Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter PRT-24
October 2012

TO: Prosthetic Providers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: *Prosthetics Manual* (Changes to MassHealth Prosthetic Regulations)

MassHealth has revised its prosthetic regulations to allow entities who employ a certified mastectomy fitter (CMF), but do not have a certified prosthetist on staff, to solely provide limited prosthetic services pertaining to breast mastectomy (breast prosthesis and related supplies).

These amendments are effective November 9, 2012.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

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

Prosthetics Manual

Pages vi, 4-1 through 4-4, 4-7, and 4-8

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(The pages listed here are no longer in effect.)

Prosthetics Manual

Page vi — transmitted by Transmittal Letter PRT-23

Pages 4-1 through 4-4 — transmitted by Transmittal Letter PRT-16

Pages 4-7 through 4-8 — transmitted by Transmittal Letter PRT-14

6. Service Codes

428.401: Introduction

130 CMR 428.000 states the requirements and procedures for the purchase and repair of prosthetic devices, customized equipment, and supplies under MassHealth. All providers of prosthetic services participating in MassHealth must comply with the regulations governing MassHealth, including, but not limited to, MassHealth regulations set forth in 130 CMR 428.000 and in 130 CMR 450.000.

428.402: Definitions

The following terms used in 130 CMR 428.000 have the meanings given in 130 CMR 428.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 428.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 428.000 and in 130 CMR 450.000.

Accessory Equipment — equipment that is fabricated primarily and customarily to modify or enhance the usefulness or functional capability of another piece of prosthetic equipment and that is generally not useful in the absence of such prosthetic equipment.

Adjusted Acquisition Cost — except where the manufacturer is the provider, the price paid by the provider to the manufacturer or any other supplier for prosthetic devices, customized equipment, or supplies, excluding all associated costs such as shipping, handling, and insurance costs in accordance with 130 CMR 428.422. Where the manufacturer is the provider, the adjusted acquisition cost is the actual cost of manufacturing such prosthetic devices, customized equipment, or supplies.

American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC) — the national certifying and accrediting body for the orthotic, prosthetic, and pedorthic professions.

Board of Certification/Accreditation, International (BOC) — a credentialing entity for practitioners and suppliers of comprehensive orthotic and prosthetic care.

Certified Mastectomy Fitter (CMF) — a health care professional with current certification through the ABC or BOC who is specifically educated and trained in the provision of breast prostheses and post-mastectomy services, including patient assessment, formulation of a treatment plan, implementation of the treatment plan and follow-up, and practice management.

Date of Service — the date the prosthesis is delivered and fitted to the MassHealth member. If the prosthetic service involves a series of fittings and adjustments, the date of service is the date on which the final adjustment is made. If the prosthetic service involves only the provision of a service (for example, a repair), then the date of service is the date on which the service was completed.

Discount — any remuneration or reduction of payment of any kind, whether direct or indirect, received by the provider.

Nursing Facility — a licensed facility that meets the provider-eligibility and certification requirements of 130 CMR 456.404 or 456.405 and whose members meet the medical eligibility

criteria under 130 CMR 456.409. Nursing facilities do not include facilities such as rest homes, state schools, and state hospitals.

Nursing Facility Visit — a visit by a provider to a nursing facility for the purpose of providing prosthetic services.

Prosthesis (or Prosthetic Equipment) — an artificial replacement for a missing body part, such as an artificial limb or total joint replacement.

Prosthetic Service — the purchase, customization, fitting, repair, replacement, or adjustment of a prosthesis or component part, or other activity performed or equipment provided in accordance with 130 CMR 428.000.

Prosthetic Supplies — products that are:

(1) fabricated primarily and customarily to fulfill a medical purpose;
(2) used in conjunction with a prosthesis or prosthetic equipment;
(3) generally not useful in the absence of a prosthesis; and
(4) non-reusable and disposable.

Prosthetics — the design, fitting, and attachment of an artificial replacement of a missing body part.

Service Facility — the place of business, physically accessible to MassHealth members, where prosthetic services, especially those involving fitting, adjustment, repair, and replacement of prostheses, are performed. A service facility does not include a MassHealth member's place of residence.

428.403: Eligible Members

(A) (1) MassHealth Members. MassHealth covers prosthetic services only when provided to eligible MassHealth members, subject to the restrictions and limitations in 130 CMR 428.000 and 450.000. 130 CMR 450.105 specifically states, for each coverage type, which services are covered and which members are eligible to receive those services.
(2) Age Limitations. In addition to any other restrictions and limitations set forth in 130 CMR 428.000 and 450.000, MassHealth covers prosthetic services only when provided to eligible MassHealth members, subject to the age limitations set forth in Subchapter 6 of the *Prosthetics Manual*.
(3) Recipients of the 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) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

428.404: Provider Eligibility

For services described in 130 CMR 428.000, the MassHealth agency pays only those providers of prosthetic services who are participating in MassHealth as of the date of service.

(A) In State. To participate in MassHealth, a provider with a service facility in Massachusetts must:

(1) primarily engage in the business of providing prosthetic and repair services to the public;
(2) meet all state and local requirements for engaging in such business;
(3) be or employ a prosthetist currently certified by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics Inc. (ABC), or the Board of Certification/Accreditation, International (BOC), unless the provider intends to solely provide breast prostheses and accessories, in which case the provider must employ, for each service facility location, at least one full-time certified mastectomy fitter, who is currently certified by the ABC or BOC.
(4) be a Medicare provider;
(5) have a service facility that is physically accessible to MassHealth members during reasonable business hours;
(6) maintain a visible sign identifying the business and hours of operation;
(7) maintain a primary business telephone listed under the name of the business in a local directory. The exclusive use of a pager, answering machine, or cell phone is prohibited; and
(8) obtain a provider number from MassHealth and, if the provider intends to solely provide breast prostheses and accessories, be designated by the MassHealth agency as a specialty provider of certified mastectomy fitter services.

(B) Out of State. A provider with no service facility in Massachusetts may participate in MassHealth only if the provider participates in the Medicaid program of the state in which the provider primarily conducts business and otherwise meets the requirements of 130 CMR 428.404(A). Such a provider may receive payment for MassHealth services only as set forth in 130 CMR 450.109.

428.405: Provider Responsibility

(A) The provider must ensure that all prosthetic equipment and supplies are:

(1) clean (sterilized when appropriate);
(2) in proper working condition;
(3) functional;
(4) free from defects; and
(5) new and unused at the time of purchase.

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(B) The provider must ensure that all prosthetic services are the most cost effective, given the medical need for which they are prescribed and the member's physical limitations.

(C) The provider must make a reasonable effort to purchase the item from the least costly reliable source by comparing prices charged by different suppliers for comparable items.

428.406: Covered Services

The MassHealth agency pays for only those prosthetic services listed in, and subject to the service limitations set forth in, Subchapter 6 of the *Prosthetics Manual*.

428.407: Service Limitations

The service limitations set forth in Subchapter 6 of the *Prosthetics Manual* apply, subject to the Early and Periodic Screening, Diagnosis, and Treatment provisions set forth in 130 CMR 450.144(A).

428.408: Noncovered Services

The MassHealth agency does not pay for any of the following:

(A) any prosthetic services for which, under comparable circumstances, the provider does not customarily bill private patients who do not have health insurance;

(B) nonmedical prosthetic services. Equipment that is used primarily and customarily for a nonmedical purpose is not considered medical equipment, even if such equipment has a medically related use;

(C) storage of prosthetic equipment or associated items; and

(D) prosthetic services that are not both medically necessary in accordance with 130 CMR 450.204 and reasonable for the treatment of a member's condition. This includes services that:

(1) cannot reasonably be expected to make a meaningful contribution to the treatment of a member's condition or the performance of the member's activities of daily living; and
(2) are more costly than a medically comparable and suitable alternative or that serve essentially the same purpose as equipment already available to the member.

428.409: Prescription Requirements

(A) The purchase of prosthetic equipment requires a written prescription signed by a licensed physician or an independent nurse practitioner. The prescription must be written on the prescriber's prescription form and must include the following information:

(1) the member's name and address;
(2) the member's MassHealth identification number;
(3) specific identification of the prescribed item;
(4) medical justification for the use of the item, including the member's diagnosis;
(5) the prescriber's address and telephone number; and
(6) the date on which the prescription was signed by the prescriber.

(B) The provider must keep the prescription on file for the period of time required by 130 CMR 450.205.

428.414: Medicare Coverage

(A) For Medicare and third-party-liability coverage, see 130 CMR 450.316 through 450.318.

(B) For Medicare-covered services that are provided to members who receive Medicare Part B benefits, the MassHealth agency does not require prior authorization.

(C) When Medicare denies a claim for prosthetic services or considers the services uncovered, the MassHealth agency requires prior authorization for those services that would require prior authorization for members without Medicare.

428.415: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary prosthetics services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 428.000, and with prior authorization.

(130 CMR 428.416 through 428.419 Reserved)

428.420: Payment for Prosthetic Services

(A) Payment to a provider for prosthetic equipment and supplies is subject to the conditions and limitations in 130 CMR 428.000 and 450.000, and will be the lower of:

(1) the provider's usual and customary charge to the general public; or

(2) the fee set forth in the schedule of maximum allowable fees established by the Massachusetts Division of Health Care Finance and Policy.

(B) Payment for the following services is included in the provider payment under 130 CMR 428.420(A). No separate payment is allowed for:

(1) the fitting of the prosthesis;

(2) instructing the member in the use of the prosthesis;

(3) the cost of the component parts and accessory equipment;

(4) repairs due to normal wear and tear within 90 days of the date of delivery; and

(5) adjustments to the prosthesis and any prosthetic component made when fitting the prosthesis and for 90 days from the date of delivery, when the adjustments are not necessitated by changes in the member's functional abilities.

428.421: Individual Consideration

When the rate of payment for the purchase or repair of certain prosthetic equipment has not been established by the Division of Health Care Finance and Policy, the MassHealth agency pays for the service based on individual consideration, subject to all other conditions of payment. Such items are identified in Subchapter 6 of the *Prosthetics Manual* by the designation "(I.C.)" next to the description of the item or service. The MassHealth agency determines the rate of payment for an individual-consideration item or service based on the provider's report of services and a current invoice that indicates the provider's adjusted acquisition cost as defined in 130 CMR 428.421 and 428.422. Payment for the fitting of a prosthesis is included in the adjusted acquisition cost. Providers must maintain adequate records to document the individual consideration claim and must provide these documents to the MassHealth agency and the Attorney General's Medicaid Fraud Control Unit upon demand (see 130 CMR 450.205). Payment to a provider for an individual consideration claim is the lower of:

(A) the provider's usual and customary charge to the general public; or

(B) the adjusted acquisition cost of the item plus a markup not to exceed:

(1) 70 percent for any item whose adjusted acquisition cost is less than $100;

(2) 50 percent for any item whose adjusted acquisition cost is $100 or greater and less than $200;

(3) 45 percent for any item whose adjusted acquisition cost is $200 or greater and less than $300; or

(4) 40 percent for any item whose adjusted acquisition cost is $300 or greater.