programs. The Division does not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other noncovered services. Such programs include freestanding alcohol or drug detoxification programs, freestanding methadone maintenance programs, residential programs, day activity programs, drop-in centers, and educational programs.

(5) Psychological Testing. The Division does not pay for psychological testing provided by a physician.

(C) Recordkeeping (Medical Records) Requirements. In addition to the provisions in 130 CMR 433.409, the following specific information must be included in the medical record for each member receiving psychiatric services:

(1) the condition or reason for which psychiatric services are provided;

(2) the member's diagnosis;

(3) the member's medical history;

(4) the member's social and occupational history;

(5) the treatment plan;

(6) the physician's short- and long-range goals for the member;

(7) the member's response to treatment; and

(8) if applicable, a copy of the signed consent for electroconvulsive therapy.

(D) Frequency of Treatment. The Division pays a physician for only one session of each type of service provided to a member in one week except for crisis intervention, as described below.

(1) In a crisis, as defined in 130 CMR 433.429(K), the Division will pay a physician for extra sessions. The physician must bill for these services using the service code for crisis intervention and must document the following in the member's record:

(a) the member is in a state of marked life change or crisis;

(b) the member's ability to function is likely to deteriorate; and

(c) the plan of treatment is to resume or to initiate regular weekly sessions after the resolution of the crisis.

(2) Although prior authorization is still required after 17 treatment sessions, the Division will pay a physician for more than one type of service provided to a member in one week if the additional service or services are medically necessary. The member's record must document the circumstances necessitating the provision of more than one type of service. The record must make clear that the substitution of one type of service for another would not adequately benefit the member and that an additional type of service is necessary.

433.429: Psychiatry Services: Scope of Services

130 CMR 433.429 describes the services that a psychiatrist may provide, including the limitations imposed on those services by the Division. For all psychotherapeutic services, the majority of time must be spent as personal interaction with the member; a minimal amount of time must be spent for the recording of data.

(A) Individual Psychotherapy. The Division pays a physician for individual psychotherapy provided to a member only when the physician treats the member. This service includes diagnostics.

(B) Family and Couple Therapy. The Division pays for therapy provided simultaneously in the same session to more than one member of the same family or to a couple whose primary complaint is the disruption of their marriage, family, or relationship. Payment is limited to one hour per session per week, regardless of the number of family members present or the presence of a cotherapist.

(C) Group Therapy. The Division pays for therapy provided to a group of persons, most of whom are not related by blood, marriage, or legal guardianship. The Division pays for group therapy only if the session lasts for at least 90 minutes with the physician. Payment is limited to one fee per group member with a maximum of 10 members per group regardless of the presence of a cotherapist.

(D) Diagnostic Services. The Division pays for the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan. This service includes an initial medication evaluation.

(E) Reevaluation. Without prior authorization, the Division pays for the reevaluation of a member who has been out of treatment for at least six months and who has used up the lifetime benefit of 17 treatment sessions. A provider may bill for a maximum of two one-hour units per member per calendar year for the purpose of designing a treatment plan and requesting prior authorization for a particular number of sessions.

(F) Long-Term Therapy. The Division defines long-term therapy as a combination of diagnostics; individual, couple, family, and group therapy; and consultation planned to extend more than 17 sessions.

(G) Short-Term Therapy. The Division defines short-term therapy as a combination of diagnostics; individual, couple, family, and group therapy; and consultation planned to terminate within 17 sessions.

(H) Medication Review. The Division pays for a member visit to the physician specifically for the prescription, review, and monitoring of medication. If this service is not combined with psychotherapy, it must be billed as a minimal office visit. The Division does not pay separately for medication review if it is performed on the same day as another service.

(I) Case Consultation. The Division pays for a consultation with another agency or person when the physician has accepted a patient for treatment and continues to assume primary responsibility for the patient's treatment, while the other agency continues to provide ancillary services.

(J) Family Consultation. The Division pays for a preplanned meeting of at least one-half hour with the parent or parents or legal guardian of a child who is being treated by the physician, when the parent or parents or legal guardian are not clients of the physician.

(K) Crisis Intervention/Emergency Services. The Division pays for an immediate mental health evaluation, diagnosis, hospital prescreening, treatment, and arrangements for further care and assistance as required, provided during all hours to members showing sudden, incapacitating emotional stress. The Division pays only for face-to-face contact; telephone contacts are not payable. The Division pays for no more than two hours of emergency services per member on a single date of service.

(L) Electroconvulsive Therapy. The Division pays for electroconvulsive therapy only when it is provided in a hospital setting by a physician and only when both the physician and the facility meet the standards set by the Massachusetts Department of Mental Health, including those relative to informed consent.

(M) After-Hours Telephone Service. The physician must provide telephone coverage during the hours when the physician is unavailable, for members who are in a crisis state.

(N) Hospital Inpatient Visit. A visit to a hospitalized member is payable only as a hospital visit (see 130 CMR 433.415) unless at least 15 minutes of psychotherapy is provided. Payment will be made for only one visit per member per day.

(O) Routine Inpatient Care. The Division pays for a maximum of three weeks of routine inpatient care without prior authorization if the admission has received a preadmission screening number from the Division or its agent in accordance with 130 CMR 433.415(A). Routine inpatient care includes the following services. The amounts of services listed are the maximum payable; fewer services may be provided.

(1) During the first week of hospitalization, the Division pays for the following:
   (a) for an initial evaluation:
      (i) up to three hours for a member under 19 years of age; and
      (ii) up to two hours for a member aged 19 or older;
   (b) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:
      (i) up to five hours for a member under 19 years of age; and
      (ii) up to three hours for a member aged 19 or older; and
   (c) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:
      (i) up to one day for a member under 19 years of age; and
      (ii) up to three days for a member aged 19 or older.

(2) During each of the second and third weeks of hospitalization, the Division pays a psychiatrist for the following:
   (a) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:
      (i) up to five hours for a member under 19 years of age; and
      (ii) up to three hours for a member aged 19 or older; and

(b) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:

(i) up to two days for a member under 19 years of age; and

(ii) up to four days for a member aged 19 years or older.

(3) The Division pays for only one type of service a day.

(4) In order to be payable, individual psychotherapy, regulation of medication, and daily medical care must involve face-to-face contact between the psychiatrist and the member.

(5) For extended hospitalization, if the hospital has complied with the Division's concurrent review process, the Division pays a psychiatrist for the services described in 130 CMR 433.429(O)(2), that is, for the same amount of services payable in the second and third weeks.

433.430: Dialysis: Service Limitations

(A) Medicare Coverage. Medicare is the primary source of payment for medical care to persons of any age who have chronic renal disease and who require hemodialysis or a kidney transplant. Members being treated for chronic renal disease must be referred to a MassHealth Enrollment Center or their Social Security Administration office to determine Medicare eligibility.

(B) Service Limitations. The Division pays for hemodialysis only to hospitalized members who are:

(1) being dialyzed for acute renal failure;

(2) receiving initial dialysis for chronic renal failure prior to continuing chronic maintenance dialysis; or

(3) receiving dialysis for complications of chronic maintenance dialysis.

433.431: Physical Medicine: Service Limitations

(A) The services listed in 130 CMR 433.431 are payable only when the physician prescribes the needed therapy, and the services are provided by the physician or by a licensed physical or occupational therapist employed by the physician.

(B) Physical medicine services include, but are not limited to, superficial or deep-heat modalities, therapeutic exercise, traction, hydrotherapy, prosthetics and orthotics training, activities of daily living and ambulation training, range of motion, and manual muscle strength assessment. Other restorative services are covered by MassHealth upon referral by a physician (see 130 CMR 433.471).

433.432: Other Medical Procedures

(A) Cardiovascular and Other Vascular Studies. Fees for cardiovascular services and other vascular studies include payment for laboratory procedures, interpretations, and physician services (except surgery and anesthesia services), unless otherwise stated. These services may be billed in addition to an office visit.

(B) Cardiac Catheterization. Fees for cardiac catheterization are for the physician's services only and include payment for the usual preassessment of the cardiac problem and the recording of intracardiac pressure.

(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 Division 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 244 CMR 4.00);

(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 244 CMR 4.00 and 130 CMR 433.433(C)(2)). The Division 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 Division, 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.

(2) Collaborative Arrangement Requirements. The independent nurse practitioner's collaborating physician must be 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 244 CMR 4.00. The nurse practitioner must submit to the Division 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 Division 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 Division 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).

(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 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 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 Division 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).

(130 CMR 433.435 Reserved)

433.436: Radiology Services: Introduction

The Division pays for radiology services only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Provider Eligibility. A provider of portable X-ray services is eligible to participate in MassHealth only if the provider is certified by Medicare.

(B) Request for Portable X-Ray Services. Portable X-ray services may be provided to a member at a mobile site (see 130 CMR 433.407(A)) at the written request of a licensed physician. This written request must specify the reason the X ray is required, the area of the body to be exposed, the number of X rays to be obtained, the views needed, and a statement of the member's condition that necessitates portable X-ray services. If the member resides in a long-term care facility, a copy of this written request must be kept in the member's medical record in the facility as well as in the member's record maintained by the physician.

(C) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (see 130 CMR 433.409), the physician must keep suitable records of radiology services performed. All X rays must be labeled adequately with the following:

(1) the member's name;
(2) the date of the examination;
(3) the nature of the examination; and
(4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

See also the general limitations described at 130 CMR 433.407.

(A) Portable X-Ray Services. In addition to radiology services provided to a member at a mobile site, the Division pays for one physician visit to the mobile site, regardless of the number of members receiving portable X-ray services at that mobile site.

(B) Computerized Axial Tomography (CT Scans). The Division pays for CT scan services (head and body scans) only when they are performed in a facility having a Determination of Need for a CT scanner by the Massachusetts Department of Public Health. The Division pays physicians directly only for the professional component (interpretation) of a CT scan. All CT scan services must meet current Medicare standards.

(C) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the Division pays physicians in accordance with the DHCFP fee schedule. The Division does not pay for the interpretation of an X ray that was previously read and taken in the same hospital. However, the Division does pay a physician for interpreting an X ray that was previously read and taken in a different hospital.

(D) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the Division pays the physician in accordance with the DHCFP fee schedule.

(E) Surgical Introductions and Interpretations. The Division pays a physician for performing surgical introductions and interpretations of films performed in a hospital inpatient or outpatient setting, with the following restrictions.

(1) Only one surgical introduction per operative session is payable in accordance with the DHCFP fee schedule.

(2) In a single operative session:

(a) no more than three additional surgical introductions using the same puncture site are payable, each in accordance with the DHCFP fee schedule; and

(b) no more than three additional selective vascular studies using the same puncture site are payable, each at the maximum allowable fee.

(3) Interpretations are payable in accordance with the DHCFP fee schedule, up to a maximum of three.

(F) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a member by one or more physicians are payable only if sufficient documentation for each is shown in the member's medical record.

(G) Interventional Radiology. If interventional radiology services are performed by two providers, the professional component is divided equally into surgical and interpretative components.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a member are payable under MassHealth.

(A) Provider Eligibility. The Division pays for laboratory tests only when they are performed on a member by a physician or by an independent clinical laboratory certified by Medicare.

(B) Payment.

(1) Except for the circumstance described in 130 CMR 433.438(B)(2), the Division pays a physician only for laboratory tests performed in the physician's office. If a physician uses the services of an independent clinical laboratory, the Division pays only the laboratory for services provided for a member.

(2) A physician may bill the Division for laboratory services provided on a fee-for-service basis by the state laboratory of the Massachusetts Department of Public Health.

(C) Information with Specimen. A physician who sends a specimen to an independent clinical laboratory participating in MassHealth must also send the following:

(1) a signed request for the laboratory services to be performed;

(2) the member's MassHealth identification number; and

(3) the physician's name, address, and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The Division does not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). However, the Division will pay a physician who collects, centrifuges, and mails a specimen to a laboratory for analysis once per member specimen, regardless of the number of tests to be performed on that specimen.

(B) Professional Component of Laboratory Services. The Division does not pay a physician for the professional component of a clinical laboratory service. The Division pays a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The Division does not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. Payment for laboratory services includes payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests

(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the physician performing the tests.

(b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.

(2) In no event may a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

(130 CMR 433.440 Reserved)

433.441: Pharmacy Services: Prescription Requirements

(A) Legal Prescription Requirements. The Division pays for legend drugs, nonlegend drugs, and those medical supplies listed at 130 CMR 433.442(C) 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, regardless of drug schedule, must contain the prescriber's unique DEA number. For Schedule VI drugs, if the prescriber has no DEA registration number, the prescriber must provide the state registration number on the prescription.

(B) Emergencies. When the pharmacist determines that an emergency exists, the Division will authorize a pharmacy to dispense at least a 72-hour, nonrefillable supply of the drug in compliance with state and federal regulations.

(C) Refills. The Division does not pay for prescription refills that exceed the specific number authorized by the prescriber up to a maximum of 11 refills. The Division does not pay for any refill dispensed after one year from the date of the original prescription. The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

(D) Quantities.

(1) Quantity Limitations. The Division requires that all drugs be prescribed and dispensed in at least a 30-day supply, but no more than a 90-day supply unless the drug is available only in a larger minimum package size. Providers must not split prescriptions by filling them for a period or quantity less than that specified by the prescriber. For example, a prescription written for a single 90-day supply may not be split into three 30-day supplies. The Division considers prescription-splitting to be fraudulent.

(2) Exceptions to Quantity Limitations. The Division allows exceptions to the limitations described in 130 CMR 433.443(D)(1) for:

(a) those drugs in therapeutic classes that are commonly prescribed for less than a 30-day supply, including but not limited to antibiotics and analgesics;

(b) drugs that, in the prescriber's professional judgement, are not clinically appropriate for the member in a 30-day supply; and

(c) 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.

433.442: Pharmacy Services: Covered Drugs and Medical Supplies

(A) Legend Drugs. The Division pays only for legend 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 Section 4401 of the Omnibus Budget Reconciliation Act of 1990.

(B) Nonlegend Drugs. The Division pays only for the nonlegend drugs listed in Appendix L of the *Physician Manual* (Nonlegend Drug List).

(C) Medical Supplies. The Division pays only for the medical supplies listed below:
(1) blood and urine testing reagent strips used for the management of diabetes;
(2) disposable insulin syringe and needle units;
(3) insulin cartridge delivery devices and needles (for example, pens);
(4) lancets; and
(5) drug delivery systems for use with metered dose inhalers (for example, aerochambers).

433.443: Pharmacy Services: Service Limitations

(A) Interchangeable Drug Products. For drugs listed in the current edition of the *Massachusetts List of Interchangeable Drug Products* (105 CMR 720.000) or any supplement thereof, the Division pays no more than the FULP or MULP, whichever applies, unless:
(1) the prescriber has requested and received prior authorization from the Division 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) Insurance Coverage.
(1) Managed Care Organizations. The Division 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.
(2) Other Health Insurance. The Division will pay for pharmacy claims for services to MassHealth members who have health insurance other than through a MassHealth MCO only if the services were provided in accordance with the regulations, including any prior-authorization requirements, and billing rules of the member's other insurance carrier.

(C) Less-Than-Effective Drugs. The Division does not pay for 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.

(D) Experimental and Investigational Drugs.
(1) The Division does not pay for any drug that is experimental, medically unproven, or investigational in nature.
(2) The Division does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the Division determines to be consistent with current medical evidence.

(E) Specific Drug Limitations.

(1) Cosmetic Drugs. The Division does not pay for drugs used for cosmetic purposes or for hair growth.

(2) Cough and Cold Preparations. The Division does not pay for legend or nonlegend preparations that contain an antitussive or expectorant as a major ingredient, or any drug used for the symptomatic relief of coughs and colds, when they are dispensed to a noninstitutionalized member.

(3) Fertility Drugs. The Division does not pay for any drugs used to treat male or female infertility (specifically including, but not limited to, A.P.L., chorionic gonadotropins, Clomid, clomiphenes, HCG, menotropins, Milphene, Pergonal, Pregnyl, Profasi, Profasi HP, and Serophene).

(4) Immunizing Biologicals and Tubercular Drugs. Immunizing biologicals and tubercular (TB) drugs available free of charge through local boards of public health or through the Massachusetts Department of Public Health are not covered. If the member has a prescription, however, the Division will pay for the following drugs for a nonambulatory member who cannot attend one of the Department of Public Health clinics: Isoniazid, Myambutal, and P.A.S. All other such drugs require prior authorization (see 130 CMR 433.444).

(5) Nongeneric Multiple-Source Drugs. Prescribers must obtain prior authorization from the Division for any nongeneric multiple-source drug identified by the Division in accordance with 130 CMR 450.303.

(6) Obesity Management. The Division does not pay for any drug used for the treatment of obesity.

(7) Sexual Dysfunction Therapy. The Division does not pay for the treatment of male or female sexual dysfunction.

(8) Sex-Reassignment Hormone Therapy. The Division does not pay for drugs related to sex-reassignment surgery. This specifically includes, but is not limited to, presurgery and postsurgery hormone therapy. The Division, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(9) Smoking Cessation. The Division does not pay for any drug used for smoking cessation.

(10) Topical Acne Drugs. The Division pays only for topical acne products for members aged 25 years and under who have cases of acne documented to be Grade II or higher.

(11) Unit-Dose Distribution System. The Division does not pay any additional fees for dispensing drugs in a unit-dose distribution system.

433.444: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from the Division for drugs identified by the Division in accordance with 130 CMR 450.303. In addition, if the limitations on covered drugs specified in 130 CMR 433.443(E) 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 Division for prior authorization for an otherwise noncovered drug or medical supply.

(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 Division approves the request, it will notify the pharmacy and the member and assign a prior-authorization number that must be written on the prescription.

(C) The Division will authorize at least a 72-hour supply of a prescription drug to the extent required by federal law. (See 42 U.S.C. 1396r-8(d)(5).) The Division acts on requests for prior authorization for a prescribed drug within a time period consistent with federal regulations.

(D) Prior authorization does not waive any other prerequisites to payment such as, but not limited to, member eligibility or requirements of other health insurers.

433.445: Pharmacy Services: Member Copayments

Under certain conditions, the Division requires that members make a copayment to the dispensing pharmacy for each original prescription and for each refill for all drugs (whether legend or nonlegend) covered by MassHealth. The copayment requirements are detailed in the Division's administrative and billing regulations at 130 CMR 450.130.

433.446: Pharmacy Services: Payment

Drugs dispensed in the office are payable at the physician's actual acquisition cost, subject to the service limitations at 130 CMR 433.404 and 433.443. The Division does not pay for any oral drugs dispensed in the office, with the exception of oral vaccines, for which the physician has not requested and received prior authorization from the Division. Claims for dispensing drugs must include the name of the drug or biological, the strength, and the dosage. A copy of the invoice showing the actual acquisition cost must be attached to the claim form. Claims without this information are denied. Payment for drugs may be claimed in addition to an office visit.

(130 CMR 433.447 through 433.450 Reserved)

PART 3. SURGERY SERVICES

433.451: Surgery Services: Introduction

(A) Provider Eligibility. The Division 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 Division 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 Division 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 the Division's regulations at 130 CMR 433.000 or 450.000 as not payable.

(6) 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 Division pays a physician for either a visit or a treatment/procedure, whichever commands a higher fee. The Division 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 Division 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 Division 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 Division pays a surgical assistant at 15 percent of the allowable fee for the surgical procedure. The Division 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 Division 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(s) and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the Division 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 Division pays for highly complex surgical procedures requiring the concomitant services of more than two surgeons as "team surgery." The Division 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 Division 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 Division 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 Division will pay 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.

(G) Independent Procedures. A number of surgery procedures are designated "I.P." in Subchapter 6 of the *Physician Manual*. I.P. is an abbreviation for independent procedure. An independent procedure is reimbursable only when no other procedure is performed during the same operative session, unless one of the exceptions in 130 CMR 433.452(G)(1) through (3) applies.

(1) When during the same operative session an additional surgery procedure performed by the same physician is designated "I.P." and requires an unrelated operative incision, the full maximum allowable fee will be paid for the procedure with the largest fee, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein. In the event that two or more procedures are scheduled at the largest amount, the full maximum allowable fee will be paid for only one of the procedures, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein.

(2) When during the same operative session one or more of the surgery procedures performed by the same physician is designated "I.P." and does not require an unrelated operative incision, the maximum allowable fee will be paid for the procedure commanding the largest fee, and no payment will be made for any other procedure.

(3) When during the same operative session all of the surgery procedures performed by the same physician are designated "I.P." and one or more requires an unrelated operative incision, payment is determined on the basis of individual consideration.

(130 CMR 433.453 Reserved)

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 Division 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 Division 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 Division pays using time units only. (b) Determining Payable Anesthesia Time. Payable anesthesia time starts when the anesthesiologist 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)(1)(b) in the number of units field on the claim. To calculate the correct number of time units, the provider must determine the number of 15-minute intervals of payable anesthesia time plus any remaining fraction, provided such fraction equals or exceeds five minutes.

(3) Multiple Surgery Procedures. When anesthesia is administered for multiple surgery procedures, the Division 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 Nurse-Anesthetist.

(1) Anesthesia services provided by a nurse-anesthetist are payable only if the nurse-anesthetist

(a) is authorized by law to perform the services;

(b) is a full-time employee of the physician and is not a salaried employee of the hospital; and

(c) performs the services under the direct and continuous supervision of the physician.

(2) The supervising physician must be in the operating suite and responsible for no more than four operating rooms. Availability of the physician by telephone does not constitute direct and continuous supervision.

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

433.455: Abortion Services

(A) Payable Services.

(1) The Division 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 Division, 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 Division 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 18th 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.

(D) Certification for Payable Abortion Form. All physicians must attach a completed Certification for Payable Abortion (CPA-2) form to each claim form submitted to the Division for a payable abortion. (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 Division 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 Division 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.

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

(C) Retroactive Eligibility. The Division does not pay for a sterilization performed during the period of a member's retroactive eligibility unless all conditions for payment listed in 130 CMR 433.456(A) are met.

(D) Locations in Which Sterilizations May Be Performed.

(1) Male sterilization must be performed by a licensed physician in a physician's office, hospital, or sterilization clinic.

(2) Female sterilization must be performed by a licensed physician in a hospital, a freestanding ambulatory surgery center, or a sterilization clinic.

(3) A hospital, a freestanding ambulatory surgery center, or a sterilization clinic in which a sterilization is performed must be licensed in compliance with Massachusetts Department of Public Health regulations at 105 CMR 140.610 through 140.614. In order to receive payment from the Division, a physician, hospital, freestanding ambulatory surgery center, or sterilization clinic must be a participating MassHealth provider.

433.457: Sterilization Services: Informed Consent

A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained in accordance with the requirements specified in 130 CMR 433.457(A) and (B).

(A) Informed Consent Requirements.

(1) The person who obtains consent (a physician, nurse, or counselor, for example) must orally provide all of the following information and advice to the member requesting sterilization:

(a) advice that the member is free to withhold or withdraw consent for the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss of any federal- or state-funded program benefits to which the member otherwise might be entitled;

(b) a description of available alternative methods of family planning and birth control;

(c) advice that the sterilization procedure is considered irreversible;

(d) a thorough explanation of the specific sterilization procedure to be performed;

(e) a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

(f) a full description of the benefits or advantages that may be expected as a result of the sterilization; and

(g) advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in 130 CMR 433.457(B)(1).

(2) The person who obtains consent must also:

(a) offer to answer any questions the member may have concerning the sterilization procedure;

(b) give the member a copy of the consent form;

(c) make suitable arrangements to ensure that the information and advice required by 130 CMR 433.457(A)(1) are effectively communicated to any member who is blind, deaf, or otherwise handicapped;

(d) provide an interpreter if the member does not understand the language used on the consent form or the language used by the person obtaining consent; and

(e) allow the member to have a witness of the member's choice present when consent is obtained.

(B) When Informed Consent Must Be Obtained.

(1) A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A member may not be sterilized at the time of a premature delivery or emergency abdominal surgery unless at least 72 hours have passed since the member gave informed consent for the sterilization in the manner specified in 130 CMR 433.457(A). In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

(2) A member's consent for sterilization will not be considered informed or voluntary if such consent is obtained or given while the member requesting sterilization is:

(a) in labor or childbirth;

(b) seeking to obtain or obtaining an abortion; or

(c) under the influence of alcohol or other substances that affect the individual's state of awareness.

(3) Shortly before the performance of the sterilization procedure, the physician performing the procedure must orally inform the member of all of the information and advice specified in 130 CMR 433.457(A)(1).

433.458: Sterilization Services: Consent Form Requirements

Informed consent for sterilization must be documented by the completion of the Division's Consent for Sterilization form in accordance with the following requirements.

(A) Required Consent Form.

(1) One of the following Consent for Sterilization forms must be used:

(a) CS-18 – for members aged 18 through 20; or

(b) CS-21 – for members aged 21 and older.

(2) Under no circumstances will the Division accept any other consent for sterilization form.

(B) Required Signatures. The member, the interpreter (if one was required), and the person who obtained the consent for sterilization must all sign and date the Consent for Sterilization form (CS-18 or CS-21) at the time of consent. After performing the sterilization procedure, the physician must sign and date the form.

(C) Required Submission and Distribution of the Consent Form. The Consent for Sterilization form (CS-18 or CS-21) must be completed and distributed as follows:

(1) the original must be given to the member at the time of consent;

(2) a copy must be included in the member's permanent medical record at the site where the sterilization is performed; and

(3) all providers must attach a copy of the completed Consent for Sterilization form (CS-18 or CS-21) to each claim made to the Division for sterilization services. When more than one provider is billing the Division (for example, the physician and the hospital), each provider must submit a copy of the completed consent form.

433.459: Hysterectomy Services

(A) Nonpayable Services. The Division does not pay for a hysterectomy provided to a member under the following conditions.

(1) The hysterectomy was performed solely for the purpose of sterilizing the member.

(2) If there was more than one purpose for the procedure, the hysterectomy would not have been performed but for the purpose of sterilizing the member.

(B) Hysterectomy Information Form. The Division pays for a hysterectomy only when the appropriate section of the Hysterectomy Information (HI-1) form is completed, signed, and dated as specified below.

(1) Prior Acknowledgment. Except under the circumstances specified below, the member and her representative, if any, must be informed orally and in writing before the hysterectomy operation that the hysterectomy will make her permanently incapable of reproducing. (Delivery in hand of the Hysterectomy Information (HI-1) form will fulfill the written requirement, but not the oral requirement.) Section (B) of the Hysterectomy Information (HI-1) form must be signed and dated by the member or her representative before the operation is performed, as acknowledgment of receipt of this information. Whenever any surgery that includes the possibility of a hysterectomy is scheduled, the member must be informed of the consequences of a hysterectomy, and must sign and date section (B) of the Hysterectomy Information (HI-1) form before surgery.

(2) Prior Sterility. If the member is sterile prior to the hysterectomy operation, the physician who performs the operation must so certify, describe the cause of sterility, and sign and date section (C)(1) of the Hysterectomy Information (HI-1) form.

(3) Emergency Surgery. If the hysterectomy is performed in an emergency, under circumstances that immediately threaten the member's life, and if the physician determines that obtaining the member's prior acknowledgment is not possible, the physician who performs the hysterectomy must so certify, describe the nature of the emergency, and sign and date section (C)(2) of the Hysterectomy Information (HI-1) form.

(4) Retroactive Eligibility. If the hysterectomy was performed during the period of a member's retroactive eligibility, the physician who performed the hysterectomy must certify that one of the following circumstances existed at the time of the operation:

(a) the woman was informed before the operation that the hysterectomy would make her sterile (the physician must sign and date section (D)(1) of the HI-1 form);

(b) the woman was sterile before the hysterectomy was performed (the physician must sign, date, and describe the cause of sterility in section (D)(2) of the HI-1 form); or

(c) the hysterectomy was performed in an emergency that immediately threatened the woman's life and the physician determined that it was not possible to obtain her prior acknowledgment (the physician must sign, date, and describe the nature of the emergency in section (D)(3) of the HI-1 form).

(C) Submission of the Hysterectomy Information Form. Each provider must attach a copy of the completed Hysterectomy Information (HI-1) form to each claim form submitted to the Division for hysterectomy services. When more than one provider is billing the Division for the same hysterectomy, each provider must submit a copy of the completed HI-1 form.

433.460: The Norplant System of Contraception

(A) Eligible Providers. The Division will pay physicians for the insertion, reinsertion, and removal of the Norplant System of Contraception (Norplant) when they provide the services directly or when the services are provided by a salaried physician, nurse practitioner, nurse midwife, or physician assistant under their supervision. (This is an exception to 130 CMR 450.301.) In order to claim payment for Norplant services, the clinician performing the procedure must be trained by either the manufacturer of Norplant or another clinician who has been trained by the manufacturer.

(B) Payable Services.

(1) Insertion. Payment for the insertion of Norplant is an all-inclusive fee for all services associated with insertion, including counseling and careful patient selection prior to insertion, the Norplant device, the insertion procedure, and one follow-up visit.

(2) Reinsertion. Payment for the reinsertion of Norplant includes removal of the old device, a new device, the insertion procedure, and one follow-up visit.

(3) Removal. The removal of a Norplant device without reinsertion is paid as a separate procedure.

(C) Patient Selection, Counseling Prior to Insertion, and Follow-Up.

(1) In order to prevent premature removal of Norplant, the Division requires careful patient selection and counseling prior to insertion. Counseling must be in accordance with the manufacturer's guidelines, and must include a detailed discussion of potential side effects, contraindications, benefits and risks, and other contraceptive options. Payment for a counseling visit prior to the day of insertion is included in the payment for insertion of Norplant. If the member decides not to proceed with the implant after counseling, the provider should bill the counseling as an office visit.

(2) An office visit following insertion is also required as a condition of payment. The visit must include an examination of the insertion site for complications, a review of potential side effects, and follow-up instructions. Payment for the follow-up visit is included in the payment for insertion and reinsertion. If more than one follow-up visit is necessary, the provider must bill each as an office visit.

(3) The provider must make every effort possible to ensure that the member returns for the follow-up visit. This includes, but is not limited to, scheduling the follow-up appointment on the day of insertion, recording the day of the follow-up appointment in the member's chart, mailing a reminder notice to the member, and reminding the member by telephone during the week of the scheduled appointment. The provider must document in the medical record the efforts made to ensure that the member returns for the follow-up visit. In order to ensure payment for the procedure, the provider must also document if the member fails to return for the follow-up visit.

(D) Service Limitations.

(1) The Division pays for the insertion and reinsertion of Norplant for female members of childbearing age with menstrual histories. The Division pays for the removal of Norplant for female members of all ages.

(2) The Division pays for the insertion or reinsertion of Norplant only once per member per five-year period.

(3) If the member has a Norplant device implanted, no other form of contraception should be prescribed, with the exception of condoms. If the Norplant device is removed for any reason, however, the Division will pay for alternative types of contraception.

(E) Payment.

(1) Payment for the services related to Norplant includes both the professional and the technical components involved. Therefore, if a facility bills the Division for services, the individual practitioner who actually performed the service may not bill separately for the same services.

(2) The Division pays all providers for Norplant services at the rate set by DHCFP for those services (114.3 CMR 16.00 and 17.00).

(130 CMR 433.461 through 433.465 Reserved)

PART 4. OTHER SERVICES

433.466: Durable Medical Equipment and Medical/Surgical Supplies: Introduction

(A) Covered Equipment. Durable medical equipment consists of products that are fabricated primarily and customarily to fulfill a medical purpose, are generally not useful in the absence of illness or injury, can withstand repeated use over an extended period of time, and are appropriate for home use. Payment for durable medical equipment and medical/surgical supplies is considered by the Division on an individual basis.

(B) Nonpayable Services

(1) The Division does not pay for durable medical equipment or medical/surgical supplies that are experimental in nature, unless prior authorization has been obtained.

(2) The Division does not pay for nonmedical equipment or supplies. Equipment that is used primarily and customarily for a nonmedical purpose is not considered medical equipment, even if such equipment has a medically related use. For example, equipment whose primary function is environmental control, comfort, or convenience, or that is provided primarily for the comfort or convenience of a person caring for the member, or that is customarily used to promote physical fitness is not covered.

(3) The Division does not pay for durable medical equipment or medical/surgical supplies that are not both necessary and reasonable for the treatment of a member's medical condition. This includes:

(a) items that cannot reasonably be expected to make a meaningful contribution to the treatment of a member's illness or injury or to the improved functioning of a member's malformed body member; and

(b) items that are substantially more costly than a medically appropriate and feasible alternative piece of equipment or that serve essentially the same purpose as equipment already available to the member.

(4) The Division does not pay for standard medical and surgical treatment products, goods, and health-related items provided to members who reside in hospitals, nursing facilities, or rehabilitation facilities.

433.467: Durable Medical Equipment and Medical/Surgical Supplies: Prescription Requirements

The purchase or rental of durable medical equipment and the purchase of medical/surgical supplies are payable only when prescribed in writing by a licensed physician. The equipment and repair services must be furnished by a participating MassHealth provider. The prescription must include the following information:

(A) the member's name, address, and member identification number;

(B) the specific identification of the prescribed equipment or supplies;

(C) the medical justification for use of the equipment or supplies;

(D) the estimated length of time that the equipment or supplies will be used by the member;

(E) the location in which the member will customarily use the equipment or supplies;

(F) the physician's address and telephone number; and

(G) the date on which the prescription was signed by the physician.

433.468: Durable Medical Equipment and Medical/Surgical Supplies: Prior-Authorization Requirements

The Division requires that the durable medical equipment provider obtain prior authorization as a prerequisite for payment for certain durable medical equipment, including hospital beds and wheelchairs, certain durable medical equipment repair services, and certain medical/surgical supplies. The request for prior authorization must be submitted by the durable medical equipment provider on the appropriate Division form.

433.469: Oxygen and Respiratory Therapy Equipment

(A) Nonpayable Services.

(1) The Division does not pay for oxygen or respiratory therapy equipment for members in acute, chronic, or rehabilitation hospitals, or in state schools.

(2) The Division does not pay for oxygen or respiratory therapy equipment when prescribed for emergency use or on an "as needed" basis for members residing in nursing facilities.

(3) The Division does not pay for respiratory therapy equipment that is investigative or experimental in nature, unless prior authorization from the Division has been obtained.

(4) The Division does not pay for nonmedical equipment or supplies. Equipment that is used primarily and customarily for a nonmedical purpose is not considered medical equipment, even if such equipment has a medically related use. For example, equipment whose primary function is environmental control, comfort, or convenience is not payable.

(5) The Division does not pay for oxygen or respiratory therapy equipment that is not both necessary and reasonable for the treatment of a member's pulmonary condition. This includes:

(a) equipment or services that cannot reasonably be expected to make a meaningful contribution to the treatment of a member's pulmonary insufficiency; and

(b) equipment or services that are substantially more costly than a medically appropriate, feasible alternative or that serve essentially the same purpose as equipment already available to the member.

(B) Prescription Requirements. The purchase of oxygen and the purchase or rental of respiratory therapy equipment are payable only when prescribed in writing by a licensed physician. The oxygen and the respiratory therapy equipment must be provided by a participating MassHealth provider. The prescription must include the following information:

(1) the member's name, address, and member identification number;
(2) the specific identification of the prescribed oxygen and equipment;
(3) the medical justification for the use of the oxygen and equipment;
(4) for oxygen: the prescribed liter flow rate and frequency of treatment;
(5) for respiratory therapy equipment: the frequency of use per day;
(6) the estimated length of time the oxygen or equipment will be used by the member;
(7) the location in which the member will customarily use the oxygen or equipment;
(8) the physician's address and telephone number; and
(9) the date on which the prescription was signed by the physician.

(C) Purchases and Rentals Requiring Prior Authorization. The Division requires that prior authorization be obtained as a prerequisite to payment for the oxygen and respiratory therapy equipment and services listed below.

(1) Purchase of any of the following requires prior authorization:
(a) respiratory therapy equipment costing more than $35.00; and
(b) gaseous and liquid oxygen provided more than three months after the date of the physician's initial prescription.

(2) Rental of the following requires prior authorization:
(a) gaseous- and liquid-oxygen delivery systems after a rental period of three months;
(b) aspirators after a rental period of three months;
(c) nebulizers after a rental period of three months;
(d) intermittent positive pressure breathing (IPPB) machines after a rental period of three months;
(e) oxygen-generating devices; and
(f) all other rental equipment.

(D) Requests for Prior Authorization. Instructions for the completion of the prior-authorization form for oxygen are in Subchapter 5 of the *Physician Manual*. Before determining the medical necessity of the items or services for which prior authorization is requested, the Division may, at its discretion, require the prescribing physician to submit an assessment of the member's pulmonary condition on a patient respiratory evaluation form supplied by the Division.

(1) All prior-authorization requests for oxygen and oxygen-generating devices must be accompanied by the results of an arterial blood gas analysis performed within the six weeks preceding the date of the request. This analysis should be performed while the member is in a stable chronic condition.

(2) All prior-authorization requests for respiratory therapy equipment must be accompanied by the results of a pulmonary function test performed within the six weeks preceding the date of the request.

433.470: Transportation Services

(A) Payable Transportation. Transportation services are payable only when a member is traveling to obtain medical services that are payable by MassHealth.

(B) Service Limitations.

(1) Members must use transportation resources such as family or friends whenever possible. When personal transportation resources are unavailable, a member must use public transportation, if available in the member's locality and suitable to his or her medical condition. Private transportation is reimbursable only when public transportation suitable to the member's medical condition is unavailable.

(2) In general, the Division pays for a member to be transported to sources of medical care only within the member's locality. Locality refers to the town or city in which the member resides and to immediately adjacent communities. However, when necessary medical services are unavailable in the member's locality, medical transportation to the nearest medical facility in which treatment is available is payable. For additional information on service limitations, see 130 CMR 407.000.

(C) Authorization.

(1) Taxi and Dial-a-Ride Transportation. Taxi and dial-a-ride transportation requires a Prescription for Taxi or Dial-a-Ride Transportation (PT-1) form completed in accordance with 130 CMR 407.423.

(2) Ambulance and Chair-Car Transportation. Nonemergency ambulance and chair car transportation require that a Medicare/Medicaid Medical Necessity Form be completed in accordance with 130 CMR 407.424. The Medical Necessity Form may be signed by a physician, physician's designee, physician assistant, nurse midwife, nurse practitioner, or managed-care representative. Information given on the medical necessity form must be supported by the member's medical record. Emergency ambulance trips do not require a prescription. However, the nature of the emergency must be supported by medical records at the hospital to which the member was transported.

(3) Multiple Trips. When a member must travel more than once per 30-day period to the same destination, all trips may be authorized for the 30-day period on one medical necessity form. The anticipated dates of each trip and the anticipated total number of trips must be entered on the form.

(4) Other Forms of Transportation. Other forms of transportation (for example, train, boat, and plane) are payable only if the member obtains prior authorization from the Division.

(D) Member Reimbursement. The Division will reimburse a member directly for expenses incurred in traveling to medical services covered by MassHealth when documented in accordance with 130 CMR 407.431.

433.471: Therapy, Speech and Hearing Clinic, and Amputee Clinic Services

(A) Payable and Nonpayable Services. The Division pays for basic restorative services (therapy, speech and hearing clinic, and amputee clinic services) to reduce physical disability and to restore the member to a satisfactory functional level. Only those services that have the greatest potential for long-term benefits are payable. The Division does not pay for medically unnecessary or experimental services.

(B) Physical, Occupational, and Speech Therapy.

(1) Physician Authorization.

(a) Physical and occupational therapy require a written referral from a licensed physician prior to the member's evaluation or treatment. The physician's orders for physical and occupational therapy must be renewed in writing every 30 days as long as the member is undergoing treatment.

(b) Speech therapy requires the written recommendation of a licensed physician or dentist prior to the member's evaluation or treatment.

(2) Service Restrictions. Maintenance therapy is not payable. Only those therapy services that have a specific functional goal are payable.

(C) Speech and Hearing Clinic Services. The member must be examined by an ear specialist (an otologist or an otolaryngologist) before referral is made to a speech and hearing clinic approved by the Division. If a hearing aid is indicated, a medical clearance stating that the member has no medical conditions to contraindicate the use of a hearing aid must accompany the referral.

(D) Amputee Clinic Services. An amputee clinic provides the following services: complete medical evaluation of the member's need for an artificial limb (prosthetic device); counseling concerning the use of the device; prescription of the device; referral to a certified prosthetic company; and follow-up evaluation. The Division pays for a prosthetic device only when it is prescribed by an amputee clinic approved by the Division.

433.472: Mental Health Services

130 CMR 433.472 describes the range of mental health services payable by MassHealth.

(A) Mental Health Center Services. It is appropriate to refer members to a mental health center when the they are no longer able to maintain their level of functioning and must seek professional help. Referral for treatment in a clinic setting is appropriate when the individuals are not harmful to themselves or to others and can maintain themselves in the community even if at a diminished level of functioning.

(1) The Division will pay for mental health center services provided by freestanding mental health centers, community health centers, hospital-licensed health centers, or hospital outpatient departments only when the Division has certified the provider to perform mental health center services.

(2) Mental health center services are payable only when provided by psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, counselors (with a master's or doctoral degree in counseling education or rehabilitation counseling), or occupational therapists.

(3) Mental health center services include diagnosis and evaluation, case consultation, medication, psychological testing if done by a licensed psychologist, and individual, couple, family, and group psychotherapy.

(B) Mental Health Practitioner Services. A member may be referred to a private mental health practitioner (a licensed physician or a licensed psychologist) for the same reason that the member may be referred to a mental health center. Mental health practitioners provide services that are more specialized and less comprehensive than the treatment and support services provided in mental health centers.

(1) The only mental health practitioners who can receive direct payment by MassHealth for diagnostic and treatment services are licensed physicians (see 130 CMR 433.428 and 433.429).

(2) The Division pays licensed psychologists only for providing psychological testing. The Division does not pay psychologists for providing psychotherapy, even under the supervision of a psychiatrist.

(C) Psychiatric Hospital Services. When psychiatric individuals require 24-hour management because they may be harmful to themselves or to others, or if they are unable to maintain themselves in the community, inpatient psychiatric services may be appropriate.

(1) The Division pays for inpatient psychiatric hospitalization only when provided to:

(a) a members aged 65 years or older in a psychiatric hospital participating in MassHealth; or

(b) a members of any age in a licensed and certified general hospital with or without an inpatient psychiatric unit.

(2) The services of an inpatient psychiatric unit include medication, individual and group therapy, milieu activities, and 24-hour observation provided by an interdisciplinary team.

(D) Psychiatric Day Treatment Services. Some members require the structure and support of a psychiatric treatment center, but do not require the overnight care provided by hospitalization. Accordingly, the member must have a suitable place to live while attending a psychiatric day treatment program. A psychiatric day treatment program may not adequately meet the needs of actively suicidal, homicidal, severely withdrawn, or grossly confused and disoriented individuals who cannot be maintained by family or friends and who are unable to travel to such a program. The Division pays for psychiatric day treatment services provided by freestanding mental health centers, hospital-licensed health centers, hospital outpatient departments, or other facilities only when the Division has certified the provider to perform psychiatric day treatment services.

(130 CMR 433.473 through 433.475 Reserved)

433.476: Alternatives to Institutional Care: Introduction

MassHealth pays for ways to help elderly and disabled members remain in the community and avoid unnecessary or premature institutional placement. These include home health, adult day health, adult foster care, private duty nursing, independent living, intermediate care for the mentally retarded, and day habilitation. Decisions about institutional placement are made by the member, the member's family, the physician, and hospital continuing-care personnel. The physician's role can often be the most influential. For this reason, it is important for the physician to be aware of the alternatives to institutional long-term care. A network of community-based support services that did not exist previously in any quantity or quality is now available in many areas of Massachusetts. Only if physicians become aware of and support the use of such services will the use of institutional services be reduced.

433.477: Alternatives to Institutional Care: Adult Foster Care

(A) Program Definition. Adult foster care is designed to provide a family-like environment for an adult who otherwise would be in a level II or III nursing facility. Each foster family may care for a maximum of two participants (elderly or disabled adults). The foster family provides 24-hour supervision and assistance with such activities of daily living as bathing, dressing, and self-administration of medications. Community support is available from such organizations as certified home health agencies and adult day health programs.

(B) Physician Responsibilities.
(1) Each member must have medical clearance prior to placement in a foster home.
(2) The member's physician is required to provide documentation of the following: a physical examination conducted within the preceding three months; current treatment including medications and diet; and a description of any physical or emotional limitations that may preclude participation in activities.
(3) The physician, with the certified home health agency nurses, must maintain follow-up care of the member.

433.478: Alternatives to Institutional Care: Home Health Services

(A) Program Definition. Home health agencies provide health and support services in the home for elderly and disabled persons who wish to remain in their homes rather than to enter an institution. These services are available between 8:00 A.M. and 9:00 P.M., and homemaker/home health aide services are available on a 24-hour or short-term basis. All services are available seven days a week. All home health agencies provide nursing and homemaker/home health aide services; in addition, most agencies provide physical, occupational, and speech therapy. The Division pays only Medicare-certified home health agencies, frequently called visiting nurse associations.

(B) Physician Responsibilities. Any physician who believes that a member needs home health services should call the home health agency directly or send written orders. A member seen by the agency must have written orders from his or her physician; these orders must be updated and recertified every 60 days.

433.479: Alternatives to Institutional Care: Private Duty Nursing Services

(A) Program Definition. A private duty nurse is a registered nurse or a licensed practical nurse who independently contracts to provide nursing services to patients who, without such services, might be institutionalized. The Division pays for nursing care in the member's home when private duty nursing services are less costly than institutional placement, provided that the professional services are medically necessary. This program provides alternative care to home-bound members whose medical and nursing needs cannot be met by a home health agency, adult day health program, or support services.

(B) Prior Authorization Requirements. Prior authorization must be obtained from the Division before private duty nursing services are payable. The attending physician and nurse must document the following: diagnosis, treatment plan, functional limitations, estimated length of service, and description of the member's social situation.

(C) Physician Responsibilities. The member's attending physician must sign the patient care plan documenting the medical necessity for private duty nursing services.

433.480: Alternatives to Institutional Care: Adult Day Health Services

(A) Program Definition. An adult day health program is a structured program of health care and socialization designed to meet the needs of persons who otherwise might be institutionalized. Adult day health services also enable some individuals who have been institutionalized to return to community living. Adult day health programs are based in a center and may be freestanding or located in nursing facilities or hospitals. Staff members of the program make arrangements for transportation to and from the center, depending upon community resources and the member's needs. The program offers the participant professional supervision, observation, and preventive health care including medical, therapeutic, restorative, counseling, and nutrition services. In addition, the program offers planned educational, recreational, and social activities. These services are provided to maintain the participant at his or her highest level of functioning, thereby preventing or delaying institutionalization. The program offers the participant's family relief from 24-hour supervision and caretaking. Adult day health programs also provide counseling to family caretakers to help them cope with their family situations.

(B) Physician Responsibilities.

(1) Each member accepted into an adult day health program must have a complete physical examination within the three months preceding the member's first program attendance day.

(2) The member's physician will be expected to furnish program staff members, upon request, with the results of this physical examination; a list of current medications and treatments; any special dietary requirements; a statement indicating any contraindications or limitations to the individual's participation in program activities; and recommendations for therapy, when applicable.

(3) Each member's physician will receive a participant care plan developed by the staff members of the program for review every three months. The program's registered nurse will request that the participant care plan be reviewed and signed by the physician and returned to the program.

433.481: Alternatives to Institutional Care: Independent Living Programs

(A) Program Definition. Independent living programs teach persons with severe physical disabilities the skills to live independently, assisted by a personal care attendant. The skills may be taught in a group residential setting or individually. For those severely disabled persons who have the ability to train and manage a personal care attendant and who are living independently in the community, the program acts as a fiscal conduit to pay the personal care attendant. Participation in this program is helpful to persons to whom a lifetime of institutional or family care is unacceptable.

(B) Physician Responsibilities. The member's physician must certify that the member is:
(1) severely physically disabled (in need of an average of four hours or more of personal care attendant services per day);
(2) wheelchair dependent for mobility;
(3) emotionally stable; and
(4) medically stable (able to participate in daily living activities without requiring frequent substantial medical care).

433.482: Alternatives to Institutional Care: Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

(A) Program Definition. Community intermediate care facilities for the mentally retarded (or for persons with related conditions) are small community-based residential programs for 15 or fewer residents. There are two types of community ICFs/MR: Type A, serving participants not capable of self-preservation, and Type B, serving ambulatory and mobile nonambulatory participants capable of self-preservation. Both types of facilities provide a planned, 24-hour program of care to persons who are mentally retarded or developmentally disabled. A member who participates in a community ICF/MR must be in need of and capable of benefiting from active treatment (for example, a program of regular participation in accordance with an individual plan of care professionally developed and administered by an interdisciplinary team). Treatment is designed to increase the participant's level of functioning and to allow the participant to become as independent as possible. Participants must have the potential through active treatment to move eventually from the ICF/MR into a setting that is less restrictive.

(B) Physician Responsibilities. The propriety of the member's placement in an ICF/MR must be certified by a physician at the time of the member's admission and recertified every 60 days. The Massachusetts Department of Mental Health regional or area office screens all potential ICF/MR residents. Physicians who believe that their patients are in need of ICF/MR services should contact the Department of Mental Health area office.

433.483: Alternatives to Institutional Care: Day Habilitation Centers

(A) Program Definition. Day habilitation centers serve persons who are mentally retarded and developmentally disabled and who need more habilitative services than are provided in less-restrictive day programs but who do not require full-time institutionalization. Day habilitation centers provide a range of intensive medical, behavioral, and therapeutic services in a culturally normative setting. The centers provide goal-oriented services that help participants reach their highest possible level of independent functioning and that facilitate the participants' moving to less-restrictive settings.

(B) Physician Responsibilities. The Division screens and refers potential members to day habilitation centers with the Massachusetts Department of Mental Health. Any physician who believes that his or her patient would benefit from day habilitation services should contact the Department of Mental Health area office.

433.484: The Massachusetts Special Education Law (Chapter 766)

(A) Requirement of Law. Chapter 766 of the Acts of 1972 is a comprehensive special education law that requires local school agencies to develop and implement individual educational plans for children with special needs. The law mandates that every child between the ages of three and 21 who has special needs should take part in a special education program. Any child entering kindergarten must have a comprehensive health and developmental examination. Any student between the ages of three and 21 who is having school-related problems will be referred to the school's Administrator of Special Education to obtain all necessary assessments, including medical, psychological, and other specialty evaluations. Based on the results of these assessments, an individualized educational plan will be developed with an emphasis on meeting the needs of the child within the regular classroom setting. In addition, any problems that have been diagnosed must receive treatment.

(B) Payment. Many of the evaluation and treatment services required by the Special Education Law are payable by MassHealth. The Division cannot pay for services provided by school personnel. Any services not furnished by MassHealth providers, such as educational and social services, that are necessary for an eligible child's special education, will be provided or arranged for by the local school agency, as required under Chapter 766.

(1) Individual MassHealth Providers. The Division will pay providers for services mandated by the Special Education Law that are furnished to children who are MassHealth members. Payment will be based on the existing fee schedules. For example, the Division will pay for a complete physical examination as required by the law for a kindergarten-aged child if the child is referred to a pediatrician or health clinic that participates in MassHealth. As required by the law, a provider who performs any assessments of eligible children after referral by an Administrator of Special Education must submit the reports to the local school agency. The provider must also take the responsibility for treatment of detected conditions.

(2) Core Evaluation Groups. The Division will pay, at a comprehensive rate, Division-approved interdisciplinary professional groups and Division-approved medical facilities that perform the medical, psychological, and family assessments of a Chapter 766 full core evaluation.

REGULATORY AUTHORITY

130 CMR 433.000: M.G.L. c. 118E, §§7 and 12.

This page is reserved.

522 Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item 23B	EPSDT	Enter an X if the member is under age 21 and the services have been provided as a result of an EPSDT screening referral or are related to an EPSDT assessment.
Item 23C	FAMILY PLANNING	If any of the services listed on the claim form are related to family planning, enter an X in the box labeled "Yes."
Item 23D	PRIOR AUTHORIZATION NO.	If billing for a service for which prior authorization is required, enter the six-digit prior-authorization number assigned by the Division.
Item 24A	DATE OF SERVICE: FROM/TO	For single dates of service, in the From column, enter, in month/day/year order, the date the service was provided. Leave the To column blank. Use a separate claim line for each date of service, except for consecutive dates. For consecutive dates of service, enter the first date of service in the From column and the last date of service in the To column. Indicate the number of days billed during this span of dates in the F ("Days or Units") column.

522 Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item 24B	PLACE OF SERVICE	Enter the code from the list below that describes the place in which the service was provided. 01 - Office or freestanding MRI center 02 – Member's home 03 - Hospital, inpatient 04 - Hospital, outpatient 05 - Emergency department 06 - Nursing facility 07 - Rest home 08 - Freestanding ambulatory surgery center 09 - Homeless shelter 10 - School-based health center 99 - Other location (If "99" is used, enter the name and address of the place of service in Item 21.)
Item 24C	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	
	TOS	Leave this item blank.
	PROCEDURE CODE	Enter the HCPCS service code that corresponds to the service provided. See Subchapter 6 of this manual for information about service codes. When billing for a service code that requires a report, attach a copy of that report to the claim form. Refer to the program regulations in Subchapter 4 of this manual, transmittal letters, and Division bulletins for report requirements.

522 Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item 24C (cont.)	MOD (MODIFIER)	For certain types of services, a two-character modifier must be entered after the service code to describe more fully the services performed. See Subchapter 6 in this manual for the modifiers and descriptions. An example of the correct use of a modifier appears in Subsection 523(E).
	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES	An entry in this item is required in the following cases. Explanations that do not fit on the form should be attached on a separate page. Do not write on the back of the claim form. Medical Supplies, Medications, Injectables. When billing for medical supplies, medications, or injectables, enter a complete description of the item, the acquisition cost, and the quantity dispensed. For drugs, include the name, strength, total dose administered, and total number of units administered (such as: mg. and cc.) and dosage. For all medical supplies, medications, injectables, and allergy serums, attach a copy of an invoice. Invoices submitted with a claim must be dated no more than 18 months before the date of service. One invoice indicating all the items for which payment is requested is acceptable. Anesthesia. Enter the beginning and ending clock time for the anesthesia service. Multiple Modifiers. If the modifier "99" is used to indicate multiple modifiers, list all the applicable modifiers.
Item 24D	DIAGNOSIS CODE	Enter the ICD-9-CM diagnosis code for the condition treated. Enter the diagnosis code exactly as it appears in the ICD-9-CM code book. Use the most specific diagnosis code available. Do not delete leading zeros; do not add trailing zeros. "V" codes are acceptable. "E" or "M" codes are not acceptable.

522 Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item 24E	CHARGES	Enter the provider's usual and customary fee (the amount you charge a person who is not a MassHealth member). Do not list services for which no charge was made. Medical Supplies, Medications, Injectables. Enter the actual acquisition cost and attach a copy of the supplier's invoice to the claim. Invoices submitted with a claim must be no more than 18 months before the date of service.
Item 24F	DAYS OR UNITS	An entry for this item is required in the following cases. Anesthesia. Enter the total number of 15-minute periods (including as one unit any remaining fraction that equals or exceeds five minutes) that make up the beginning and ending clock time for the anesthesia service. Refer to 130 CMR 433.454 for regulation regarding reporting anesthesia time. If no units are entered, the procedure is paid at the base rate. For consecutive dates of service, enter the total number of days on which the service was provided.

522 Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item 34	ADJUSTMENT/RESUBMITTAL	Enter an X in Adjustment or Resubmittal only when an entry is required by the instructions for correcting a claim. See the section on correcting claims elsewhere in these billing instructions. Do not make any entry in this item without completing Item 35.
Item 35	FORMER TRANSACTION CONTROL NO. (TCN)	When an entry is required in this item, enter the 10-character transaction control number (TCN) assigned to the original claim, if valid. The TCN appears on the remittance advice that listed the original claim as paid or denied.
Item 36	FOR OFFICE USE ONLY	Leave this item blank.

523 Examples of Completed Claim Forms

This section contains examples of claims for the different billing situations listed below. For assistance with a billing situation not explained in these examples, contact MassHealth Provider Service. See Appendix A in this manual for the appropriate address and telephone numbers.

Example (A) - Office Visit

This example shows a claim for an office visit and laboratory work provided in an office setting. The member also has other health insurance that made a partial payment as indicated in the other paid amount column.

Example (B) - Hospital Care

This example shows a claim for an initial hospital visit and subsequent hospital days.

Example (C) - Anesthesia Services

This example shows a claim for anesthesia services, for 1.5 hours of anesthesia (6 units x 15 minutes).

Example (D) - Services Referred by a Primary Care Clinician (PCC)

This example shows a claim for a consultation provided at the request of the member's PCC.

Example (E) – Nurse Midwife Services

This example shows a claim for services provided by a certified nurse midwife employed by a physician, with the proper use of a modifier.

Example (F) - Family Planning Services

This example shows a claim for the insertion of a Norplant device provided in an office setting.

Example (G) - Initial Well-Child Visit on the Claim Form No. 5

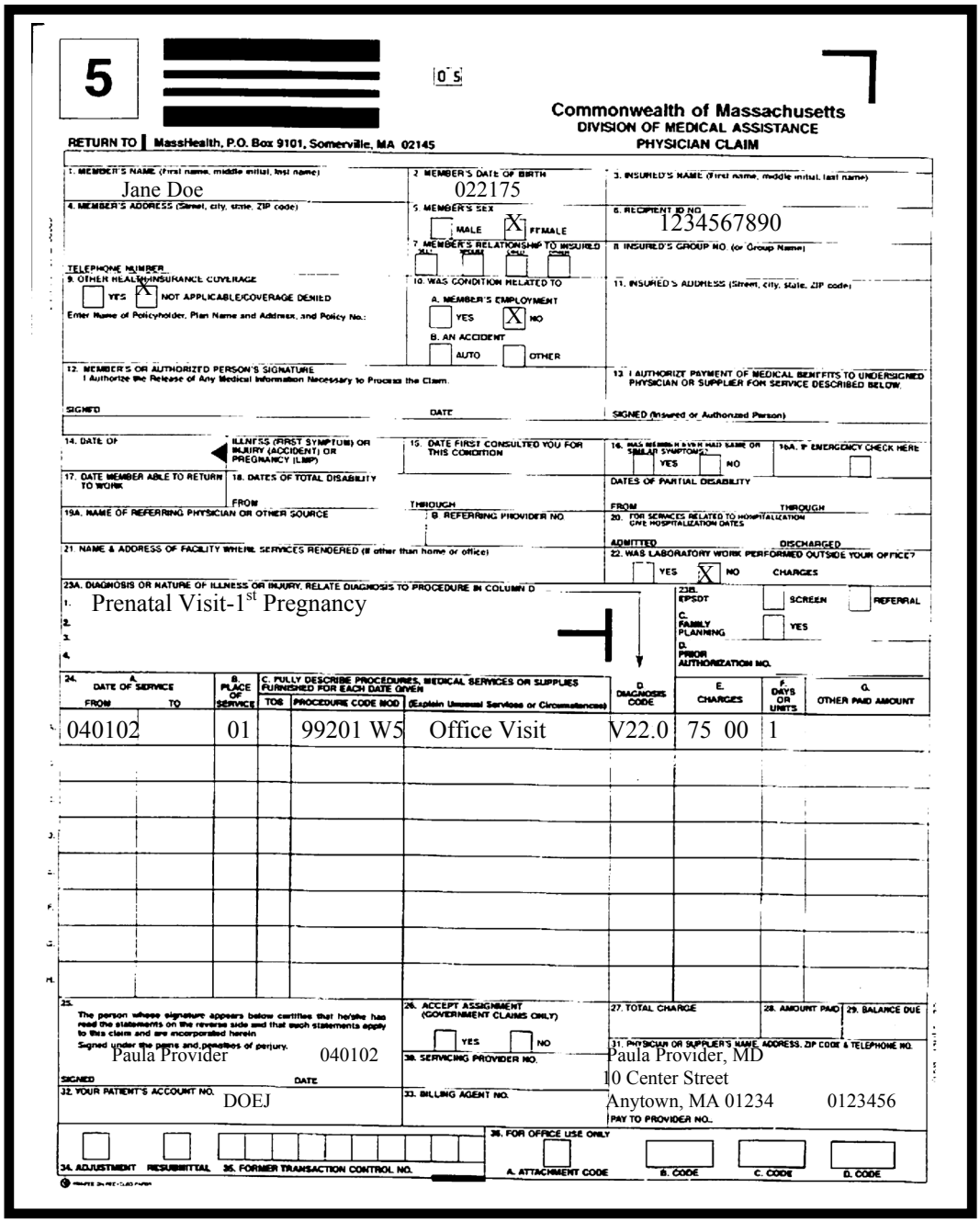
This example shows an initial well-child visit on the claim form no. 5. This type of service is allowed only once per member, per provider. An initial well-child visit must be provided in the office only.

Example (H) – Multiple Surgeries (Modifier 99)

This example shows a member who had a cyst removed and 2 cataract surgeries.

523 Examples of Completed Claim Forms (cont.)

(E) Nurse Midwife Services



5 [redacted] 05

Commonwealth of Massachusetts
DIVISION OF MEDICAL ASSISTANCE
PHYSICIAN CLAIM

RETURN TO | MassHealth, P.O. Box 9101, Somerville, MA 02145

1. MEMBER'S NAME (First name, middle initial, last name): Jane Doe
2. MEMBER'S DATE OF BIRTH: 022175
3. INSURED'S NAME (First name, middle initial, last name)
4. MEMBER'S ADDRESS (Street, city, state, ZIP code)
5. MEMBER'S SEX: MALE [ ] FEMALE [X]
6. RECIPIENT ID NO.: 1234567890
7. MEMBER'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (or Group Name)
TELEPHONE NUMBER
9. OTHER HEALTH INSURANCE COVERAGE: YES [ ] NOT APPLICABLE/COVERAGE DENIED [X]
Enter Name of Policyholder, Plan Name and Address, and Policy No.:
10. WAS CONDITION RELATED TO: A. MEMBER'S EMPLOYMENT: YES [ ] NO [X]; B. AN ACCIDENT: AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. MEMBER'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the Release of Any Medical Information Necessary to Process the Claim.
SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
SIGNED (Insured or Authorized Person)
14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS SIMILAR SYMPTOMS OR SAME OR SIMILAR ILLNESS HAD YOU EVER HAD? YES [ ] NO [ ]
16A. IF EMERGENCY CHECK HERE [ ]
17. DATE MEMBER ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19A. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
19B. REFERRING PROVIDER NO.
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [X] CHARGES
23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D
1. Prenatal Visit-1st Pregnancy
2.
3.
4.
23B. EPSDT SCREEN [ ] REFERRAL [ ]
C. FAMILY PLANNING YES [ ]
D. PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. TOS	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE MOD	(Explain Unusual Services or Circumstances)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. OTHER PAID AMOUNT
040102		01		99201 W5	Office Visit	V22.0	75 00	1	

25. The person whose signature appears below certifies that he/she has read the statements on the reverse side and that such statements apply to this claim and are incorporated herein. Signed under the penalties of perjury.
Paula Provider 040102
SIGNED DATE
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES [ ] NO [ ]
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. SERVICING PROVIDER NO.
31. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
Paula Provider, MD
10 Center Street
Anytown, MA 01234 0123456
32. YOUR PATIENT'S ACCOUNT NO. DOEJ
33. BILLING AGENT NO.
PAY TO PROVIDER NO.
34. ADJUSTMENT [ ] RESUBMITTAL [ ] 35. FORMER TRANSACTION CONTROL NO.
36. FOR OFFICE USE ONLY
A. ATTACHMENT CODE B. CODE C. CODE D. CODE

523 Examples of Completed Claim Forms (cont.)

(F) Family Planning Services

5 [redacted] 05

Commonwealth of Massachusetts
DIVISION OF MEDICAL ASSISTANCE
PHYSICIAN CLAIM

RETURN TO | MassHealth, P.O. Box 9101, Somerville, MA 02145

1. MEMBER'S NAME (First name, middle initial, last name): Mary Doe
2. MEMBER'S DATE OF BIRTH: 081680
3. INSURED'S NAME (First name, middle initial, last name)
4. MEMBER'S ADDRESS (Street, city, state, ZIP code)
5. MEMBER'S SEX: MALE [ ] FEMALE [X]
6. RECIPIENT ID NO.: 0123456789
7. MEMBER'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (or Group Name)
TELEPHONE NUMBER
9. OTHER HEALTH INSURANCE COVERAGE: YES [ ] NOT APPLICABLE/COVERAGE DENIED [X]
Enter Name of Policyholder, Plan Name and Address, and Policy No.:
10. WAS CONDITION RELATED TO: A. MEMBER'S EMPLOYMENT: YES [ ] NO [X]; B. AN ACCIDENT: AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. MEMBER'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the Release of Any Medical Information Necessary to Process the Claim.
SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
SIGNED (Insured or Authorized Person)
14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS MEMBER EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16A. IF EMERGENCY CHECK HERE [ ]
17. DATE MEMBER ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19A. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
19. REFERRING PROVIDER NO.
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [X] CHARGES

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D
1. Norplant - Insertion
2.
3.
4.

23B. EPSDT SCREEN [ ] REFERRAL [ ]
C. FAMILY PLANNING YES [X]
D. PRIOR AUTHORIZATION NO.

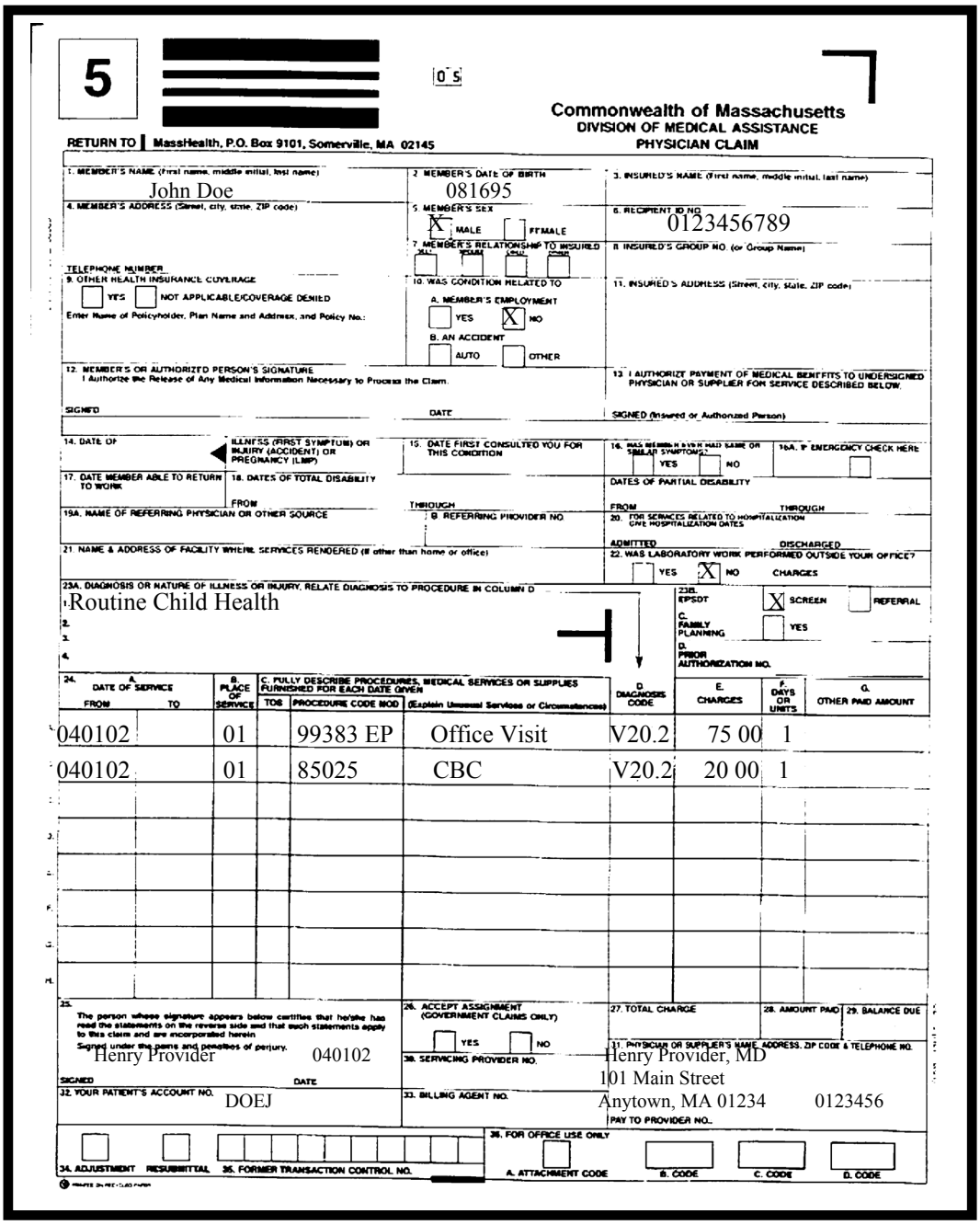
24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. TOS	PROCEDURE CODE MOD (Explain Unusual Services or Circumstances)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. OTHER PAID AMOUNT
040102		01		11975 Norplant Insert.	V255	521 00	1	

25. The person whose signature appears below certifies that he/she has read the statements on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.
SIGNED Henry Provider DATE 040102
32. YOUR PATIENT'S ACCOUNT NO. DOEJ
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES [ ] NO [ ]
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. SERVICING PROVIDER NO.
31. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
Henry Provider, MD
101 Main Street
Anytown, MA 01234 0123456
33. BILLING AGENT NO.
PAY TO PROVIDER NO.

34. ADJUSTMENT [ ] RESUBMITTAL [ ] 35. FORMER TRANSACTION CONTROL NO.
36. FOR OFFICE USE ONLY
A. ATTACHMENT CODE B. CODE C. CODE D. CODE

523 Examples of Completed Claim Forms (cont.)

(G) Initial Well-Child Visit on the Claim Form No. 5



5 [redacted] 0 5

Commonwealth of Massachusetts
DIVISION OF MEDICAL ASSISTANCE
PHYSICIAN CLAIM

RETURN TO | MassHealth, P.O. Box 9101, Somerville, MA 02145

1. MEMBER'S NAME (First name, middle initial, last name): John Doe
2. MEMBER'S DATE OF BIRTH: 081695
3. INSURED'S NAME (First name, middle initial, last name)
4. MEMBER'S ADDRESS (Street, city, state, ZIP code)
5. MEMBER'S SEX: X MALE ☐ FEMALE
6. RECIPIENT ID NO: 0123456789
7. MEMBER'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
8. INSURED'S GROUP NO. (or Group Name)
TELEPHONE NUMBER
9. OTHER HEALTH INSURANCE COVERAGE: ☐ YES ☐ NOT APPLICABLE/COVERAGE DENIED
Enter Name of Policyholder, Plan Name and Address, and Policy No.:
10. WAS CONDITION RELATED TO: A. MEMBER'S EMPLOYMENT ☐ YES X NO; B. AN ACCIDENT ☐ AUTO ☐ OTHER
11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. MEMBER'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the Release of Any Medical Information Necessary to Process the Claim.
SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
SIGNED (Insured or Authorized Person)
14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
16A. IF EMERGENCY CHECK HERE ☐
17. DATE MEMBER ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19A. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
19B. REFERRING PROVIDER NO.
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES X NO CHARGES
23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D
1. Routine Child Health
2.
3.
4.
23B. EPSDT X SCREEN ☐ REFERRAL
C. FAMILY PLANNING ☐ YES
D. PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	TOS	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE MOD	(Explain Unusual Services or Circumstances)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. OTHER PAID AMOUNT
040102		01		99383 EP	Office Visit	V20.2	75 00	1	
040102		01		85025	CBC	V20.2	20 00	1	

25. The person whose signature appears below certifies that he/she has read the statements on the reverse side and that such statements apply to this claim and are incorporated herein. Signed under the pains and penalties of perjury.
Henry Provider 040102
SIGNED DATE
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) ☐ YES ☐ NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. SERVICING PROVIDER NO.
31. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
Henry Provider, MD
101 Main Street
Anytown, MA 01234 0123456
32. YOUR PATIENT'S ACCOUNT NO. DOEJ
33. BILLING AGENT NO.
PAY TO PROVIDER NO.
34. ADJUSTMENT ☐ RESUBMITTAL ☐
35. FORMER TRANSACTION CONTROL NO.
36. FOR OFFICE USE ONLY
A. ATTACHMENT CODE ☐ B. CODE ☐ C. CODE ☐ D. CODE ☐

523 Examples of Completed Claim Forms (cont.)

(H) Multiple Surgeries (Modifier 99)

5 [redacted] 05

Commonwealth of Massachusetts
DIVISION OF MEDICAL ASSISTANCE
PHYSICIAN CLAIM

RETURN TO | MassHealth, P.O. Box 9101, Somerville, MA 02145

1. MEMBER'S NAME (First name, middle initial, last name): Harold Doe
2. MEMBER'S DATE OF BIRTH: 081635
3. INSURED'S NAME (First name, middle initial, last name)
4. MEMBER'S ADDRESS (Street, city, state, ZIP code)
5. MEMBER'S SEX: X MALE ☐ FEMALE
6. RECIPIENT ID NO: 0123456789
7. MEMBER'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
8. INSURED'S GROUP NO. (or Group Name)
TELEPHONE NUMBER
9. OTHER HEALTH INSURANCE COVERAGE: ☐ YES ☐ NOT APPLICABLE/COVERAGE DENIED
Enter Name of Policyholder, Plan Name and Address, and Policy No.:
10. WAS CONDITION RELATED TO: A. MEMBER'S EMPLOYMENT ☐ YES X NO; B. AN ACCIDENT ☐ AUTO ☐ OTHER
11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. MEMBER'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the Release of Any Medical Information Necessary to Process the Claim.
SIGNED
DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
SIGNED (Insured or Authorized Person)
14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
16A. IF EMERGENCY CHECK HERE ☐
17. DATE MEMBER ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19A. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
19B. REFERRING PROVIDER NO.
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES X NO CHARGES
23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D
1. Cyst removed and 2 cataract surgeries.
2.
3.
4.
23B. EPSDT ☐ SCREEN ☐ REFERRAL
C. FAMILY PLANNING ☐ YES
D. PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. TOS	PROCEDURE CODE MOD	(Explain Unusual Services or Circumstances)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. OTHER PAID AMOUNT
040102		01		68020	incision cyst	3699	100 00	1	
040102		01		66820 51	incision cataract	3699	300 00	1	
040102		01		66820 99	99 = 50 & 51	3699	300 00	1	

25. The person whose signature appears below certifies that he/she has read the statements on the reverse side and that such statements apply to this claim and are incorporated herein. Signed under the pains and penalties of perjury.
Henry Provider 040102
SIGNED DATE
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) ☐ YES ☐ NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. SERVICING PROVIDER NO.
31. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
Henry Provider, MD
101 Main Street
Anytown, MA 01234 0123456
32. YOUR PATIENT'S ACCOUNT NO. DOEJ
33. BILLING AGENT NO.
PAY TO PROVIDER NO.
34. ADJUSTMENT ☐ RESUBMITTAL ☐
35. FORMER TRANSACTION CONTROL NO.
36. FOR OFFICE USE ONLY
A. ATTACHMENT CODE B. CODE C. CODE D. CODE

524 Reserved.

526 Item-by-Item Instructions for Claim Form No. 4 (cont.)

Item 1	PROVIDER'S NAME, ADDRESS & TELEPHONE NO.	Enter the provider's name, address, and telephone number.
Item 2	PAY TO PROVIDER NO.	Enter the provider's seven-digit MassHealth provider number of the individual practitioner or group practice organization, if applicable.
Item 3	BILLING AGENT NO.	If this form was prepared by a billing agent, enter the seven-digit number assigned to the agent, if one was assigned; otherwise, leave this item blank.
Item 4	SERVICING PROVIDER'S NAME	If the provider who furnished the service is part of a group practice, enter the name of the provider who furnished the service.
Item 5	SERVICING PROVIDER NO.	If the provider furnished the service as part of a group practice, enter the seven-digit MassHealth provider number assigned to the individual provider. If not, leave this item blank.
Item 6	PLACE OF SERVICE	Enter the code from the list below that describes the place in which the service was provided. 01 - Office 03 - Inpatient hospital 04 - Outpatient hospital 10 - School-based health center
Item 7	RECIPIENT'S NAME	Enter the member's name.

526 Item-by-Item Instructions for Claim Form No. 4 (cont.)

Item 8	RECIPIENT ID NO.	Enter the complete 10-character member identification number (ID) that is printed on the MassHealth card below or beside the member's name. These characters may be all numbers or a combination of numbers and letters. The member ID on the temporary MassHealth card may include an asterisk as the 10th character.
Item 9	DATE OF BIRTH	Enter the member's date of birth in month/day/year order.
Item 10	SEX	Enter either an M for male or an F for female.
Item 11	PATIENT ACCOUNT NO.	Enter the patient account number or member's last name (no more than 10 characters). The patient account number or name will be printed on the remittance advice with the claim.
Item 12	PRIMARY DIAGNOSIS CODE	Enter the ICD-9-CM diagnosis code for "Routine Infant or Child Health Check."
Item 13	PRIMARY DIAGNOSIS NAME	Enter "Routine Infant or Child Health Check."
Item 14	SECONDARY DIAGNOSIS CODE	When a secondary diagnosis exists, enter the appropriate ICD-9-CM diagnosis code.

526 Item-by-Item Instructions for Claim Form No. 4 (cont.)

Item 19	PROCEDURE CODE-MODIFIER	Enter the HCPCS service code that corresponds to the service provided. See Subchapter 6 of this manual for information about service codes. Line A, EPSDT Assessment (Screening): Bill for well-child-care visits provided in accordance with the EPSDT Schedule on line A only. Do not enter service codes for any other services on line A. Enter the appropriate modifier that corresponds to the service provided, if applicable. Lines B through D: Bill for other well-child-care services and treatment, such as related laboratory tests, titmus vision tests, vaccines, or hospital visits for newborns, on lines B through D only. Do not enter service codes for well-child-care visits provided in accordance with the EPSDT Schedule on lines B through D.
Item 20	TREAT REL. TO DIAG	Leave this item blank.
Item 21	UNITS OF SERVICE	Enter the total number of days or units the service was provided.

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601 Introduction

MassHealth providers must refer to the American Medical Association's *Current Procedural Terminology* (CPT) *2002* manual for the service codes and service descriptions when billing for services provided to MassHealth members. The Division pays for all medicine, radiology, surgery, and anesthesia CPT codes in effect at the time of service, subject to all conditions and limitations described in the Division's regulations at 130 CMR 433.000 and 450.000, ***except*** for those codes listed in Section 602 of this subchapter. In addition, a physician may request prior authorization for any medically necessary service for a member under 21 years of age.

- Section 602 lists service codes that are not payable under MassHealth.
- Section 603 lists service codes that have special requirements or limitations. Beside each service code in Section 603 is an explanation of the requirement or limitation.
- Section 604 lists locally assigned service codes and Level II HCPCS codes that are payable under MassHealth. The local codes listed in Section 604 are intended only for services provided to MassHealth members.
- Section 605 lists service code modifiers payable under MassHealth.

602 Nonpayable Codes

The Division does not pay for services billed under the following codes.

0001T	11921	15826	21125	44136
0002T	11922	15828	21127	47133
0005T	11950	15829	21245	48160
0006T	11951	15876	21246	48550
0007T	11952	15877	21248	50300
0008T	11954	15878	21249	54900
0009T	15775	15879	22841	54901
0010T	15776	17340	32491	55200
0012T	15780	17360	32850	55300
0013T	15781	17380	33930	55400
0014T	15782	19316	33940	55870
0016T	15783	19324	36415	55970
0017T	15786	19325	36468	55980
0018T	15787	19355	36469	58321
0019T	15788	19370	36540	58322
0020T	15789	19371	41870	58323
0021T	15792	19396	41872	58345
0023T	15793	20930	43752	58350
0024T	15810	20936	43842	58750
0025T	15811	21120	43843	58752
0026T	15819	21121	44132	58760
10040	15824	21122	44133	58970
11920	15825	21123	44135	58974

602 Nonpayable Codes (cont.)

58976	77409	88020	90659	92354
59412	77411	88025	90660	92355
63043	77412	88027	90669	92358
63044	77413	88028	90680	92370
65760	77414	88029	90700	92371
65765	77416	88036	90701	92390
65767	77417	88037	90702	92391
65771	77418	88040	90708	92392
69090	77520	88045	90709	92393
71550	77522	88099	90710	92395
71551	77523	88125	90712	92396
71552	77525	89250	90718	92510
72159	77790	89251	90720	92531
72198	78267	89252	90721	92532
73225	78268	89253	90723	92533
76085	78351	89254	90744	92534
76093	78890	89255	90748	92548
76094	78891	89256	90845	92559
76140	80500	89257	90865	92560
76150	80502	89258	90875	92561
76350	82075	89259	90876	92562
76390	82962	89260	90880	92564
76400	84061	89261	90885	92597
77300	84830	89264	90889	92598
77301	86079	89300	90901	93660
77305	86585	89310	90911	93668
77310	86890	89320	90939	93760
77315	86891	89321	90940	93762
77321	86910	89325	90989	93770
77326	86911	89329	90993	93784
77327	86927	89330	90997	93786
77328	86930	90281	90999	93788
77331	86931	90378	91132	93790
77332	86932	90379	91133	94015
77333	86945	90396	92314	95052
77334	86950	90633	92315	95120
77336	86965	90634	92316	95125
77370	86985	90636	92317	95130
77399	88000	90645	92325	95131
77401	88005	90646	92330	95132
77402	88007	90647	92335	95133
77403	88012	90648	92340	95134
77404	88014	90657	92341	95144
77406	88016	90658	92342	95145
77407			92352	95146
77408			92353	95147

602 Nonpayable Codes (cont.)

95148	99001	99374	99566
95149	99002	99375	99567
95165	99024	99377	99568
95170	99025	99378	99569
95824	99056	99379	
95965	99058	99380	
95966	99071	99401	
95967	99075	99402	
96000	99078	99403	
96001	99080	99404	
96002	99082	99411	
96003	99090	99412	
96004	99091	99420	
96100	99100	99429	
96105	99116	99450	
96110	99135	99455	
96111	99140	99456	
96115	99141	99500	
96117	99142	99501	
96150	99172	99502	
96151	99178	99503	
96152	99190	99504	
96153	99191	99505	
96154	99192	99506	
96155	99271	99507	
96567	99272	99508	
96902	99273	99509	
97005	99274	99510	
97006	99275	99511	
97014	99288	99512	
97139	99289	99539	
97530	99290	99551	
97537	99315	99552	
97545	99316	99553	
97546	99354	99554	
97601	99355	99555	
97602	99356	99556	
97780	99357	99557	
97781	99358	99558	
97802	99359	99559	
97803	99360	99560	
97804	99361	99561	
98940	99362	99562	
98941	99371	99563	
98942	99372	99564	
98943	99373	99565	

603 Codes That Have Special Requirements or Limitations

The following service codes are payable by MassHealth, subject to all conditions and limitations in the Division's regulations at 130 CMR 433.000 and 450.000, but require specific attachments or prior authorization, or have other specific instructions or limitations. Refer to Section 604 for specific requirements or limitations for HCPCS Level II and locally assigned service codes.

Legend:

*: Available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
Centrifuging required: Service Code 99000 may only be used to pay a physician who centrifuges and mails a specimen to a laboratory for analysis. (See 130 CME 433.439.)
Covered for adults ≥ 19: This code is only payable for adults aged 19 or older.
CPA-2: A completed Certification of Payable Abortion Form must be attached to the claim.
CS-18: A completed Sterilization Consent Form (for members aged 18 through 20) must be attached to the claim.
CS-21: A completed Sterilization Consent Form (for members aged 21 and older) must be attached to the claim.
HI-1: A completed Hysterectomy Information Form must be attached to the claim.
IC: Claim requires individual consideration. See 130 CMR 433.406 for more information.
PA for OMT >20: Prior authorization is required for more than 20 osteopathic manipulative therapy visits in a 12-month period.
PA for PT >20: Prior authorization is required for more than 20 physical therapy visits, regardless of modality, in a 12-month period.
PA: Service requires prior authorization. See 130 CMR 433.408 for more information.
Urgent Care Only: Service Codes 99050, 99052, and 99054 may be used only for urgent care provided in the office after hours, in addition to the basic service.

Service Code and Req. or Limit	
01999	IC
15820	PA
15821	PA
15822	PA
15823	PA
15831	IC; PA
15832	IC; PA
15833	IC; PA
15834	IC; PA
15835	IC; PA
15836	IC; PA
15837	IC; PA
15838	IC; PA
15839	IC; PA
15999	IC
17999	IC
19140	PA

Service Code and Req. or Limit	
19318	PA
19328	PA
19330	PA
19340	PA
19342	PA
19350	PA
19357	PA
19361	PA
19364	PA
19366	PA
19367	PA
19368	PA
19369	PA
19380	PA
19499	IC
20999	IC
21076	IC; PA

603 Codes That Have Special Requirements or Limitations (cont.)

Service Code and Req. or Limit	
21077	IC; PA
21079	IC; PA
21080	IC; PA
21081	IC; PA
21082	IC; PA
21083	IC; PA
21084	IC; PA
21085	IC; PA
21086	IC; PA
21087	IC; PA
21088	IC; PA
21089	IC; PA
21110	IC
21137	PA
21138	PA
21139	PA
21141	PA
21142	PA
21143	PA
21145	PA
21146	PA
21147	PA
21150	PA
21151	PA
21154	PA
21155	PA
21159	PA
21160	PA
21172	PA
21175	PA
21179	PA
21180	PA
21181	PA
21182	PA
21183	PA
21184	PA
21188	PA
21193	PA
21194	PA
21195	PA
21196	PA
21198	PA
21206	PA
21208	PA

Service Code and Req. or Limit	
21209	PA
21210	PA
21215	PA
21230	PA
21235	PA
21240	PA
21242	PA
21243	PA
21244	PA
21247	PA
21255	PA
21256	PA
21260	PA
21261	PA
21263	PA
21267	PA
21268	PA
21270	PA
21275	PA
21280	PA
21282	PA
21295	PA
21296	PA
21299	IC; PA
21499	IC
21899	IC
22899	IC
22999	IC
23929	IC
24940	IC
24999	IC
25915	IC
25999	IC
26989	IC
27299	IC
27599	IC
27899	IC
28360	IC
28899	IC
29799	IC
29800	PA
29804	PA
29999	IC
30400	PA

603 Codes That Have Special Requirements or Limitations (cont.)

Service Code and Req. or Limit		Service Code and Req. or Limit	
30410	PA	41850	IC
30420	PA	41899	IC
30430	PA	42140	PA
30435	PA	42280	PA
30450	PA	42281	PA
30999	IC	42299	IC
31299	IC	42699	IC
31599	IC	42999	IC
31899	IC	43289	IC
32851	PA	43496	IC
32852	PA	43499	IC
32853	PA	43659	IC
32854	PA	43846	PA
32999	IC	43847	PA
33935	PA	43848	PA
33945	PA	43999	IC
33979	IC	44209	IC
33980	IC	44799	IC
33999	IC	44899	IC
36299	IC	44979	IC
36470	PA	45999	IC
36471	PA	46999	IC
37799	IC	47134	IC; PA
38129	IC	47135	IC; PA
38230	PA	47136	IC; PA
38231	PA	47379	IC
38240	PA	47399	IC
38241	PA	47579	IC
38589	IC	47999	IC
38999	IC	48554	PA
39499	IC	48556	PA
39599	IC	48999	IC
40799	IC	49329	IC
40840	PA	49659	IC
40842	PA	49906	IC
40843	PA	49999	IC
40844	PA	50549	IC
40845	PA	50949	IC
40899	IC	51597	HI-1
41599	IC	51715	PA
41820	IC; PA	51925	HI-1
41822	IC	52327	PA
41823	IC	53850	PA
41828	IC	53852	PA

603 Codes That Have Special Requirements or Limitations (cont.)

Service Code and Req. or Limit	
53899	IC
54240	PA
54250	PA
54400	PA
54401	PA
54405	PA
54440	IC
54699	IC
55250	CS-18 or CS-21
55450	CS-18 or CS-21
55559	IC
55899	IC
56800	PA
56805	PA; IC
57335	PA; IC
58150	HI-1
58152	HI-1
58180	HI-1
58200	HI-1
58210	HI-1
58240	HI-1
58260	HI-1
58262	HI-1
58263	HI-1
58267	HI-1
58270	HI-1
58275	HI-1
58280	HI-1
58285	HI-1
58550	HI-1
58578	IC
58579	IC
58600	CS-18 or CS-21
58605	CS-18 or CS-21
58611	CS-18 or CS-21
58615	CS-18 or CS-21
58661	CS-18 or CS-21
58670	CS-18 or CS-21
58671	CS-18 or CS-21
58679	IC
58951	HI-1
58999	IC
59135	HI-1
59525	HI-1

Service Code and Req. or Limit	
59840	CPA-2; (first trimester)
59841	CPA-2; (first trimester)
59850	CPA-2; (second trimester, third trimester in hospital only)
59851	CPA-2; (second trimester, third trimester in hospital only)
59852	CPA-2; (second trimester, third trimester in hospital only)
59855	CPA-2
59856	CPA-2
59857	CPA-2
59898	IC
59899	IC
60659	IC
60699	IC
62287	IC
64999	IC
66999	IC
67299	IC
67399	IC
67599	IC
67900	PA
67901	PA
67902	PA
67903	PA
67904	PA
67906	PA
67908	PA
67909	PA
67911	PA
67916	PA
67917	PA
67923	PA
67924	PA
67961	PA
67966	PA
67971	PA
67973	PA
67974	PA
67975	PA
67999	IC
68399	IC
68899	IC
69300	PA

603 Codes That Have Special Requirements or Limitations (cont.)

Service Code and Req. or Limit		Service Code and Req. or Limit	
69399	IC	83527	IC
69710	IC	83937	IC
69799	IC	84140	IC
69930	PA	84143	IC
69949	IC	84449	IC
69979	IC	84466	IC
70336	PA	84586	IC
71555	IC	84999	IC
73725	IC	85097	IC
74185	IC	85999	IC
76380	IC	86341	IC
76499	IC	86359	IC
76999	IC	86490	IC
77299	IC	86510	IC
77399	IC	86849	IC
77499	IC	86850	IC
77799	IC	86860	IC
78099	IC	86870	IC
78172	IC	86901	IC
78199	IC	86915	IC
78282	IC	86920	IC
78299	IC	86921	IC
78399	IC	86922	IC
78414	IC	86999	IC
78459	IC	87901	PA
78491	IC	87903	PA
78492	IC	87904	PA
78499	IC	87999	IC; PA
78599	IC	88162	IC
78608	IC	88172	IC
78609	IC	88180	IC
78699	IC	88182	IC
78799	IC	88199	IC
78810	IC	88299	IC
78990	IC	88399	IC
78999	IC	89100	IC
79300	IC	89399	IC
79420	IC	90283	IC; PA
79900	IC	90287	IC; PA
79999	IC	90288	IC
80103	IC	90291	IC
80406	IC	90296	IC
81099	IC	90371	IC
82154	IC	90375	IC

603 Codes That Have Special Requirements or Limitations (cont.)

Service Code and Req. or Limit	
90376	IC
90384	IC
90385	IC
90386	IC
90389	IC
90393	IC
90399	IC
90473	IC
90474	IC
90476	IC
90477	IC
90581	IC
90585	IC
90586	IC
90632	IC
90665	IC
90675	IC
90676	IC
90690	IC
90691	IC
90692	IC
90693	IC
90703	IC
90704	IC
90705	IC
90706	IC
90707*	IC; Covered for adults ≥ 19
90713*	IC; Covered for adults ≥ 19
90716*	IC; Covered for adults ≥ 19
90717	IC
90719	IC
90725	IC
90727	IC
90732	IC
90733	IC
90735	IC
90740	IC
90743*	IC
90746	IC
90747	IC
90749	IC
90799	IC
90899	IC

Service Code and Req. or Limit	
90935	For hospitalized member only; not for chronic maintenance
90937	For hospitalized member only; not for chronic maintenance
90945	For hospitalized member only; not for chronic maintenance
90947	For hospitalized member only; not for chronic maintenance
90999	IC
91299	IC
92065	PA
92250	PA
92310	PA
92311	PA; includes supply of lenses
92312	PA; includes supply of lenses
92313	PA; IC; includes supply of lenses
92326	PA
92499	IC
92525	IC
92599	IC
92953	IC
93799	IC
94642	IC
94772	IC
94799	IC
95199	IC
95875	IC
95999	IC
96423	IC
96425	IC
96545	IC
96549	IC
96913	IC
96999	IC
97001	PA for PT >20
97002	PA for PT >20
97003	PA for PT >20
97004	PA for PT >20
97010	PA for PT >20
97012	PA for PT >20
97016	PA for PT >20
97018	PA for PT >20
97020	PA for PT >20
97022	PA for PT >20

603 Codes That Have Special Requirements or Limitations (cont.)

Service Code and Req. or Limit	
97024	PA for PT >20
97026	PA for PT >20
97028	PA for PT >20
97032	PA for PT >20
97033	PA for PT >20
97034	PA for PT >20
97035	PA for PT >20
97036	PA for PT >20
97039	PA for PT >20; IC
97110	PA for PT >20
97112	PA for PT >20
97113	PA for PT >20; IC
97116	PA for PT >20
97124	PA for PT >20
97140	PA for PT >20
97150	PA for PT >20
97504	PA for PT >20
97520	PA for PT >20
97532	PA for PT >20
97533	PA for PT >20
97535	PA for PT >20
97542	PA for PT >20
97799	IC
98925	PA for OMT >20
98926	PA for OMT >20
98927	PA for OMT >20
98928	PA for OMT >20

Service Code and Req. or Limit	
98929	PA for OMT >20
98928	IC
98929	IC
98940	IC
98941	IC
98942	IC
98943	IC
99000	Centrifuging required
99050	Urgent care only
99052	Urgent care only
99054	Urgent care only
99070	IC; excluding family planning supplies and supplies, such as trays, used in the collection of specimens
99185	IC
99186	IC
99195	For hematologic disorders only
99199	IC
99296	IC
99297	IC
99344	IC
99345	IC
99350	IC
99436	IC
99499	IC

605 Modifiers

604 HCPCS Level II and Locally Assigned Service Codes

The locally assigned service codes and service descriptions are exclusive to MassHealth. These local codes describe services that are not recognized in the CPT code book. The local codes are intended only for services provided to MassHealth members.

Service Code	Description
	Family Planning Supplies
A4261	Cervical cap for contraceptive use (I.C.)
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg. (150 mg. Depo Provera) (I.C.)
J1056	Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg./25 mg. (5 mg./25 mg. Lunelle) (I.C.)
S4989	Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies (I.C.)
S4993	Oral contraceptives (birth control pills) actual to maximum cost of $4.00 per cycle
X1051	Diaphragm (including applicator and contraceptive cream or jelly)
X1052	Condoms (three)
X1054	Contraceptive jelly
X1056	Contraceptive cream
X1057	Vaginal contraceptive film (three)
X1058	Contraceptive foam
X1059	Female condoms with lubricant (three)
X1060	Female condoms with lubricant (six)
X1061	Contraceptive suppositories (package of 12)
X1063	Cervical sponges (three)
X1069	Medications and injectables related to family planning services, with the exception of Rho(D) human immune globulin and contraceptive injectables, such as Depo Provera (The Division will pay for the items listed under Service Code X1069 at the provider's cost.) (I.C.)
	Miscellaneous Services and Supplies
R0070	Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen
X0410	Allergenic extract, single-unit-dose, administered by either the preparer or dispenser of the extract
X0411	Preparation of a multi-dose vial of allergenic extract, for dispensing and administration by another physician.
X0412	Stinging insect venom(s) (I.C.)
X0415	Palivizumab (Synagis) supplied in a physician's office. This code requires prior authorization. (I.C.) (P.A.)
X3333	Injectable and infusible drugs and devices supplied in a physician's office that require prior authorization (I.C.) (P.A.)
X5539	Emergency psychiatry service (per 30 minute unit, four units maximum per date of service)
X5552	Administration of VFC pediatric vaccines for individuals 18 years and under (not for use in conjunction with an office visit or other outpatient visit)
X5911	Emergency department screening for determination of level of care

605 Modifiers

The following service code modifiers are allowed for billing under MassHealth. See Subchapter 5 of the *Physician Manual* for billing instructions related to the use of modifiers.

26 Professional component
50 Bilateral procedure
51 Multiple procedures
54 Surgical care only
62 Two surgeons
66 Surgical team
80 Assistant surgeon
82 Assistant surgeon (when qualified resident surgeon not available)
99 Multiple modifiers
DS Services to Department of Social Services (DSS) children. To identify an initial visit for a child in the care and custody of the Department of Social Services (DSS), when delivered within seven calendar days of the child being taken into DSS custody, add the modifier DS to the end of the appropriate service code.
EP Initial well-child visit provided by a physician, independent nurse practitioner, or independent nurse midwife in accordance with the EPSDT Schedule. To identify a well-child office visit provided by a physician, independents nurse practitioner, or independent nurse midwife as an initial health assessment (screening), add the modifier EP to the appropriate preventive medicine service code. Refer to 130 CMR433.433(C) for the definition of independent nurse practitioner. Refer to 130 CMR 433.419(C) for the definition of independent nurse midwife.
Y3 Subsequent well-child visit provided by a physician, independent nurse practitioner, or independent nurse midwife in accordance with the EPSDT Schedule. To identify a well-child office visit provided by a physician, independent nurse practitioner, or independent nurse midwife as a subsequent health assessment (screening), add the modifier Y3 to the end of the appropriate preventive medicine service code. Refer to 130 CMR 433.433(C) for the definition of independent nurse practitioner. Refer to 130 CMR 433.419(C) for the definition of independent nurse midwife.
R3 Non-independent nurse practitioner services. To identify services provided by a non-independent nurse practitioner who is employed by a physician, add the modifier R3 to the end of the appropriate service code. Refer to 130 CMR 433.433(D) for the definition of non-independent nurse practitioner.
R4 Initial well-child visit provided by a non-independent nurse practitioner in accordance with the EPSDT Schedule. To identify a well-child office visit provided by a non-independent nurse practitioner (employed by a physician) as an initial health assessment (screening), add the modifier R4 to the end of the appropriate preventive medicine service code. Refer to 130 CMR 433.433(D) for the definition of non-independent nurse practitioner.
R5 Subsequent well-child visit provided by a non-independent nurse practitioner in accordance with the EPSDT Schedule. To identify a well-child office visit provided by a non-independent nurse practitioner (employed by a physician) as a subsequent health assessment (screening), add the modifier R5 to the end of the appropriate preventive medicine service code. Refer to 130 CMR 433.433(D) for the definition of non-independent nurse practitioner.
S1 Physician assistant services. To identify services provided by a physician assistant employed by a physician or group practice, add the modifier S1 to the end of the appropriate service code.

605 Modifiers (cont.)

S2 Initial well-child visit provided by a physician assistant in accordance with the EPSDT Schedule. To identify a well-child office visit provided by physician assistant as an initial health assessment (screening), add the modifier S2 to the end of the appropriate preventive medicine service code.

S3 Subsequent well-child visit provided by a physician assistant in accordance with the EPSDT Schedule. To identify a well-child office visit provided by a physician assistant as a subsequent health assessment (screening), add the modifier S3 to the end of the appropriate preventive medicine service code.

W5 Non-independent nurse midwife services. To identify services provided by a non-independent nurse midwife who is employed by a physician, add the modifier W5 to the end of the appropriate service code. Refer to 130 CMR 433.419(D) for definition of non-independent nurse midwife.

W6 Initial well-child visit provided by a non-independent nurse midwife in accordance with the EPSDT Schedule To identify a well-child office visit provided by a non-independent nurse midwife (employed by a physician) as an initial health assessment (screening), add the modifier W6 to the end of the appropriate preventive medicine service code. Refer to 130 CMR 433.419(D) for the definition of non-independent nurse midwife.

W7 Subsequent well-child visit provided by a non-independent nurse midwife in accordance with the EPSDT Schedule. To identify a well-child office visit provided by a non-independent nurse midwife (employed by a physician) as a subsequent health assessment (screening), add the modifier W7 to the end of the appropriate preventive medicine service code. Refer to 130 CMR 433.419(D) for the definition of non-independent nurse midwife.

W8 Emergency treatment in a nursing facility. To identify a visit to a nursing facility for emergency treatment, add the modifier W8 to the end of the nursing facility visit service code.

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