Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
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MASSHEALTH
TRANSMITTAL LETTER PHY-99
January 2004

TO: Physicians Participating in MassHealth

FROM: Beth Waldman, Acting Commissioner Beth Waldman

RE: *Physician Manual* (Prior Authorization for Certain Therapy Visits)

This letter transmits revisions to the physician regulations about therapy services. Effective February 1, 2004, a provider must obtain prior authorization from MassHealth before providing more than **eight** physical-therapy visits, **eight** occupational-therapy visits, and **15** speech/ language therapy visits (including group therapy and evaluation) to a member within a 12-month period.

The 12-month period for the initial eight or 15 visits begins on the date of the first therapy visit on or after February 1, 2004. For example, if a member's first therapy visit is February 20, 2004, the 12-month period is February 20, 2004, through February 19, 2005. To simplify accounting of therapy visits, and to allow time for providers to request prior authorization without interrupting an established regimen of therapy to members currently receiving therapy services, MassHealth will begin counting therapy visits for dates of service on or after February 1, 2004. Regardless of the number of therapy visits a member has had before February 1, MassHealth will count the first visit occurring on or after February 1, 2004, as the first visit toward the eight or 15 visits that are allowed without prior authorization. No payment is made for services in excess of eight physical therapy, eight occupational therapy, and 15 speech/language therapy visits to a provider in a 12-month period, unless prior authorization has been obtained from MassHealth.

Examples:

1. If a member's first physical-therapy visit after February 1, 2004, is March 22, 2004, then the 12-month period for physical therapy is March 22, 2004, through March 21, 2005. MassHealth will pay the provider for seven additional physical-therapy visits before March 22, 2005, without prior authorization. To avoid disruption in treatment, providers are encouraged to request prior authorization as soon as they believe that medically necessary therapy will exceed the number of visits allowed without prior authorization.

2. If the same member receives occupational therapy in addition to physical therapy, and the first occupational-therapy visit is April 29, 2004, then the 12-month period for occupational therapy is April 29, 2004, through April 28, 2005. MassHealth will pay the provider for seven additional occupational-therapy visits before April 29, 2005, without prior authorization.

Exception: If a member is receiving therapy under a prior authorization given by MassHealth before February 1, 2004, MassHealth will not count visits authorized by that prior authorization toward the initial eight or 15 visits allowed without prior authorization. Rather, after the number of visits approved before February 1, 2004, are provided, or after the prior authorization expires, whichever is sooner, a member may receive eight or 15 therapy visits, as allowed under these new regulations, within a 12-month period before the provider must request another prior authorization.

> **Example:** If a member is receiving speech/language therapy under a prior authorization that was issued before February 1, 2004, and that expires on May 15, 2004, then the 12-month period for speech/language therapy begins on the date of the first visit after the date the prior authorization expires. If this member's next speech/language therapy visit is May 20, 2004, then the 12-month period in this example begins on May 20, 2004. MassHealth will pay for a total of 15 speech/language therapy visits between May 20, 2004, and May 19, 2005, without prior authorization.

Under Transmittal Letter PHY-70, MassHealth did not permit payment for a second comprehensive evaluation. Effective February 1, 2004, MassHealth will cover a second comprehensive evaluation in a 12-month period, subject to prior authorization. A provider must obtain prior authorization for a second comprehensive evaluation in a 12-month period for a member whose level of functioning has decreased significantly or whose diagnosis has changed.

Therapy Visits

In accordance with physician regulations at 130 CMR 433.401, a therapy visit is defined as a personal contact provided as an office or outpatient visit for the purpose of providing a covered physical or occupational therapy service by a physician or licensed physical or occupational therapist employed by the physician. Additionally, speech therapy services provided by a physician as an office visit or outpatient visit is considered a therapy visit.

A physical or occupational therapy visit is characterized by date of service, not by the number of modalities or procedures provided on the date of service, nor by the time required to provide the physical medicine service. The number of units of physical or occupational service codes provided should not exceed four per visit or one hour per visit and should reflect the actual time that the member is being treated.

Requesting Prior Authorization

To request prior authorization, the provider must complete the Request for Prior Authorization form as instructed in MassHealth's billing instructions, or use the Web-based Automated Prior Authorization System (APAS), which is available at www.masshealth-apas.com.

In addition, the provider must complete a Request and Justification for Therapy Services form and attach it to the prior-authorization request, whether the request is submitted on paper or using APAS. The therapist must sign the Request and Justification for Therapy Services form. If a physician will perform the therapy, the physician performing the therapy should sign the form. If you are using APAS, you can either download this MassHealth form from APAS, or complete it on line and submit it electronically as part of the request.

You can also download the Request and Justification form from the MassHealth Provider Services Web site at www.mahealthweb.com. Click on Publications and Forms. If you prefer, you can also request supplies of this form from this Web site or by submitting a written request to the following address or fax number.

MassHealth
Attn: Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: 703-917-4937

When requesting forms, include the name and quantity of the form, your MassHealth provider number, street address (no post office boxes), and contact name and telephone number.

Billing for Services with Prior Authorization

MassHealth will notify the provider and member in writing of its decision on the request for prior authorization. When billing for services, you must enter the prior-authorization number on the claim as indicated below. This prior-authorization number is printed on the approval letter, and if you used APAS to request prior authorization, it is also listed on APAS. When billing for authorized services:

- Enter the six-character prior-authorization number in Item 23D of claim form no. 5 or its electronic equivalent.

- Do not include on the same claim form (or electronic equivalent) any therapy services that are part of the original eight or 15 that do not require prior authorization.

- Submit a separate claim form (or its electronic equivalent) for each type of therapy (physical, occupational, or speech/language) for members who have received authorization for more than one type. (**Note:** Each type of therapy will have a separate prior-authorization number.)

Maintenance Program

The attached revisions to the physician regulations also clarify that MassHealth does not pay for performance of a maintenance program. A maintenance program is defined as repetitive activities intended to maintain function that can be performed safely and effectively without the skilled assistance of a qualified therapist. MassHealth pays for designing a maintenance program and instructing the member, member's family, or other persons in its use as part of a regular treatment visit, not as a separate service.

Revisions to Subchapter 6

This letter also transmits revisions to Subchapter 6 of the *Physician Manual* to reflect the revised maximum number of therapy services that may be provided to a member without prior authorization.

Effective Date

These regulations are effective February 1, 2004.

Questions

If you have any questions about the information in this letter, please call 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, 4-3, 4-4, 4-9 through 4-14, 4-21, 4-22, 4-47, 4-48, 6-3, 6-4, and 6-9 through 6-12

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

Physician Manual

Pages 4-3 and 4-4 — transmitted by Transmittal Letter PHY-95

Pages iv, 4-9 through 4-14, 4-21, 4-22, 4-47, and 4-48 — transmitted by Transmittal Letter PHY-92

Pages 6-3, 6-4, and 6-9 through 6-12 — transmitted by Transmittal Letter PHY-97

4. PROGRAM REGULATIONS

Part 1. General Information

Part 2. Medical Services

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 that has been determined to be therapeutically equivalent (that is, "A-rated") by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

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

Maintenance Program — repetitive activities intended to maintain function that can be performed safely and effectively without the skilled assistance of a qualified therapist.

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by MassHealth. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 433.443(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 433.000.

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.

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.

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

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.

(E) Therapy Services Requiring Prior Authorization. Prior authorization is required for the following therapy services provided by any MassHealth provider to eligible MassHealth members.

(1) more than eight occupational-therapy visits or eight physical-therapy visits, including a comprehensive evaluation and group-therapy visits, for a member within a 12-month period;

(2) more than 15 speech/language therapy visits, including a comprehensive evaluation and group-therapy visits, for a member within a 12-month period; and

(3) a second comprehensive evaluation in a 12-month period for a member whose level of functioning has decreased significantly or whose diagnosis has changed.

(F) 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 MassHealth 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 provided 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, MassHealth will disallow payment for the claimed service.

(C) MassHealth may at its discretion request, and upon such request the physician must provide, 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. MassHealth 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 MassHealth 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 MassHealth as set forth in 130 CMR 450.206. MassHealth 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 MassHealth 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.) MassHealth 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. MassHealth pays for office visits provided for the purposes of family planning. MassHealth 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. MassHealth pays a physician for medical care provided in a hospital emergency department only when the hospital's claim does not include a charge for the physician's services.

(B) Emergency Department Screening Fee. For a member enrolled in the PCC Plan for whom no emergency services were provided, MassHealth pays 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. MassHealth pays 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) MassHealth 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, MassHealth does pay for such visits.

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

(1) MassHealth 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. MassHealth 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. MassHealth 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

MassHealth 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. MassHealth 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)). MassHealth 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 MassHealth, 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 MassHealth 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. MassHealth 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

MassHealth 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.

(J) Family Consultation. MassHealth 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. MassHealth 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. MassHealth pays only for face-to-face contact; telephone contacts are not payable. MassHealth pays for no more than two hours of emergency services per member on a single date of service.

(L) Electroconvulsive Therapy. MassHealth 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. MassHealth pays for a maximum of three weeks of routine inpatient care without prior authorization if the admission has received a preadmission screening number from MassHealth 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, MassHealth 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, MassHealth 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) MassHealth 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 MassHealth's concurrent review process, MassHealth 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. MassHealth 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, subject to all general conditions of payment, including the requirement to obtain prior authorization as described in 130 CMR 433.408.

(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).

(C) The Division does not pay for performance of a maintenance program. The Division pays for designing a maintenance program and instructing the member, member's family, or other persons in its use as part of a regular treatment visit, not as a separate service.

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) 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 Wheelchair Van Transportation. Nonemergency ambulance and wheelchair van transportation requires 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 MassHealth.

(D) Member Reimbursement. MassHealth 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. MassHealth 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. MassHealth 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, and prior authorization after eight visits, including an evaluation and group-therapy visits. The physician's orders for physical and occupational therapy must be renewed in writing every 60 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, and prior authorization after 15 visits, including an evaluation and group-therapy visits.

(2) Service Restrictions. MassHealth does not pay for performance of a maintenance program. MassHealth pays for designing a maintenance program and instructing the member, member's family, or other persons in its use as part of a regular treatment visit, not as a separate service.

(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 MassHealth. 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. MassHealth pays for a prosthetic device only when it is prescribed by an amputee clinic approved by MassHealth.

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) MassHealth pays for mental health center services provided by freestanding mental health centers, community health centers, hospital-licensed health centers, or hospital outpatient departments only when MassHealth 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) MassHealth pays licensed psychologists only for providing psychological testing. MassHealth 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) MassHealth 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.

602 Nonpayable CPT Codes (cont.)

95052	98940	99371	99565
95120	98941	99372	99566
95125	98942	99373	99567
95130	98943	99374	99568
95131	99001	99375	99569
95132	99002	99377	
95133	99024	99378	
95134	99025	99379	
95824	99026	99380	
95965	99027	99401	
95966	99056	99402	
95967	99058	99403	
96000	99071	99404	
96001	99075	99411	
96002	99078	99412	
96003	99080	99420	
96004	99082	99429	
96100	99090	99450	
96105	99091	99455	
96110	99100	99456	
96111	99116	99500	
96115	99135	99501	
96117	99140	99502	
96150	99141	99503	
96151	99142	99504	
96152	99172	99505	
96153	99190	99506	
96154	99191	99507	
96155	99192	99509	
96567	99271	99510	
96902	99272	99511	
97005	99273	99512	
97006	99274	99551	
97014	99275	99552	
97139	99288	99553	
97530	99315	99554	
97537	99316	99555	
97545	99354	99556	
97546	99355	99557	
97601	99356	99558	
97602	99357	99559	
97780	99358	99560	
97781	99359	99561	
97802	99360	99562	
97803	99361	99563	
97804	99362	99564	

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.

Legend:

*: Available free of charge through the Massachusetts Immunization Program for children under 19 years of age.

Centrifuging required: Service Code 99000 may be used only to pay a physician who centrifuges and mails a specimen to a laboratory for analysis. (See 130 CMR 433.439.)

Covered for adults ≥ 19: This code is payable only for adults aged 19 or older.

CPA-2: A completed Certification of Payable Abortion Form must be completed. See 130 CMR 450.234 through 450.260 and 130 CMR 433.455 for more information.

CS-18: A completed Sterilization Consent Form (for members aged 18 through 20) must be completed. See 130 CMR 450.234 through 450.260 and 130 CMR 433.456 through 433.458 for more information.

CS-21: A completed Sterilization Consent Form (for members aged 21 and older) must be completed. See 130 CMR 450.234 through 450.260 and 130 CMR 433.456 through 433.458 for more information.

HI-1: A completed Hysterectomy Information Form must be completed. See 130 CMR 450.234 through 450.260 and 130 CMR 433.459 for more information.

IC: Claim requires individual consideration. See 130 CMR 433.406 for more information.

PA for OMT >8: Prior authorization is required for more than eight osteopathic manipulative therapy visits in a 12-month period.

PA for OT >8: Prior authorization is required for more than eight occupational therapy visits in a 12-month period.

PA for PT >8: Prior authorization is required for more than eight physical therapy visits, regardless of modality, in a 12-month period.

PA for ST >15: Prior authorization is required for more than 15 speech/language therapy visits 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.

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

Service Code and Req. or Limit	
78459	IC
78491	IC
78492	IC
78499	IC
78599	IC
78608	IC
78609	IC
78699	IC
78799	IC
78810	IC
78990	IC
78999	IC
79300	IC
79420	IC
79900	IC
79999	IC
80103	IC
80406	IC
81099	IC
82154	IC
83527	IC
83880	IC
83937	IC
84140	IC
84143	IC
84302	IC
84449	IC
84466	IC
84586	IC
84999	IC
85004	IC
85032	IC
85049	IC
85380	IC
85999	IC
86341	IC
86359	IC
86849	IC
86850	IC
86860	IC
86870	IC
86901	IC
86920	IC
86921	IC
86922	IC
86999	IC
87255	IC
87267	IC
87271	IC
87999	IC; PA
88174	IC
88175	IC
88180	IC
88182	IC
88199	IC
88299	IC
88399	IC
89055	IC
89399	IC
90288	IC
90291	IC
90296	IC
90371	Covered for adults ≥17
90378	IC, PA
90393	IC
90399	IC
90473	IC
90474	IC
90476	IC
90477	IC
90581	IC
90632	Covered for adults ≥17
90660	IC, PA
90665	IC
90690	IC
90692	IC
90693	IC
90707	Covered for adults ≥17
90713	Covered for adults ≥17
90716	Covered for adults ≥17
90719	IC
90725	IC
90727	IC
90732	Covered for adults ≥17
90749	IC, PA
90799	IC
90899	IC

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

Service Code and Req. or Limit		Service Code and Req. or Limit	
90935	For hospitalized member only; not for chronic maintenance	96549	IC
		96913	IC
90937	For hospitalized member only; not for chronic maintenance	96999	IC
		97001	PA for PT >8
90945	For hospitalized member only; not for chronic maintenance	97002	PA for PT >8
		97003	PA for OT >8
90947	For hospitalized member only; not for chronic maintenance	97004	PA for OT >8
		97010	PA for PT >8
90999	IC	97012	PA for PT >8
91123	IC	97016	PA for PT >8
91299	IC	97018	PA for PT >8
92065	IC; PA	97020	PA for PT >8
92250	PA	97022	PA for PT >8
92310	PA	97024	PA for PT >8
92311	PA; includes supply of lenses	97026	PA for PT >8
92312	PA; includes supply of lenses	97028	PA for PT >8
92313	IC; PA; includes supply of lenses	97032	PA for PT >8
92326	PA	97033	PA for PT >8
92499	IC	97034	PA for PT >8
92506	PA for ST >15	97035	PA for PT >8
92507	PA for ST >15	97036	PA for PT >8
92508	PA for ST >15	97039	IC; PA for PT >8
92526	PA for ST >15	97110	PA for PT >8
92610	PA for ST >15	97112	PA for PT >8
92605	IC; PA	97113	IC; PA for PT >8
92606	IC	97116	PA for PT >8
92610	PA	97124	PA for PT >8
92611	PA	97140	PA for PT >8
92613	IC	97150	PA for PT >8
92615	IC	97504	PA for OT >8
92617	IC	97520	PA for OT >8
92700	IC	97532	PA for OT >8
92953	IC	97533	PA for OT >8
93799	IC	97535	PA for OT >8
94642	IC	97542	PA for OT >8
94772	IC	97799	IC
94799	IC	98925	PA for OMT >8
95071	IC	98926	PA for OMT >8
95199	IC, PA	98927	PA for OMT >8
95875	IC	98928	PA for OMT >8
95999	IC	98929	PA for OMT >8
96423	IC	98928	IC
96425	IC	98929	IC
96545	IC	98940	IC

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

Service Code	and Req. or Limit
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
99289	IC
99290	IC
99296	IC
99298	IC
99299	IC
99344	IC
99345	IC
99350	IC
99499	IC
99600	IC

604 HCPCS Level II Service Codes

This section lists Level II HCPCS codes that are payable under MassHealth. Refer to the Centers for Medicare and Medicaid Web site at www.cms.gov/medicare/hcpcs for more detailed descriptions when billing for Level II HCPCS codes provided to MassHealth members.

Service Code	Service Description
A4261	Cervical cap for contraceptive use (IC)
A4266	Diaphragm for contraceptive use
A4267	Contraceptive supply, condom, male, each
A4268	Contraceptive supply, condom, female, each
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each
H2011	Crisis intervention service, per 15 minutes
J0170	Injection, adrenalin, epinephrine, up to 1 ml ampule (IC)
J0256	Injection, alpha 1- proteinase inhibitor – human, 10 mg (IC)
J0270	Injection, alprostadil, 1.25 mcg (PA) (IC)
J0290	Injection, ampicillin sodium 500 mg (IC)
J0295	Injection, ampicillin sodium / sulbactam sodium, per 1.5 g (IC)
J0456	Injection, azithromycin, 500 mg (IC)
J0460	Injection, atropine sulfate, up to 0.3 mg (IC)
J0475	Injection, baclofen, 10 mg (PA) (IC)
J0476	Injection, baclofen, 50 mcg for intrathecal trial (PA) (IC)
J0530	Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units (IC)
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units (IC)
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units (IC)
J0560	Injection, penicillin G benzathine, up to 600,000 units (IC)
J0570	Injection, penicillin G benzathine, up to 1,200,000 units (IC)
J0580	Injection, penicillin G benzathine, up to 2,400,000 units (IC)
J0585	Botulinum toxin type A, per unit (PA) (IC)
J0587	Botulinum toxin type B, per 100 units (PA) (IC)
J0640	Injection, leucovorin calcium, per 50 mg (IC)
J0690	Injection, cefazolin sodium, 500 mg (IC)
J0694	Injection, cefoxitin sodium, 1 g (IC)
J0696	Injection, ceftriaxone sodium, per 250 mg (IC)
J0697	Injection, sterile cefuroxime sodium, per 750 mg (IC)
J0702	Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg (IC)
J0704	Injection, betamethasone sodium phosphate, per 4 mg (IC)
J0780	Injection, prochlorperazine, up to 10 mg (IC)
J0880	Injection, darbepoetin alfa, 5 mcg (PA) (IC)
J0900	Injection, testosterone enanthate and estradiol valerate, up to 1 cc (IC)
J1020	Injection, methylprednisolone acetate, 20 mg (IC)
J1030	Injection, methylprednisolone acetate, 40 mg (IC)
J1040	Injection, methylprednisolone acetate, 80 mg (IC)
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (150 mg Depo Provera) (IC)
J1056	Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg (5 mg/25 mg Lunelle) (IC)
J1060	Injection, testerone cypionate and estradiol cypionate, up to 1 ml (IC)