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***Executive Office of Health and Human Services***
***Office of Medicaid***
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MASSHEALTH
TRANSMITTAL LETTER PHY-98
January 2004

**TO:** Physicians Participating in MassHealth

**FROM:** Beth Waldman, Director, Office of Medicaid

**RE:** *Physician Manual* (Revised Regulations)

Effective February 1, 2004, MassHealth has revised its physician regulations. Some of these changes may affect the way that you bill for certain services. This letter transmits revisions to the physician regulations and describes the related billing changes.

**Revisions**

The physician regulations have been revised to:
- eliminate global-fee payments for all services that have a professional and technical component;
- update laboratory provisions;
- clarify MassHealth's policy about drugs and biologicals dispensed in the physician's office;
- eliminate the requirement that the physician attach a copy of the Certification for Payable Abortion form to the claim for abortions; and
- clarify that MassHealth may use the supplier's invoice to determine payment of claims for drugs and supplies.

**Billing Changes**

- **Elimination of Global Billing for Services with a Professional and Technical Component**
  For dates of service on or after February 1, 2004, providers may no longer bill for the global-fee method of payment when the provider has provided both the professional and technical components of a service. Physicians, nurse practitioners, and nurse midwives providing both the professional and technical components of a service must bill for these components separately to receive the equivalent of the global payment. This change will allow MassHealth to track the specific services provided and avoid duplication of payment for the component parts of a service.

  Currently, providers bill for the global fee by reporting the service code for an applicable service on one claim line without a modifier. By reporting the service without a modifier, the provider is paid a single global fee for both the professional and technical components.

  Effective for dates of service beginning February 1, 2004, to receive payment for both the professional and technical components, the provider must bill each component on separate claim lines. To bill for the professional component, the provider must append modifier 26 to the appropriate service code. If the physician is also billing for the technical component, the provider must report the same service code on a second claim line, and append modifier TC.

Services that have professional and technical components must be billed with a modifier. Any claims for such services that are not billed with modifier 26 or TC for dates of service on or after February 1, 2004, will be denied with error code 135, "modifier required." (On the HIPAA-compliant 835 remittance advice transaction, this will be reflected as an adjustment reason code 04 and remarks code M78.)

**Please Note:** MassHealth continues to prohibit physicians from billing for the technical component only.

- **Certification of Payable Abortion Form (CPA-2) Attachment**
  As described in Physician Bulletin 79, the requirement that physicians attach a copy of the Certification for Payable Abortion form to their claims for abortions was eliminated for dates of service on and after October 16, 2003. The revised regulation transmitted in this letter codifies this change.

  MassHealth permits providers to maintain the CPA-2 form on file in their office rather than submitting the attachment with the claim. The requirement to complete and maintain the CPA-2 form remains in effect. (See 130 CMR 433.455(D).)

- **Drugs and Biologicals Dispensed in the Office**
  For drugs and biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Physician Manual*, the provider must also attach to the claim a copy of the invoice showing the actual acquisition cost, if billing on paper. For 837P transactions, the claim will be suspended, and a Claim Attachment Form (CAF) requesting a copy of the invoice will be mailed to the provider. (For more information about CAFs, see All Provider Bulletin 125, dated September 2003.) You do not need to submit a copy of the invoice if the code for the drug or biological does not require individual consideration.

**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.

**Effective date**

The attached regulations are effective February 1, 2004.

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

Physician Manual

Pages iv, 4-7, 4-8, 4-27, 4-28, 4-31, 4-32, 4-37, and 4-38

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

Physician Manual

Pages iv, 4-7, 4-8, 4-27, 4-28, 4-37, and 4-38 — transmitted by Transmittal Letter PHY-92

Pages 4-31 and 4-32 — transmitted by Transmittal Letter PHY-95

4. PROGRAM REGULATIONS

Part 1. General Information



Part 2. Medical Services

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) MassHealth has designated certain services in Subchapter 6 of the *Physician Manual* as requiring individual consideration. This means that MassHealth 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. MassHealth 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) MassHealth 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 MassHealth deems relevant;
(6) the policies, procedures, and practices of other third-party insurers;
(7) the payment rate for drugs as set forth in MassHealth's pharmacy regulations at 130 CMR 406.000; and
(8) for drugs or supplies, a copy of the invoice from the supplier showing the actual acquisition cost.

433.407: Service Limitations: Professional and Technical Components of Services and Procedures

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

(A) Definitions.

(1) Mobile Site – any site other than the physician's office, but not including community health centers, hospital outpatient departments, or hospital-licensed health centers.
(2) Professional Component – the component of a service or procedure representing the physician's work interpreting or performing the service or procedure.

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

(B) Payment. A physician may bill for the professional component of a service or procedure or, subject to the conditions of payment set forth in 130 CMR 433.407(C), both the professional and technical components of the service or procedure. MassHealth does not pay a physician for providing the technical component only of a service or procedure.

(C) Conditions of Payment for the Provision of Both the Professional and Technical Components of a Service or Procedure. Only the physician providing the professional component of the service or procedure may bill for both the professional and technical components. This constitutes a limited exception to 130 CMR 450.301. A physician may bill for providing both the professional and technical components of a service or procedure in the physician's office only when one of the following conditions is met:

(1) the physician owns or leases the equipment used to perform the service or procedure, provides the technical component (either directly or by employing a technician), and provides the professional component; or

(2) the physician subcontracts with a licensed Medicare-certified entity to provide the technical component of the service or procedure either in the physician's office or at a mobile site, and provides the professional component.

433.408: Prior Authorization

(A) Introduction.

(1) Subchapter 6 of the *Physician Manual* lists codes that require prior authorization as a prerequisite for payment. MassHealth will not pay for services if billed under any of these codes, unless the provider has obtained prior authorization from MassHealth 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 MassHealth'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) Surgical Introductions and Interpretations. MassHealth 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. MassHealth 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), MassHealth pays a physician only for laboratory tests performed in the physician's office. If a physician uses the services of an independent clinical laboratory, MassHealth pays only the laboratory for services provided for a member.

(2) A physician may bill MassHealth 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. MassHealth 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, MassHealth 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. MassHealth does not pay a physician for the professional component of a clinical laboratory service. MassHealth pays a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. MassHealth 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.

(E) Forensic Services. MassHealth does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438, including but not limited to:

(1) tests performed to establish paternity;

(2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and

(3) post-mortem examinations.

(130 CMR 433.440 Reserved)

(7) Experimental and Investigational Drugs. MassHealth does not pay for any drug that is experimental, medically unproven, or investigational in nature.

(C) Service Limitations.

(1) MassHealth covers drugs that are not explicitly excluded under 130 CMR 433.443(B). The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 433.000. The MassHealth Drug List can be viewed on MassHealth's Web site, and copies may be obtained upon request. MassHealth will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List accordingly. (See 130 CMR 450.303.)

(2) MassHealth does not pay for the following types of drugs or drug therapy without prior authorization:

(a) 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 (DPH);

(b) nongeneric multiple-source drugs;

(c) drugs used for the treatment of male or female sexual dysfunction;

(d) drugs related to sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. MassHealth, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993; and

(e) retinoids for members aged 26 or older. MassHealth pays for retinoids for members under age 26, and all other topical acne products for members of all ages who have cases of acne Grade II or higher, without prior authorization.

(3) MassHealth does not pay any additional fees for dispensing drugs in a unit-dose distribution system.

(4) MassHealth does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as MassHealth determines to be consistent with current medical evidence.

433.444: Pharmacy Services: Insurance Coverage

(A) Managed Care Organizations. MassHealth 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.

(B) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill MassHealth for the primary insurer's copayment for the primary carrier's preferred drug without regard to whether MassHealth generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 433.443(C)(2)(a), (c), (d), and (e). In such cases, the prescriber must obtain prior authorization from MassHealth in order for the pharmacy to bill MassHealth for the primary insurer's copayment.

433.445: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from MassHealth for drugs identified by MassHealth in accordance with 130 CMR 450.303. If the limitations on covered drugs specified in 130 CMR 433.442(A) and 433.443(A) and (C) would result in inadequate treatment for a diagnosed medical condition, the prescriber may submit a written request, including written documentation of medical necessity, to MassHealth for prior authorization for an otherwise noncovered drug.

(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 MassHealth approves the request, it will notify the pharmacy and the member.

(C) MassHealth will authorize at least a 72-hour emergency supply of a prescription drug to the extent required by federal law. (See 42 U.S.C. 1396r-8(d)(5).) MassHealth 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.

433.446: Pharmacy Services: Member Copayments

Under certain conditions, MassHealth 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 MassHealth's administrative and billing regulations at 130 CMR 450.130.

433.447: Pharmacy Services: Payment

Drugs and biologicals dispensed in the office are payable, subject to the service limitations at 130 CMR 433.404, 433.406, and 433.443. MassHealth does not pay a physician separately for drugs that are considered routine and integral to the delivery of a physician's professional services in the course of diagnosis or treatment. Such drugs are commonly provided without charge or are included in the physician's fee for the service. MassHealth 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 MassHealth. Claims for drugs and biologicals that are listed in Subchapter 6 of the *Physician Manual* must include the name of the drug or biological, strength, dosage, and number of units dispensed. A copy of the invoice showing the actual acquisition cost must be attached to the claim form for drugs and/or biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Physician Manual*, and must include the National Drug Code (NDC). Claims without this information are denied. MassHealth does not pay for a biological if the Massachusetts Department of Public Health distributes the biological free of charge. Payment for drugs may be claimed in addition to an office visit.

(130 CMR 433.448 through 433.450 Reserved)

433.455: Abortion Services

(A) Payable Services.

(1) MassHealth 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. MassHealth, 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. MassHealth 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 complete a Certification for Payable Abortion (CPA-2) form and retain the form in the member's record. (Instructions for obtaining the Certification for Payable Abortion form are in Appendix A of all provider manuals.) To identify those abortions that meet federal reimbursement standards, specified in 42 CFR 449.100 through 449.109, MassHealth 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. MassHealth 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. MassHealth, 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. MassHealth 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. MassHealth 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.