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

MassHealth
Transmittal Letter RHB-20
January 2012

TO: Rehabilitation Centers Participating in MassHealth

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

RE: Revisions to Subchapter 6 (Service Codes and Descriptions)

Section 6507 of the federal Patient Protection and Affordable Care Act (Public Laws 111-148 and 111-152), as implemented by the Centers for Medicare & Medicaid Services (CMS), requires state Medicaid agencies to incorporate compatible methodologies of the National Correct Coding Initiative (NCCI). NCCI was implemented by CMS to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. This requirement is effective for claims for dates of service on or after October 1, 2010, that are processed by MassHealth on or after April 1, 2011.

Medically Unlikely Edits (MUEs)

MUEs are units-of-service edits that define for certain HCPCS/CPT codes the number of units of service beyond which the reported number of units of service is unlikely to be correct. Providers are advised to review *All Provider Bulletin 209*, issued in April 2011, which describes in greater detail NCCI MUE requirements and provides the link to the CMS Web site that providers may access to obtain a full list codes to which MUEs apply.

To conform to NCCI coding edits, MassHealth has updated Subchapter 6 of the *Rehabilitation Center Manual* to reflect revisions made to the maximum units allowed for Service Codes **92507, 92508, and 97150** from four units per visit to one unit per visit. These service codes were previously payable for MassHealth based on a 15-minute unit (maximum four units per visit), and are now payable based on a single unit (maximum one unit per visit) instead of on minutes.

Consequently, the Division of Health Care Finance and Policy (DHCFP) has revised the rates for these three codes. The new rates for these codes take effect for dates of service beginning June 1, 2011. MassHealth had previously informed providers of these changes through a message text issued in June 2011.

Fee Schedule

If you wish to obtain a fee schedule, you may download the Division of Health Care Finance and Policy regulations at no cost at www.mass.gov/dhcfp. You may also purchase a paper copy of Division of Health Care Finance and Policy regulations from either the Massachusetts State Bookstore or from the Division of Health Care Finance and Policy (see addresses and telephone numbers below). You must contact them first to find out the price of the paper copy of the publication. The regulation title is 114.3 CMR 39.00: Rehabilitation Clinic Services, Audiological Services, Restorative Services.

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

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

Procedure-to-Procedure Code Pair Editing

In addition to implementing MUEs as described above, MassHealth has also implemented NCCI procedure-to-procedure code pair editing, which are automated prepayment edits that prevent improper payment when certain service codes are billed by the same provider for the same member on the same date of service. Rehabilitation centers are again advised to review *All Provider Bulletin 209*, which describes in greater detail NCCI procedure-to-procedure edit requirements and provides the link to the CMS Web site that providers may access to obtain a full list of codes to which procedure-to-procedure edits apply.

Claims Processing

All rehabilitation center claims submitted to MassHealth for dates of service on or after October 1, 2010, that are processed on or after April 1, 2011, will be edited for NCCI procedure-to-procedure edits. With the exception of claims for service codes 92507, 92508 and 97150, rehabilitation center claims submitted to MassHealth for dates of service on or after October 1, 2010, that are processed on or after April 1, 2011, will be edited for NCCI MUEs. Claims with Service Codes 92507, 92508, and 97150 with dates of service on or after October 1, 2010, that are processed on or after June 1, 2011, will be edited for MUEs. Any such claims using HCPCS/CPT codes that include code pairs on the NCCI edit list, or using codes billed with units of service greater than the MUE limit, will result in payment denials.

Due to the timing of system updates, MassHealth may need to later reprocess and adjust claims to ensure proper NCCI editing.

Please note that MUE limits and procedure-to-procedure code edits supersede any approved prior authorizations (PAs) n the system. Claims over the MUE limit or that include code pairs on the NCCI edit lists will be denied even if they have an approved PA that would otherwise allow coverage and payment of the service. If a claim with such an approved PA is denied solely due to NCCI editing, providers should request agency review of the denial. Consult *All Provider Bulletin 209* for further information about NCCI editing, including Agency review and appeals of claims denials.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site 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.)

Rehabilitation Center Manual

Pages vi, vii, and 6-1 through 6-4

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

Rehabilitation Center Manual

Pages vi and vii — transmitted by Transmittal Letter RHB-15

Pages 6-1 and 6-2 — transmitted by Transmittal Letter RHB-18

Pages 6-3 and 6-4 — transmitted by Transmittal Letter RHB-16

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Each manual in the series contains administrative regulations, billing regulations, program regulations, service codes and descriptions, billing instructions, and general information. MassHealth's regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. Regulations promulgated by MassHealth are assigned Title 130 of the Code. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other provider manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For therapists, those matters are covered in 130 CMR Chapter 430.000, reproduced as Subchapter 4 in the *Rehabilitation Center Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which provide instructions for substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth's effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and with MassHealth members.

430.601: Introduction

All rehabilitation centers participating in MassHealth must comply with the regulations of MassHealth, including, but not limited to, 130 CMR 430.000 and 450.000.

(A) Definitions.

(1) Eligible Provider of Rehabilitation Center Services – a freestanding center providing rehabilitation services that is licensed by the Massachusetts Department of Public Health and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

(2) Group Session – therapeutic services directed toward more than one patient in a single visit, using group participation as a treatment technique.

(3) Maintenance Program – repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment and skill of a licensed therapist for safety and effectiveness.

(4) Occupational Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence, preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

(5) Physical Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

(6) Physician's Comprehensive Rehabilitation Evaluation – a cardiopulmonary, neuromuscular, orthopedic, and functional assessment performed at a rehabilitation center by a physician.

(7) Rehabilitation – the process of providing, in a coordinated manner, those comprehensive services deemed appropriate to the needs of a physically disabled individual, in a program designed to achieve objectives of improved health and welfare with the realization of his or her maximum physical, social, psychological, and vocational potential.

(8) Speech/Language Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of presence of a communication disability), and those that impair comprehension, spoken, written, or other symbol systems used for communication.

(9) Therapist's Evaluation – an evaluation performed by a physical therapist, an occupational therapist, or a speech therapist at a rehabilitation center.

(10) Therapy Visit – a personal contact with a member by a licensed physical therapist, occupational therapist, or speech and language therapist for the purpose of providing a covered service.

430.601: Introduction (cont.)

(B) Eligible Members.

(1) (a) MassHealth Members. MassHealth covers rehabilitation services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105 specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(b) 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.

(2) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

(C) General Requirements.

(1) The rate of payment for a service is the lower of either the provider's usual fee to patients other than MassHealth members or the amount in the applicable Division of Health Care Finance and Policy fee schedule.

(2) The rates of payment do not apply to the following services:

(a) medical services except as required for a comprehensive rehabilitation evaluation;

(b) psychology services; and

(c) audiology services.

(D) Prior Authorization.

(1) MassHealth requires rehabilitation centers to obtain prior authorization for the following services to eligible MassHealth members. (See also 130 CMR 450.303.)

(a) more than 20 occupational-therapy visits or 20 physical-therapy visits, including group-therapy visits, for a member in a 12-month period; and

(b) more than 35 speech/language therapy visits, including group-therapy visits, for a member in a 12-month period.

(2) The rehabilitation center must submit all prior-authorization requests in accordance with the instructions in Subchapter 5 of the *Rehabilitation Center Manual*. 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.

(E) Maintenance Programs.

(1) MassHealth pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. MassHealth does not pay for performance of a maintenance program, except as provided in 130 CMR 430.601(E)(2).

(2) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

602 Service Codes and Descriptions

(A) MassHealth pays for the services represented by the codes listed in Subchapter 6 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 430.000 and 450.000. A rehabilitation center may request prior authorization for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age, even it if is not designated as covered or payable in Subchapter 6 of the *Rehabilitation Center Manual.*

(B) A unit is defined as a specified period of time to be used when billing on the MassHealth-designated claim form or when requesting services on the MassHealth-designated prior-authorization form. A unit may equal 15 minutes or one hour, or may not have a defined time frame, depending upon the particular service code.

(C) Some service codes require prior authorization (P.A.). See 130 CMR 430.601(D) for prior authorization requirements.

Service Code	Modifier	Service Description
		Therapist Services
97799	GP	Unlisted physical medicine/rehabilitation service or procedure, services delivered under an outpatient physical therapy plan of care (each 15 minutes, maximum six units per visit) (use to bill for treatment provided by a physical therapist)
97799	GO	Unlisted physical medicine/rehabilitation service or procedure, services delivered under an outpatient occupational therapy plan of care (each 15 minutes, maximum six units per visit) (use to bill for treatment provided by an occupational therapist)
92507		Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual (maximum one unit per visit) (use to bill for treatment provided by a speech therapist)
97150	GP	Therapeutic procedure(s), group (two or more individuals), services delivered under an outpatient physical therapy plan of care (maximum one unit per visit) (use to bill for group physical therapy session)
97150	GO	Therapeutic procedure(s), group (two or more individuals), services delivered under an outpatient occupational therapy plan of care (maximum one unit per visit) (use to bill for group occupational therapy session)
92508		Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals (maximum one unit per visit (use to bill for group speech therapy session)
97001		Physical therapy evaluation (per hour, maximum two hours) (use to bill for adult evaluation by physical therapist)
97003		Occupational therapy evaluation (per hour, maximum two hours) (use to bill for adult evaluation by occupational therapist)
92506		Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status (per hour, maximum three hours) (use to bill for adult evaluation by speech therapist)

602 Service Codes and Descriptions (cont.)

Service Code	Modifier	Service Description
97001	HA	Physical therapy evaluation, child/adolescent program (per hour, maximum three hours) (use to bill for pediatric (age 21 and younger) evaluation by physical therapist)
97003	HA	Occupational therapy evaluation, child/adolescent program (per hour, maximum three hours) (use to bill for pediatric (age 21 and younger) evaluation by occupational therapist)
92506	HA	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status, child/adolescent program (per hour, maximum four hours) (use to bill for pediatric (age 21 and younger) evaluation by speech therapist)
		Physician Services
99203		Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of low complexity
99205		Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (written report required): - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity
99212		Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a problem-focused history; - a problem-focused examination; - straightforward medical decision making
99214		Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components (written report required): - a detailed history; - a detailed examination; - medical decision making of moderate complexity
99215		Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components (written report required): - a comprehensive history; - a comprehensive examination; - medical decision making of high complexity