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MASSHEALTH  
TRANSMITTAL LETTER CHC-74  
June 2006

**TO:** Community Health Center Providers Participating in MassHealth

**FROM:** Beth Waldman, Medicaid Director *BW*

**RE:** *Community Health Center Manual* (Revised Regulations About Tobacco Cessation Services)

Beginning July 1, 2006, MassHealth will cover individual and group tobacco cessation counseling and pharmacotherapy through the MassHealth smoking cessation benefit. Those members eligible to receive physician services, community health center services, acute outpatient hospital services, and pharmacy services are covered for tobacco cessation services, based on their MassHealth coverage type as described at 130 CMR 450.105.

### **Cessation Counseling Benefit**

Since stopping tobacco use may require multiple attempts, this benefit is designed to allow members and providers as much flexibility as possible. Members may use up to 16 counseling sessions in any combination of group or individual face-to-face sessions per 12-month cycle, including two intake/assessment sessions. Prior authorization is required for counseling sessions beyond these limits. For further detail please see the attachment "MassHealth Tobacco Cessation Counseling Benefit."

### **Pharmacotherapy Benefit**

MassHealth will cover medically necessary drugs used for tobacco cessation, subject to all other provisions of 130 CMR 406.000. Members may obtain a 90-day supply of the nicotine patch, gum, or lozenge, per cessation attempt. The nicotine inhaler and nasal spray require prior authorization. A maximum of two 90-day treatment regimens are covered per member per 12-month cycle. Additional nicotine replacement therapy (NRT) requires prior authorization. The pharmacotherapy benefit also covers other medically necessary drugs for tobacco cessation, such as bupropion (the generic form of Zyban). Please see the MassHealth Drug List for further details about the pharmacotherapy benefit for tobacco cessation. The MassHealth Drug List can be found at [www.mass.gov/druglist](http://www.mass.gov/druglist). It can also be accessed from the MassHealth Pharmacy home page at [www.mass.gov/masshealth/pharmacy](http://www.mass.gov/masshealth/pharmacy).

### **Cessation Counseling Provider Qualifications**

Physicians, as well as certain mid-level providers (registered nurses, physician assistants, nurse practitioners, and nurse midwives) may provide tobacco cessation counseling to MassHealth members. Other health care providers with specific training in the provision of tobacco cessation counseling may also qualify to provide counseling, and physicians who supervise those providers must ensure that they are trained by a degree-granting institute of higher education and have completed at least eight hours of course instruction. All nonphysicians must provide services under the supervision of a physician.

## **Coding and Billing for Tobacco Cessation Services**

Claims for tobacco cessation counseling must be submitted using Healthcare Common Procedure Coding System (HCPCS) Service Code G0376. Distinct modifiers are required with the HCPCS code for claims processing. These modifiers vary by the type of service provided and by the type of provider. Please see the attachment "Tobacco Cessation Coding and Rates Chart" for important coding information. For more information about the reimbursement rates for the tobacco cessation counseling services, please see the Division of Health Care Finance and Policy Web site at [www.mass.gov/dhcfp](http://www.mass.gov/dhcfp).

Service Code G0376 code and relevant modifiers are in Subchapter 6 of the *Community Health Center Manual* under tobacco cessation services.

This transmittal letter also removes Appendix D, which is obsolete, and transmits a revised Appendix F, Admission Guidelines (updated terminology).

These regulations are effective July 1, 2006.

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](mailto:providersupport@mahealth.net), or fax your inquiry to 617-988-8974.

### NEW MATERIAL

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

#### Community Health Center Manual

Pages iv-a, vi, 4-1, 4-2, 4-11, 4-12, 4-25 through 4-28, 6.9-1, 6.9-2, and F-1 through F-4

### OBSOLETE MATERIAL

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

#### Community Health Center Manual

Pages iv-a, 4-1, 4-2, 4-25, and 4-26 — transmitted by Transmittal Letter CHC-72

Page vi — transmitted by Transmittal Letter CHC-71

Pages 4-11 and 4-12 — transmitted by Transmittal Letter CHC-65

Pages D-1 and D-2 — transmitted by Transmittal Letter CHC-54

Pages F-1 through F-4 — transmitted by Transmittal Letter CHC-61

**MassHealth Tobacco Cessation Counseling Benefit (Attachment 1)**

MassHealth strongly encourages providers to inquire about all members' smoking status and recommend that they try to quit by referring them to the best available resource for tobacco cessation counseling. Clinical evidence indicates that the best treatment outcomes are achieved when members receive a combination of tobacco cessation counseling and pharmacotherapy.

Component	Duration	Limits
<b>Intake/Assessment/Planning</b> Face-to-face intake, assessment, and treatment planning as a component of treatment	At least 45 minutes	Maximum of one intake, assessment and treatment planning per course of treatment. Two such sessions are permitted per 12-month cycle*
<b>In-Depth – Individual</b> Face-to-face behavioral counseling for tobacco cessation	At least 30 minutes	Maximum 16 sessions per 12-month cycle*
<b>In-Depth – Group</b> Face-to-face group behavioral counseling for tobacco cessation	Minimum 60 to 90 minutes per group sessions, minimum of 5, maximum of 12 members per group session	Maximum 16 sessions per 12-month cycle*

\* A total of 16 face-to-face counseling sessions, using any combination of intake/assessment/planning, in-depth individual or in-depth group counseling sessions are permitted for each member per 12-month cycle without prior authorization.

**MassHealth Tobacco Cessation HCPCS Code and Modifiers (Attachment 2)**

	Tobacco Cessation Counseling Services		
	Individual tobacco cessation counseling visit, at least 30 minutes	Individual tobacco cessation intake/assessment counseling visit, at least 45 minutes	Group tobacco cessation counseling visit, at least 60 to 90 minutes
<b>Servicing Provider</b>	<b>Service Code + Modifier</b>	<b>Service Code + Modifier</b>	<b>Service Code + Modifier</b>
Physician, Independent Nurse Practitioner, Independent Nurse Midwife, Community Health Center (CHC), Outpatient Hospital Department (OPD)*	<b>G0376</b>	<b>G0376 TF</b>	<b>G0376 HQ</b>
Nurse Practitioner (employed by physician or CHC, CHC or physician billing)	<b>G0376 SA</b>	<b>G0376 U2</b>	<b>G0376 U3</b>
Nurse Midwife (employed by physician or CHC, CHC or physician billing)	<b>G0376 SB</b>	<b>G0376 U2</b>	<b>G0376 U3</b>
Physician's Assistant (employed by physician or CHC, CHC or physician billing)	<b>G0376 HN</b>	<b>G0376 U2</b>	<b>G0376 U3</b>
Registered Nurse (employed by physician or CHC, CHC or physician billing)	<b>G0376 TD</b>	<b>G0376 U2</b>	<b>G0376 U3</b>
Tobacco Cessation Counselor (employed by physician or CHC, CHC or physician billing)	<b>G0376 U1</b>	<b>G0376 U2</b>	<b>G0376 U3</b>

\*OPDs will receive the PAPE (clinic visit rate/ facility rate) for this service. OPDs cannot bill separately for services provided by mid-level providers, this will be included in the facility rate. This means they will use only Service Code G0376 code with TF and HQ modifiers.

**Modifiers:**

TF = intermediate level of care

HQ = group setting

SA = nurse practitioner

SB = nurse midwife

HN = bachelor's degree level (used for physician assistant)

TD = RN

U1 = defined for use by "tobacco cessation counselor"

U2 = defined for use as "intake assessment, non-physician provider employed by physician"

U3 = defined for use as "group visit, non-physician provider employed by physician"

**Tobacco Cessation Counseling Service Rates**

Service Code (modifiers)	Mid-Level Practitioner Rate (85%)		Physician Rate	
	NFAC Rate(\$)	FAC Rate(\$)	NFAC Rate(\$)	FAC Rate(\$)
<b>G0376 (SA,SB,HN,TD,U1)</b> Individual Counseling 30 minutes	42.10	41.39	49.53	48.69
<b>G0376 (TF or U2)</b> Individual Counseling Intake 45 minutes	63.20	62.08	74.30	73.04
<b>G0376 (HQ or U3)</b> Group Counseling 60 to 90 minutes	25.26	24.83	29.72	29.21

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405.401: Introduction

All community health centers participating in MassHealth must comply with the regulations governing MassHealth, including but not limited to 130 CMR 405.000 and 130 CMR 450.000.

405.402: Definitions

The following terms used in 130 CMR 405.000 have the meanings given in 130 CMR 405.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 405.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 405.000 and in 130 CMR 450.000.

340B Covered Entities – facilities and programs eligible to purchase discounted drugs through a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992.

340B Drug-Pricing Program – a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their patients.

Family Practitioner — a licensed physician who is board-eligible or board-certified in family practice. A family practitioner provides continuous, accessible medical care with emphasis on the family unit that combines appreciation of both the biomedical and psychosocial dimensions of illness. The family practitioner assumes responsibility for and provides most of the member’s health care, and coordinates the member’s total health needs.

Freestanding Clinic — any institution licensed as a clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, s. 51 that is not part of a hospital and that possesses its own legal identity, maintains its own patient records, and administers its own budget and personnel. Such institutions include community health centers and mental health centers.

Group Clinic Visit — a session conducted by a physician, physician assistant, nurse practitioner, or registered nurse to introduce preventive medicine approaches to personal health and safety and to present self-help and personal management information concerning family medicine, adult medicine, sex education, and chronic illness. Tobacco cessation group clinic visits may be provided by MassHealth-qualified tobacco cessation counseling providers as defined in 130 CMR 405.472.

Health Practitioner — an individual who can diagnose and treat medical problems whether by authority of his or her own license or by the delegated authority of a licensed medical professional.

HIV Pre-Test Counseling Visit — a face-to-face meeting at the CHC between the member and a physician, physician assistant, nurse practitioner, registered nurse, or counselor (working under the supervision of one of the aforementioned) for the purpose of providing counseling before HIV testing. Providers will offer information on risk factors and implications of both positive and negative test results, in accordance with established protocols of the Massachusetts Department of Public Health.

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HIV Post-Test Counseling Visit — a face-to-face meeting at the CHC between the member and a physician, physician assistant, nurse practitioner, registered nurse, or counselor (working under the supervision of one of the aforementioned) for the purpose of providing counseling after HIV testing. Such counseling will include information about the implications of positive and negative test results, risk-reduction techniques, partner notification, and referral to medical and support services, in accordance with established protocols of the Massachusetts Department of Public Health.

Home Visit — a face-to-face meeting between a member and a physician, physician assistant, nurse practitioner, or registered nurse in the member's residence for examination, diagnosis, or treatment.

Hospital Visit — a face-to-face meeting between a member and a physician, physician assistant, nurse practitioner, or registered nurse when the member has been admitted to a hospital by a physician on the CHC's staff.

Individual Medical Visit — a face-to-face meeting at the CHC between a member and a physician, physician assistant, nurse practitioner, or registered nurse for medical examination, diagnosis, or treatment.

Individual Mental Health Visit — a face-to-face meeting at the CHC between a member and a psychiatrist for mental health examination and diagnosis.

Institutionalized Individual — for purposes of 130 CMR 405.428 through 405.430, an individual who is:

- (1) involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or other facility for the care and treatment of mental illness; or
- (2) confined, under a voluntary commitment, in a psychiatric hospital or other facility for the care and treatment of mental illness.

Mentally Incompetent Individual — for purposes of 130 CMR 405.428 through 405.430, an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

Nursing Facility Visit — a visit by a physician, physician assistant, nurse practitioner, or registered nurse to a member who has been admitted to a nursing facility, extended care facility, or convalescent or rest home.

Primary or Elective Care — medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. This care includes but is not limited to physical examination, diagnosis and management of illness, ongoing health maintenance, accident prevention, and referral when necessary. This care does not require the specialized resources of a hospital emergency department.



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405.416: Quality Assessment Program

(A) A CHC must have in effect a program for internal quality assessment that is based on written policies, standards, and procedures, and that includes the following:

- (1) a review of the CHC's performance including, but not limited to, adequacy of recordkeeping, referral procedures and follow-up, medication review, quality of patient care, and identification of deficient areas of performance;
- (2) recommendations for correcting any deficiencies identified in the review; and
- (3) a review of any such corrective action.

(B) These reviews must be conducted at least twice a year by a committee composed of the professional services director, representatives of each professional discipline on the CHC's staff, consumers, and, if possible, health professionals not employed at the CHC. Activities of the committee must be documented in minutes or a report and made available to the MassHealth agency upon request.

405.417: Maximum Allowable Fees

The Massachusetts Division of Health Care Finance and Policy determines the maximum allowable fees for CHC services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 405.000. The maximum allowable fees for CHC services are the lowest of the following:

- (A) the CHC's usual and customary fee;
- (B) the CHC's actual charge submitted; or
- (C) the maximum allowable fee listed in the applicable Division of Health Care Finance and Policy fee schedule.

405.418: Nonreimbursable Services

(A) MassHealth does not pay a CHC for performing, administering, or dispensing experimental, unproven, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, MassHealth continues to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(B) MassHealth does not pay a CHC for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).

(130 CMR 405.419 and 405.420 Reserved)

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405.421: Visits: Service Limitations

The following restrictions and limitations apply to visits as defined in 130 CMR 405.402.

(A) Individual Medical Visit. An individual medical visit may not be used for mental health services or for HIV pre- or post-test counseling visits.

(B) Individual Mental Health Visit. An individual mental health visit conducted by a person other than a psychiatrist (for example, a psychologist, nurse, physician assistant, social worker, or counselor) is not reimbursable. An individual mental health visit must be for the sole purpose of examination and diagnosis, and must not include mental health treatment.

(C) Group Clinic Visit. All instructional group sessions for members must be carried out by a physician, nurse practitioner, registered nurse, or physician assistant. A group visit conducted by other kinds of professionals (for example, social workers, counselors, or nutritionists) is not reimbursable as a group clinic visit. These limitations do not apply to group clinic visits for tobacco cessation.

(D) HIV Pre- and Post-Test Counseling Visits. The CHC may be reimbursed for a maximum of two HIV pre-test counseling and two HIV post-test counseling visits per member per test. A maximum of four pre-test counseling visits and four post-test counseling visits per calendar year per member are reimbursable.

(E) Home Visit. A home visit must be used to deliver episodic care in the member's home when a health practitioner has determined that it is not advisable for the member to visit the CHC. The medical record must document the reasons for a home visit. A house-bound member with chronic medical and nursing care needs must be referred to a Medicare-certified home health agency.

(F) Treatments or Procedures. The CHC may bill for a visit, a treatment, or a procedure, but may not bill for more than one of these services provided to the same member on the same date when the services are performed in the same location. This limitation does not apply to tobacco cessation counseling services provided by a physician or other qualified staff member under the supervision of a physician on the same day as a visit. Examples of treatments or procedures are a vasectomy or an amniocentesis.

(G) Urgent Care. The MassHealth agency pays an enhanced fee for urgent care when such care is provided at the CHC Monday through Friday from 5:00 P.M. to 6:59 A.M., and from Saturday at 7:00 A.M. through Monday at 6:59 A.M.

405.422: Obstetric Services: Introduction

(A) 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 for covered obstetric services. The global-fee method is available only when the conditions in 130 CMR 405.423 are met.

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405.466: Pharmacy Services: Participation in the 340B Drug-Pricing Program for Outpatient CHC Pharmacies

(A) Notification of Participation. A CHC that is a 340B-covered entity may provide drugs to MassHealth members through the 340B drug-pricing program provided that it notifies the MassHealth agency by submitting to the MassHealth agency a copy of the form used to register with the Health Resources and Services Administration, Office of Pharmacy Affairs (OPA), as a 340B-covered entity and, if applicable, a copy of the OPA form used to certify the contracted pharmacy services. The CHC may provide and bill for 340B drugs to MassHealth members, provided directly or through a subcontract, after the MassHealth agency confirms, in writing, its receipt of the CHC's notification and copy of its OPA registration form, in accordance with 130 CMR 405.466(A).

(B) Subcontracting for 340B Outpatient CHC Pharmacy Services.

(1) A CHC that is a 340B-covered entity may contract with a MassHealth pharmacy provider to dispense 340B drugs for the 340B-covered entity's MassHealth patients. All such subcontracts between the 340B-covered entity and a pharmacy provider must be in writing, ensure continuity of care, specify that the CHC pays the pharmacy, specify that such payment constitutes payment in full for 340B drugs provided to MassHealth members, be consistent with all applicable provisions of 130 CMR 406.000, and are subject to approval by the MassHealth agency. The 340B-covered entity must comply with the requirements of 130 CMR 405.466(A) by submitting to the MassHealth agency a copy of the form used to register with the Health Resources and Services Administration, Office of Pharmacy Affairs (OPA), as a 340B-covered entity and a copy of the OPA form used to certify the contracted pharmacy services for the 340B drug-pricing program.

(2) The CHC is legally responsible to MassHealth for the performance of any subcontractor. The CHC must ensure that every pharmacy subcontractor is licensed by the Massachusetts Board of Registration in Pharmacy, is a MassHealth pharmacy provider, and that services are furnished in accordance with MassHealth pharmacy regulations at 130 CMR 406.000 and all other applicable MassHealth requirements, including but not limited to, those set forth in 130 CMR 450.000.

(C) Termination or Changes in 340B Drug-Pricing Program Participation. A CHC must provide the MassHealth agency 30 days' advance written notice of its intent to discontinue, or change in any way material to MassHealth, the manner in which it provides 340B outpatient drugs for its MassHealth patients.

(D) Payment for 340B Outpatient CHC Pharmacy Services. MassHealth pays the 340B-covered entity for outpatient CHC pharmacy services, whether provided and billed directly or through a subcontractor, at the rates established in DHCFFP regulations at 114.3 CMR 31.00.

(130 CMR 405.467 through 405.470 Reserved)

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405.471: Optional Reimbursable Services

A CHC may elect to provide the following services on site or by referral, but it is not required to do so under 130 CMR 405.000. The CHC must notify the MassHealth agency in writing of each service listed in 130 CMR 405.471(A) through (F) that the CHC will provide on site. All services provided on site must be provided and payment claimed in compliance with the applicable MassHealth regulations for each service, including applicable fee schedules. Services the CHC may elect to provide include:

- (A) adult day health services;
- (B) adult foster care;
- (C) day habilitation;
- (D) family planning;
- (E) psychiatric day treatment; and
- (F) speech and hearing services as described in 130 CMR 413.000.

405.472: Tobacco Cessation Services

(A) Introduction. MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 405.472(B) and pharmacotherapy treatment, including nicotine replacement therapy (NRT), in accordance with 130 CMR 406.000.

(B) Tobacco Cessation Counseling Services.

(1) MassHealth covers a total of 16 group and individual counseling sessions per member per 12-month cycle, without prior authorization. These sessions may be any combination of group and individual counseling. All individual counseling sessions must be at least 30 minutes, except for intake sessions, which must be at least 45 minutes. Intake sessions are limited to two per member per 12-month cycle, without prior authorization.

(a) Individual counseling consists of face-to-face tobacco cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobacco cessation services as set forth in 130 CMR 405.472(B) and (C).

(b) Group tobacco treatment counseling consists of a scheduled professional counseling session with a minimum of three and a maximum of 12 members and has a duration of at least 60 to 90 minutes.

(c) Individual and group counseling also includes collaboration with and facilitating referrals to other health care providers to coordinate the appropriate use of medications, especially in the presence of medical or psychiatric comorbidities.

(2) The individual and group tobacco cessation counseling services must include the following:

(a) education on proven methods for stopping the use of tobacco, including:

- (i) a review of the health consequences of tobacco use and the benefits of quitting;
- (ii) a description of how tobacco dependence develops and an explanation of the

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biological, psychological, and social causes of tobacco dependence; and  
 (iii) a review of evidence-based treatment strategies and the advantages and disadvantages of each strategy;

(b) collaborative development of a treatment plan that uses evidence-based strategies to assist the member to attempt to quit, to continue to abstain from tobacco, and to prevent relapse, including:

(i) identification of personal risk factors for relapse and incorporation into the treatment plan;

(ii) strategies and coping skills to reduce relapse risk; and

(iii) a plan for continued aftercare following initial treatment; and

(c) information and advice on the benefits of nicotine replacement therapy or other proven pharmaceutical or behavioral adjuncts to quitting smoking, including:

(i) the correct use, efficacy, adverse events, contraindications, known side effects, and exclusions for all tobacco dependence medications; and

(ii) the possible adverse reactions and complications related to the use of pharmacotherapy for tobacco dependence.

(C) Provider Qualifications for Tobacco Cessation Counseling Services.

(1) Qualified Providers.

(a) Physicians, registered nurses, nurse practitioners, nurse midwives, and physician assistants may provide tobacco cessation counseling services without additional experience or training in tobacco cessation counseling services.

(b) All other providers of tobacco cessation counseling services must be under the supervision of a physician, and must complete a course of training in tobacco cessation counseling by a degree-granting institution of higher education with a minimum of eight hours of instruction.

(2) Supervision of Tobacco Cessation Counseling Services. A physician must supervise all non-physician providers of tobacco cessation counseling services.

(D) Tobacco Cessation Services: Claims Submission. A CHC may submit claims for tobacco cessation counseling services that are provided by physicians, nurse practitioners, registered nurses, nurse midwives, physician assistants, and MassHealth-qualified tobacco cessation counselors according to 130 CMR 405.472(B) and (C). See Subchapter 6 of the *Community Health Center Manual* for service codes and descriptions.

(130 CMR 405.473 through 405.495 Reserved)

405.496: Utilization Management Program

The MassHealth agency pays for procedures and hospital stays that are subject to the Utilization Management Program only if the applicable requirements of the program as described in 130 CMR 450.207 through 450.211 are satisfied. Appendix E of the *Community Health Center Manual* contains the name, address, and telephone number of the contact organization for the screening program and describes the information that must be provided as part of the review process.

REGULATORY AUTHORITY

130 CMR 405.000: M.G.L. c. 118E, §§ 7 and 12.

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609 Tobacco Cessation Services

Service

Code

Service Description

G0376	Tobacco cessation individual counseling provided by a physician, an independent Nurse Practitioner, or an independent Nurse Midwife. Community Health Centers are also a provider type that provides this service using this code.
G0376-HQ	Tobacco cessation group counseling, at least 90 minutes in duration, provided by a physician.
G0376-HN	Tobacco cessation individual counseling provided by a Physician's Assistant.
G0376-SA	Tobacco cessation individual counseling provided by a Nurse Practitioner.
G0376-SB	Tobacco cessation individual counseling provided by a Nurse Midwife.
G0376-TD	Tobacco cessation individual counseling provided by a Registered Nurse.
G0376-TF	Tobacco cessation individual counseling, intermediate level of care (intake/assessment) provided by a physician.
G0376-U1	Tobacco cessation individual counseling provided by a tobacco cessation counselor.
G0376-U2	Tobacco cessation individual intake/assessment counseling, at least 45 minutes in duration, provided by a Nurse Practitioner, Nurse Midwife, Physician's Assistant, Registered Nurse, or a tobacco cessation counselor, under the supervision of a Physician.
G0376-U3	Tobacco cessation group counseling, at least 90 minutes in duration, provided by a Nurse Practitioner, Nurse Midwife, Physician's Assistant, Registered Nurse, or a tobacco cessation counselor, under the supervision of a Physician.

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## Acute Inpatient Hospital Admission Guidelines

### A. Introduction

This appendix is intended to help providers make appropriate decisions about the medical necessity of acute inpatient hospital admissions. These guidelines have been approved by physicians from several medical specialties who have active practices in Massachusetts. Providers making decisions on whether to admit a member as an inpatient should use their medical judgment and these guidelines. Services that meet the medical-necessity criteria at 130 CMR 450.204 and the rules governing reimbursement of inpatient, outpatient, and observation services in 130 CMR 410.414 (see section E of this appendix) or 415.414 (see section C of this appendix) are reimbursable by MassHealth.

### B. Definitions

The reimbursability of services defined below is not determined by these definitions, but by application of MassHealth regulations referenced in 130 CMR 450.000 and in section A above.

Inpatient Services — medical services provided to a member admitted to an acute inpatient hospital.

Observation Services — outpatient hospital services provided anywhere in an acute inpatient hospital, to evaluate a member's condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Outpatient Hospital Services — medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, day-surgery services, and recovery-room services.

Outpatient Services — medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home.

### C. Medical Determination

*[excerpted from MassHealth acute inpatient hospital regulations at 130 CMR 415.414]*

To support the medical necessity of an inpatient admission, the provider must adequately document in the member's medical record that a provider with applicable expertise expressly determined that the member required services involving a greater intensity of care than could be provided safely and effectively in an outpatient setting. Such a determination may take into account the amount of time the member is expected to require inpatient services, but must not be based solely on this factor. The decision to admit is a medical determination that is based on factors, including but not limited to the:

- (1) member's medical history;
- (2) member's current medical needs;
- (3) severity of the signs and symptoms exhibited by the member;
- (4) medical predictability of an adverse clinical event occurring with the member;
- (5) results of outpatient diagnostic studies;
- (6) types of facilities available to inpatients and outpatients; and
- (7) MassHealth Acute Inpatient Hospital Admission Guidelines (in section D of this appendix).

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#### **D. Acute Inpatient Hospital Admission Guidelines**

The following guidelines describe admissions that generally are not medically necessary. This is not an all-inclusive list. MassHealth or its agent may also determine that other admissions not characterized in this list are medically unnecessary and nonreimbursable on an inpatient basis.

1. The admission occurs following observation services, and the admitting provider has not documented at least one of the following in the medical record at the time the decision to admit is made:
  - Failure to respond to outpatient treatment and a clear deterioration of the patient’s clinical status;
  - a significant probability that the treatment plan will continue to need frequent clinical modifications and what specific modifications are necessary;
  - instability of the patient that is a deviation from either normal clinical parameters or the patient’s baseline; or
  - a requirement for more intensive services than were already being delivered while the patient was on observation status, and a physician’s order for each specific new service.
2. The admission occurs when the member’s condition had improved significantly in response to outpatient treatment with a progression toward either normal clinical parameters or the member’s baseline.
3. The admission is for further monitoring or observing for potential complications when the member undergoes a procedure that is appropriately performed in an outpatient setting according to the current standards of care, the procedure is performed without complications, and the member’s clinical status is approaching either normal clinical parameters or his or her baseline.
4. The admission is primarily for providing or monitoring the services and treatment of a member with multiple or complex medical needs whose needs were adequately being met in a setting other than an acute inpatient hospital prior to that admission.
5. The admission of a member whose baseline clinical status is outside of the normal clinical parameters and whose condition has been managed successfully on an outpatient basis, when the admission is based primarily on the member’s abnormal status, unless that status has significantly deteriorated.
6. The admission is primarily to observe for the possible progression of labor when examination and monitoring does not indicate definite progression of active labor leading to delivery.
7. The admission is primarily for education, teaching, minor medication changes and/or monitoring, or adjustment of therapies associated with a medically stable condition(s).
8. The admission is primarily because the member requires sedation or anesthesia in order to conduct diagnostic tests that are appropriately performed in an outpatient setting according to the current standards of care, when there are no serious complications requiring inpatient services.
9. The admission of a member whose baseline condition requires the use of complex medical technology, when the admission is primarily due to the need for such technology or other maintenance services related to the pre-existing medical condition(s), unless the member’s condition is significantly deteriorating.

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10. The admission is primarily for a continuation of treatment or monitoring that has already been delivered effectively in the home, hospital outpatient department, or other institutional setting.
11. The admission of a member who is a patient or resident in another institutional setting, and is admitted primarily for diagnostic or treatment services that could have been provided in the member's current institutional setting or by using outpatient services.
12. The admission of a member who has simple, uncomplicated, outpatient surgery and is being admitted primarily because of the time of day or the need for postoperative observation.
13. The admission is primarily due to the:
  - amount of time a member has spent as an outpatient in a hospital or other outpatient setting;
  - time of day a member recovers from outpatient surgery;
  - need for education of the member, parent, or primary caretaker;
  - need for diagnostic testing or obtaining consultations;
  - need to obtain medical devices or equipment or arrange home care or other noninstitutional services;
  - age of the member;
  - convenience of the physician, hospital, member, family, or other medical provider;
  - type of unit within the hospital in which the member is placed; or
  - need for respite care.

## E. Observation Services

*[excerpted from MassHealth outpatient hospital regulations at 130 CMR 410.414]*

Reimbursable Services. MassHealth covers medically necessary observation services provided by acute inpatient hospitals. Reimbursable observation services may exceed 24 hours, and do not need to be provided in a distinct observation unit. To qualify for reimbursement of observation services, the medical record must specifically document when those services began and ended, the purpose of observation, and the name of the physician who ordered it. Acute inpatient hospitals will be reimbursed for these observation services on an outpatient basis in accordance with the signed provider agreement with the MassHealth agency.

### Nonreimbursable Services.

- (1) Nonreimbursable observation services include but are not limited to:
  - (a) services that are not reasonable or necessary for the diagnosis or treatment of the member; and
  - (b) routine preparation and recovery services associated with diagnostic testing or outpatient surgery.
- (2) The following services are not reimbursable as a separate service:
  - (a) postoperative monitoring during a standard recovery period that should be characterized as recovery-room services; and
  - (b) observation services provided concurrently with therapeutic services such as chemotherapy.

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