Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter PHY-123
January 2009

TO: Physician Providers Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: *Physician Manual* (Application of Fluoride Varnish by Pediatricians and Other Qualified Health Care Professionals)

This letter transmits revisions to the MassHealth physician regulations at 130 CMR 433.000 effective October 1, 2008. The revised regulations allow pediatricians and other qualified health care professionals to apply medically necessary fluoride varnish to eligible MassHealth members under age 21.

Covered Service

Effective October 1, 2008, physicians and other qualified health care professionals may apply fluoride varnish to eligible MassHealth members under age 21. In general, MassHealth expects that this will occur during a pediatric preventive care visit. The purpose of applying fluoride varnish during a well child visit is to increase access to preventive dental treatment in an effort to intercept and prevent early childhood caries in children at moderate to high risk for dental caries.

Please note: This service does not require a referral for members of the PCC Plan.

Eligible Members

This service is primarily intended for children up to age 3; however, the service is allowed for children up to age 21 who are eligible for MassHealth.

Qualified Providers

Physicians, physician assistants, nurse practitioners, registered nurses, and licensed practical nurses who complete the required training as described below, are eligible to apply the fluoride varnish subject to the limitations of state law.

Required Training

Providers must complete a MassHealth-approved training program on how to apply fluoride varnish, maintain proof of completion of the training, and provide such documentation to MassHealth upon request. For a list of MassHealth-approved training programs and additional information and resources, please visit the MassHealth Web site page that will be available on Monday, February 2, 2009, www.mass.gov/masshealth/fluoridevarnish.

Restrictions/Limitations

Fluoride varnish application is not recommended to exceed one application every 180 days from first tooth eruption (usually at 6 months) to the third birthday. This service is recommended during a well child visit and will be delivered along with oral health anticipatory guidance that includes patient self-management goals as well as appropriate dental referral, if necessary.

Communications

Any member without a dental provider should be referred to an appropriate dental provider. MassHealth Dental Customer Service can assist members in locating a dental provider. MassHealth Dental Customer Service can be reached at 1-800-207-5019, or e-mail your inquiry to inquiries@masshealth-dental.net.

Billing Requirements

Providers must submit claims for fluoride varnish services in accordance with applicable program regulations. Providers should bill MassHealth with Service Code D1206 on the MassHealth Claim Form No. 5 or transmitted through the 837P format. Physicians should **not** use the mid-level modifiers (SA, SB, or HN) when submitting a claim for fluoride varnish services provided by a qualified staff member as listed in 130 CMR 433.448(C) under the supervision of a physician.

For MassHealth managed care organization (MCO) members, providers must contact the appropriate MCO customer service center listed below.

Boston Medical Center HealthNet Plan: 1-888-900-1451
Fallon Community Health Plan: 1-866-275-3247
Network Health: 1-888-257-1985
Neighborhood Health Plan: 1-800-462-5449

If you have any questions about the information in this bulletin, 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.)

Physician Manual

Pages iv-a, 4-39 through 4-44, 6-11, and 6-12

OBSOLETE MATERIAL

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

Physician Manual

Pages iv-a and 4-39 through 4-42 — transmitted by Transmittal Letter PHY-122

Pages 4-43 and 4-44 — transmitted by Transmittal Letter PHY-109

Pages 6-11 and 6-12 — transmitted by Transmittal Letter PHY-121

4. Program Regulations (cont.)

MassHealth-covered medications.

(2) Medicare Part D One-Time Supplies. The MassHealth agency pays for one-time supplies of prescribed medications, as described in 130 CMR 406.414(C)(2)(a) and (b), if the medication is a MassHealth-covered medication and the MassHealth member would otherwise be entitled to MassHealth pharmacy benefits but for being eligible for Medicare prescription drug coverage. MassHealth prior authorization does not apply to such one-time supplies. The MassHealth agency pays for the one-time supplies in all instances in which the pharmacist cannot bill a Medicare Part D prescription drug plan at the time the prescription is presented. The MassHealth agency pays for a one-time 72-hour supply of prescribed medications.

(3) Cost-Sharing Assistance for MassHealth Members Enrolled in a Medicare Part D Prescription Drug Plan. For the purpose of 130 CMR 433.444(C)(3)(a) and (b), the "applicable MassHealth copayment" is the copayment the MassHealth member would pay for prescription drugs if the drugs were covered by MassHealth and not covered by Medicare Part D. MassHealth members who are enrolled in a Medicare Part D prescription drug plan and are charged a copayment or deductible in excess of the member's applicable MassHealth copayment for a drug that MassHealth would otherwise cover, must pay the applicable MassHealth copayment and the MassHealth agency pays the difference between the applicable MassHealth copayment and the amount charged by the Medicare Part D prescription drug plan.

433.445: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from the MassHealth agency for drugs identified by the MassHealth agency 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 the MassHealth agency 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 the MassHealth agency approves the request, it will notify the pharmacy and the member.

(C) The MassHealth agency 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).) The MassHealth agency acts on requests for prior authorization for a 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.

(E) 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 406.000. MassHealth evaluates the prior-authorization status of drugs on an ongoing basis, and updates the MassHealth Drug List accordingly.

433.446: Pharmacy Services: Member Copayments

Under certain conditions, the MassHealth agency requires that members make a copayment to the dispensing pharmacy for each original prescription and for each refill for all drugs (whether prescription or over-the-counter) covered by MassHealth. The copayment requirements are detailed in 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. The MassHealth agency 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. The MassHealth agency does not pay separately for any oral drugs dispensed in the office for which the physician has not requested and received prior authorization from the MassHealth agency, with the exception of oral vaccines and oral radiopharmaceuticals, which do not require prior authorization. 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. The MassHealth agency 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.

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

The MassHealth agency pays for all medically necessary physician services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 433.000, and with prior authorization.

433.449: Fluoride Varnish Services

(A) Eligible Members. Members must be under the age of 21 to be eligible for the application of fluoride varnish.

(B) Qualified Providers. Physicians, nurse practitioners, registered nurses, licensed practical nurses, and physician assistants may apply fluoride varnish subject to the limitations of state law. Providers must complete a MassHealth-approved training on the application of fluoride varnish, maintain proof of completion of the training, and provide such proof to the MassHealth agency upon request.

(C) Billing for an Office Visit and Fluoride Varnish Treatment/Procedure. A physician may bill for fluoride varnish services provided by the physician or a qualified staff member as listed in 130 CMR 433.449(B) under the supervision of a physician. The physician may bill for an office visit, in addition to the fluoride varnish application, only if fluoride varnish was not the sole service, treatment, or procedure provided during the visit.

(D) Claims Submission. Physicians and independent nurse practitioners may submit claims for fluoride varnish services when they provide those services directly to MassHealth members. These are the only MassHealth provider types who may bill for this service independently under these regulations. A physician may also submit claims for fluoride varnish services that are provided by nurse practitioners, registered nurses, licensed practical nurses, and physician assistants according to 130 CMR 433.449(C). See Subchapter 6 of the *Physician Manual* for service codes and descriptions.

(130 CMR 433.450 Reserved)

Part 3. Surgery Services

433.451: Surgery Services: Introduction

(A) Provider Eligibility. The MassHealth agency will pay a physician for surgery only if the physician is scrubbed and present in the operating room during the major portion of the operation. (See 130 CMR 433.421(D)(1) for the single exception to this requirement.)

(B) Nonpayable Services. The MassHealth agency does not pay for
(1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment. This specifically includes, but is not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries;
(2) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment);
(3) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the

physical effects of physical disease or defect, or traumatic injury;
(4) services billed under codes listed in Subchapter 6 of the *Physician Manual* as not payable;
(5) services otherwise identified in MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable; and
(6) services billed with otherwise-covered service codes when such codes are used to bill for nonpayable circumstances as described in 130 CMR 433.404.

433.452: Surgery Services: Payment

The maximum allowable fees for the surgery services apply to surgery procedures performed in any setting. The MassHealth agency pays a physician for either a visit or a treatment/procedure, whichever commands a higher fee. The MassHealth agency does not pay for both a visit and a treatment/procedure provided to a member on the same day when they are performed in the same location. All maximum allowable fees for surgery procedures include payment for the initial application of casts, traction devices, or similar appliances.

(A) Obstetrics. Obstetric fees include payment for procedures performed and care given to a member in a hospital or at home. However, the MassHealth agency will give individual consideration to a claim for extended obstetric preoperative or postoperative care due to unusual circumstances, if the physician requests it and attaches adequate medical documentation to the claim form.

(B) Inpatient Services.
(1) For surgery procedures performed on an inpatient in a licensed hospital, the fees include payment for preoperative diagnosis and postoperative care during the period of hospitalization.
(2) The MassHealth agency will give individual consideration to a claim for extended preoperative or postoperative care due to unusual circumstances if the physician requests it and attaches adequate medical documentation to the claim form.
(3) A physician who performs an inpatient surgery procedure but does not provide the postoperative care will be paid 85 percent of the maximum allowable fee. The physician providing the postoperative care will be paid according to the applicable office, hospital, or home visit fee.

(C) Surgical Assistants. The MassHealth agency pays a surgical assistant at 15 percent of the allowable fee for the surgical procedure. The MassHealth agency will not pay for a surgical assistant if a surgical assistant is used in less than five percent of the cases for that procedure nationally. In addition, the MassHealth agency will not pay for a surgical assistant if
(1) any component of the surgery is billed using a team surgery modifier pursuant to 130 CMR 433.452(D) or a two-surgeon modifier pursuant to 130 CMR 433.452(E); or
(2) the surgery services were provided in a teaching hospital that has an approved training program related to the medical specialty required for the surgical procedure and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the MassHealth agency will pay for a surgical assistant if the member's medical record documents that a qualified resident was unavailable at the time of the surgery.

(D) Team Surgery. Under some circumstances, the MassHealth agency pays for highly complex surgical procedures requiring the concomitant services of more than two surgeons as "team surgery." The MassHealth agency pays a single consolidated payment for team surgery to the director of the surgical team. To receive payment, the director of the team must use the team surgery modifier. Payment includes all surgical assistant fees. The director of the surgical team is

expected to distribute the MassHealth payment to the other physician members of the surgical team.

(E) Two Surgeons (Co-Surgery). The MassHealth agency pays for co-surgery when two surgeons work together as primary surgeons performing distinct parts of a reportable procedure. To receive payment, each surgeon must use the two surgeons modifier. The MassHealth agency pays 57.5 percent of the allowable fee to each of the two surgeons. Payment includes all surgical assistant fees.

(F) Multiple Procedures. In most circumstances, the MassHealth agency pays for only one operative procedure in a single operative session. For example, it is inappropriate to request payment for both an exploratory laparotomy and an appendectomy, or for both an arthrotomy and a meniscectomy. When two definitive procedures are performed during the same operative session, and neither procedure is designated "I.P." (for independent procedure - see 130 CMR 433.452(G), the full maximum allowable fee will be paid for one procedure, and 50 percent of the maximum allowable fee will be paid for each additional procedure.

(G) Independent Procedures. A number of surgery procedures are designated "I.P." in Subchapter 6 of the *Physician Manual*. I.P. is an abbreviation for independent procedure. An independent procedure is reimbursable only when no other procedure is performed during the same operative session, unless one of the exceptions in 130 CMR 433.452(G)(1) through (3) applies.

(1) When during the same operative session an additional surgery procedure performed by the same physician is designated "I.P." and requires an unrelated operative incision, the full maximum allowable fee will be paid for the procedure with the largest fee, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein. In the event that two or more procedures are scheduled at the largest amount, the full maximum allowable fee will be paid for only one of the procedures, and 50 percent of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein.

(2) When during the same operative session one or more of the surgery procedures performed by the same physician is designated "I.P." and does not require an unrelated operative incision, the maximum allowable fee will be paid for the procedure commanding the largest fee, and no payment will be made for any other procedure.

(3) When during the same operative session all of the surgery procedures performed by the same physician are designated "I.P." and one or more requires an unrelated operative incision, payment is determined on the basis of individual consideration.

(130 CMR 433.453 Reserved)

433.454: Anesthesia Services

(A) Payment.

(1) Payment Determination. Payment for anesthesia services is determined using base anesthesia units and time units. To determine payment, the MassHealth agency multiplies the anesthesia unit fee established by DHCFP by the time units reported on the claim pursuant to 130 CMR 433.454(A)(2)(c), plus the number of base units, if any have been set by DHCFP. The number of base units is the same for a surgical procedure, regardless of the type of anesthesia administered, including acupuncture (see 130 CMR 433.454(C)).

(2) Calculation.

(a) Anesthesia Units. The MassHealth agency pays for anesthesia services by multiplying the time units plus any base anesthesia units by the unit fee established by DHCFP. If DHCFP has not established base anesthesia units for a service, the MassHealth agency pays using time units only.

(b) Determining Payable Anesthesia Time. Payable anesthesia time starts when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or equivalent area. Payable anesthesia time ends when the patient may be safely placed under postoperative supervision.

(c) Reporting Time Units. A provider's claim must report only payable time units. It must not include base anesthesia units or units that exceed the criteria described in 130 CMR 433.454(A)(1)(b) in the number of units field on the claim. To calculate the correct number of time units, the provider must determine the number of 15-minute intervals of payable anesthesia time plus any remaining fraction, provided such fraction equals or exceeds five minutes.

(3) Multiple Surgery Procedures. When anesthesia is administered for multiple surgery procedures, the MassHealth agency applies only the base anesthesia units for the procedure with the largest number of units to determine the maximum allowable fee.

(B) Services Provided by a Nurse-Anesthetist.

(1) Anesthesia services provided by a nurse-anesthetist are payable only if the nurse-anesthetist

(a) is authorized by law to perform the services;

(b) is a full-time employee of the physician and is not a salaried employee of the hospital; and

(c) performs the services under the direct and continuous supervision of the physician.

(2) The supervising physician must be in the operating suite and responsible for no more than four operating rooms. Availability of the physician by telephone does not constitute direct and continuous supervision.

(C) Acupuncture as an Anesthetic. The MassHealth agency pays for acupuncture only as a substitute for conventional surgical anesthesia.

604 HCPCS Level II Service Codes

This section lists Level II HCPCS codes that are payable under MassHealth. Refer to the Centers for Medicare & Medicaid Services 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
A4641	Radiopharmaceutical, diagnostic, not otherwise classified (IC)
A9500	Technetium Tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries (IC)
A9502	Technetium Tc-99m tetrofosmin, diagnostic, per study dose, up to 40 millicuries (IC)
A9503	Technetium Tc-99m medronate, diagnostic, per study, up to 30 millicuries (IC)
A9505	Thallium T1-201 thallous chloride, diagnostic, per millicurie (IC)
A9512	Technetium Tc-99m pertechnetate, diagnostic, per millicurie (IC)
A9537	Technetium Tc-99m mebrofenin, diagnostic, per study dose, up to 15 millicuries (IC)
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients
G0105	Colorectal cancer screening; colonoscopy on individual at high risk
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes self-management training services, group session (two or more), per 30 minutes
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (two or more individuals), each 30 minutes
H2011	Crisis intervention service, per 15 minutes
J0129	Injection, abatacept, 10 mg (PA)
J0135	Injection, adalimumab, 20 mg (PA)
J0170	Injection, adrenalin, epinephrine, up to 1 ml ampule
J0215	Injection, alefacept, 0.5 mg (PA)
J0256	Injection, alpha 1-proteinase inhibitor–human, 10 mg
J0290	Injection, ampicillin sodium, 500 mg
J0295	Injection, ampicillin sodium/sulbactam sodium, per 1.5 g
J0348	Injection, anidulafungin, 1 mg
J0456	Injection, azithromycin, 500 mg
J0460	Injection, atropine sulfate, up to 0.3 mg
J0475	Injection, baclofen, 10 mg
J0476	Injection, baclofen, 50 mcg for intrathecal trial
J0530	Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units

604 HCPCS Level II Service Codes (cont.)

Service Code	Service Description
J0560	Injection, penicillin G benzathine, up to 600,000 units
J0570	Injection, penicillin G benzathine, up to 1,200,000 units
J0580	Injection, penicillin G benzathine, up to 2,400,000 units
J0585	Botulinum toxin type A, per unit (PA)
J0587	Botulinum toxin type B, per 100 units (PA)
J0592	Injection, buprenorphine HCL, 0.1 mg
J0640	Injection, leucovorin calcium, per 50 mg
J0690	Injection, cefazolin sodium, 500 mg
J0694	Injection, cefoxitin sodium, 1 g
J0696	Injection, ceftriaxone sodium, per 250 mg
J0697	Injection, sterile cefuroxime sodium, per 750 mg
J0702	Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg
J0704	Injection, betamethasone sodium phosphate, per 4 mg
J0780	Injection, prochlorperazine, up to 10 mg
J0835	Injection, cosyntropin, per 0.25 mg
J0881	Injection, darbepoetin alfa, 1 mcg (non-ESRD use) (PA)
J0882	Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis) (PA)
J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units (PA)
J0886	Injection, epoetin alfa, 1000 units (for ESRD on dialysis) (PA)
J0900	Injection, testosterone enanthate and estradiol valerate, up to 1 cc (IC)
J1020	Injection, methylprednisolone acetate, 20 mg
J1030	Injection, methylprednisolone acetate, 40 mg
J1040	Injection, methylprednisolone acetate, 80 mg
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
J1070	Injection, testosterone cypionate, up to 100 mg
J1080	Injection, testosterone cypionate, 1 cc, 200 mg
J1094	Injection, dexamethasone acetate, 1 mg
J1100	Injection, dexamethosone sodium phosphate, 1 mg
J1160	Injection, digoxin, up to 0.5 mg
J1170	Injection, hydromorphone, up to 4 mg
J1200	Injection, diphendydramine HCl, up to 50 mg
J1260	Injection, dolasetron mesylate, 10 mg
J1320	Injection, amitriptyline HCl, up to 20 mg (IC)
J1438	Injection, etanercept, 25 mg (PA)
J1440	Injection, filgrastim (G-CSF), 300 mcg
J1441	Injection, filgrastim (G-CSF), 480 mcg
J1460	Injection, gamma globulin, intramuscular, 1 cc
J1470	Injection, gamma globulin, intramuscular, 2 cc
J1480	Injection, gamma globulin, intramuscular, 3 cc
J1490	Injection, gamma globulin, intramuscular, 4 cc
J1500	Injection, gamma globulin, intramuscular, 5 cc
J1510	Injection, gamma globulin, intramuscular, 6 cc