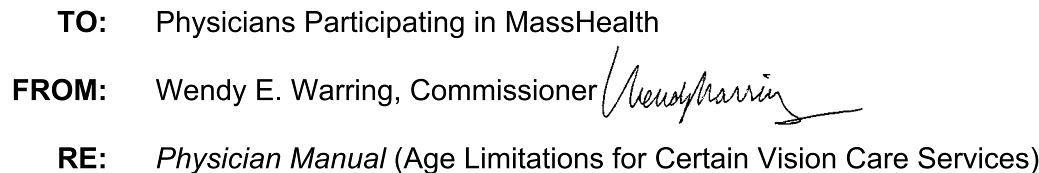
Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER PHY-93
December 2002

TO: Physicians Participating in MassHealth

FROM: Wendy E. Warring, Commissioner



RE: *Physician Manual* (Age Limitations for Certain Vision Care Services)

Beginning January 1, 2003, age restrictions have been added to certain vision services. The Division's current budget appropriation requires these changes, at a minimum, to cover expected deficiencies.

The attached regulations, which describe these changes, are effective January 1, 2003.

I. Age Limitations for Certain Vision Care Services

Effective January 1, 2003, the Division will cover the following vision care services only when provided to eligible MassHealth members under age 21: ophthalmic materials, specifically including, but not limited to, complete eyeglasses or eyeglass parts; the dispensing of ophthalmic materials; contact lenses; and other visual aids, except that this age limitation will not apply to visual magnifying aids for use by members who are both diabetic and legally blind. Visual magnifying aids do not include eyeglasses or contact lenses.

As of January 1, 2003, you should inform MassHealth members aged 21 and older that MassHealth no longer covers these services. **The changes to the regulations do not alter vision care services for members under age 21.**

II. Service-Specific Prior Authorizations Approved or Appealed Prior to January 1, 2003

If MassHealth approved a prior-authorization (PA) request for a member aged 21 and older on or before October 25, 2002, and the request was for any of the services listed above, MassHealth will continue to pay for those services through the authorized period. Until December 31, 2002, MassHealth will approve medically necessary PA requests for members aged 21 and older for a 90-day period from the date the PA request is approved or changed. After December 31, 2002, MassHealth will no longer approve PA requests for members aged 21 and older for the services listed above.

If a member appeals any prior-authorization decision made prior to January 1, 2003, the Division will pay for the service if the Board of Hearings or a court does not uphold the Division's decision.

III. Claims for Custom-Made Goods

The Division will pay for custom-made goods in the following circumstances for dates of service after January 1, 2003:

- custom-made goods started before January 1, 2003, but not completed until after; and
- custom-made goods where the prior-authorization expiration date is after January 1, 2003.

As stated in 130 CMR 450.231(B), "the 'date of service' is the date on which a medical service is furnished to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers medical goods to a member, which goods had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date prior to the final delivery of the goods, the Division will reimburse the provider for the goods…"

Providers must submit paper claims for these services with all applicable documentation as outlined in 130 CMR 450.231(B) to the following address.

Division of Medical Assistance
Claims Operations Unit
Attention: After Cancel Unit
600 Washington Street
Boston, MA 02111

IV. Prior-Authorization Requests for Visual Magnifying Aids for Members Aged 21 and Older

As of January 1, 2003, visual magnifying aids for MassHealth members aged 21 and older who are both diabetic and legally blind can be billed using Service Codes V2600, V2610, V2615, and V2799. These service codes require prior authorization.

Prior-authorization requests for visual magnifying aids for members aged 21 and older must clearly state that the member is diabetic and legally blind.

Effective for dates of service on or after January 1, 2003, any claims for visual magnifying aids for members aged 21 and older who are both diabetic and legally blind must contain the ICD-9-CM diagnosis code. To ensure that your claims for visual magnifying aids for these members are appropriately identified, enter the diagnosis name that accurately describes the member's condition in Item 23A of claim form no. 5, and the corresponding ICD-9-CM diagnosis code in Item 24D.

V. Additional Regulation Change

In addition to the new age limitation for certain vision care services, a correction has been made to 130 CMR 433.403. The reference to acute hospitals has been deleted from the section about participating providers to correct a change made in April 2002. Acute hospital regulations are found in the *Acute Inpatient Manual* and the *Outpatient Manual.*

VI. Web Site Access and Questions

This transmittal letter and the revised regulations are available on the Division's Web site at www.mass.gov/dma.

If you have any questions, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

<u>NEW MATERIAL</u>
(The pages listed here contain new or revised language.)

<u>Physician Manual</u>

Pages 4-5, 4-6, 4-17, and 4-18

<u>OBSOLETE MATERIAL</u>
(The pages listed here are no longer in effect.)

<u>Physician Manual</u>

Pages 4-5, 4-6, 4-17, and 4-18 — transmitted by Transmittal Letter PHY-92

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 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.

433.424: 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) (1) The Division pays for eyeglasses and other ophthalmic materials, only when provided to members who are under the age of 21 as set out in 130 CMR 433.425(D)(2), 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.)

(2) Age Limitations. In addition to any other restrictions and limitations set forth in the Division's regulations, the Division covers the following services only when provided to eligible MassHealth members who are under age 21: ophthalmic materials, specifically including, but not limited to, complete eyeglasses or eyeglass parts; the dispensing of ophthalmic materials; contact lenses; and other visual aids, except that this age limitation does not apply to visual magnifying aids for use by members who are both diabetic and legally blind. Visual magnifying aids do not include eyeglasses or contact lenses.

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.