

130 CMR: DIVISION OF MEDICAL ASSISTANCE

130 CMR 434.000: PSYCHIATRIC HOSPITAL OUTPATIENT SERVICES

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434.401: Introduction

130 CMR 434.000 establishes the requirements for the provision of psychiatric hospital outpatient services under MassHealth. The MassHealth agency pays for outpatient visits and ancillary services (such as radiographic views, laboratory tests, and pharmacy items) that are medically necessary and appropriately provided. The quality of such services must meet professionally recognized standards of care. All psychiatric inpatient hospitals participating in MassHealth that provide psychiatric hospital outpatient services must comply with the MassHealth regulations, including but not limited to MassHealth regulations set forth in 130 CMR 434.000 and 450.000.

434.402: Definitions

The following terms used in 130 CMR 434.000 have the meanings given in 130 CMR 434.402 unless the context clearly requires a different meaning.

Child and Adolescent Needs and Strengths — a tool that provides a standardized way to organize information gathered during behavioral-health clinical assessments. A Massachusetts version of the tool has been developed and is intended to be used as a treatment decision support tool for behavioral-health providers serving MassHealth members under the age of 21.

Couple Therapy — for the purposes of mental health services, therapeutic services provided to a couple whose primary complaint is the disruption of their marriage, family, or relationship.

Crisis Intervention/Emergency Services — immediate mental health evaluation, diagnosis, hospital prescreening, treatment, and arrangements for further care and assistance as required, provided during all hours to members showing sudden, incapacitating emotional stress.

Diagnostic Services — for the purposes of mental health services, the examination and determination of a patient's psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan.

Family Consultation — a preplanned meeting with a parent, foster parent, legal guardian, or caretaker of a child or adolescent who is being treated, when the parent, foster parent, legal guardian, or caretaker is not the focus of the meeting.

Family Therapy — for the purposes of mental health services, the treatment of more than one member of a family simultaneously in the same session.

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Group Therapy — for the purposes of mental health services, the application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

Individual Therapy — for the purposes of mental health services, a therapeutic service provided to an individual.

Institutionalized Individual — an individual who is either

- (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 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.

Maintenance Therapy — repetitive therapy that is performed when a person can progress no further toward functional independence but that is or may be necessary to prevent regression.

Medication Visit — for the purposes of mental health services, a member visit specifically for the prescription, review, and monitoring of medication by a licensed psychiatrist or licensed clinician with prescriptive authority or for the administration of prescribed intramuscular medication by a licensed nurse or physician.

Mental Illness — mental and emotional disorders as defined in the current American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disease*, 4th edition (DSM-IV).

Psychiatric Hospital Outpatient Services — services provided to members on an outpatient basis in a psychiatric inpatient hospital.

Psychiatric Inpatient Hospital — any psychiatric facility or inpatient program in a licensed psychiatric facility that has six beds or more for inpatient use, is certified by the Massachusetts Department of Public Health for participation in Medicare, and primarily treats patients whose principal diagnosis is based on the DSM-IV. For out-of-state psychiatric inpatient hospital providers, certification for participation in MassHealth by the appropriate state agency may be substituted. "Primarily treats" means that, over a six-month period, inpatient care has been provided to a patient population of which 51% or more consistently have a principal diagnosis that is psychiatric.

Psychiatric Outpatient Visit — a psychiatric hospital outpatient service involving a face-to-face encounter between an eligible member and a licensed practitioner for diagnosis, examination, or treatment.

Psychological Testing — the use of standardized test instruments by a licensed psychologist to evaluate aspects of an individual's functioning, including aptitudes, educational achievements, cognitive processes, emotional conflicts, and type and degree of psychopathology, subject to the limitations of 130 CMR 434.480(H).

Short-term Therapy — for the purposes of mental health services, a combination of diagnostics and individual, couple, family, and group therapy planned to end within 12 sessions.

434.403: Eligible Members

(A)(1) MassHealth Members. MassHealth covers psychiatric hospital outpatient 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.

(2) 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.

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

434.404: Exclusion of MassHealth Managed Care Members

130 CMR 434.000 does not apply to members participating in a MassHealth managed care plan. Participation in a MassHealth managed care plan is subject to change. Providers are responsible for verifying member status on a daily basis. For more information see 130 CMR 450.117.

434.405: Provider Eligibility

Payment for the services described in 130 CMR 434.000 will be made only to the outpatient department of a psychiatric hospital participating in MassHealth on the date of service.

(A) In-state. To participate in MassHealth, psychiatric inpatient hospitals located in Massachusetts must

- (1) operate under a psychiatric inpatient hospital license issued by the Massachusetts Department of Mental Health;
- (2) have a signed provider contract with the MassHealth agency that specifies the conditions of participation in MassHealth; and
- (3) participate in the Medicare program.

(B) Out-of-state. To participate in MassHealth, an out-of-state psychiatric inpatient hospital must obtain a MassHealth provider number and meet the following criteria:

- (1) operate under a hospital license from or be approved as a hospital by the governing or licensing agency in its state;
- (2) participate in the Medicare program; and
- (3) participate in that state's Medical Assistance program (or the equivalent).

434.406: Nonreimbursable Services

(A) The MassHealth agency will not pay for any of the following services:

- (1) nonmedical services, such as social, educational, and vocational services;
- (2) maintenance therapy for occupational, speech, or physical therapy services;
- (3) canceled or missed appointments;
- (4) telephone conversations and telephone consultations;
- (5) court testimony;
- (6) research or the provision of experimental, unproven, or otherwise medically unnecessary procedures or treatments;
- (7) the provision of whole blood; however, administrative and processing costs associated with the provision of blood and its derivatives are reimbursable;
- (8) vocational rehabilitation services;
- (9) sheltered workshops;
- (10) recreational services;
- (11) life-enrichment services;
- (12) alcohol or drug drop-in centers; and
- (13) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).

(B) The MassHealth agency will not pay for pharmacy services such as, but not limited to, the following:

- (1) amphetamines used for appetite control;
- (2) laxatives and stool softeners;
- (3) cough and cold preparations;
- (4) hexachlorophene preparations;
- (5) less-than-effective drugs;
- (6) hormone therapy related to sex-reassignment surgery; and
- (7) drugs related to the treatment of male or female infertility.

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434.407: Payment

- (A) Payment for psychiatric hospital outpatient services in Massachusetts will be made at the rate for services established in the signed provider contract with the MassHealth agency, subject to the limitations set forth in 130 CMR 434.407.
- (B) For purposes of making payments, the following limitations apply.
- (1) The MassHealth agency will not pay for psychiatric hospital outpatient services provided to a member who is an inpatient at the same or a different hospital on the same day.
 - (2) If a member receives psychiatric hospital outpatient services at one facility and, later on the same day, is admitted as an inpatient to another facility, the MassHealth agency will pay both hospitals for services.
 - (3) When a member is admitted to inpatient status through the emergency room or outpatient department, the MassHealth agency will pay for only the inpatient stay. The MassHealth agency will not pay for services furnished in the emergency room or outpatient department on the admitting day.
- (C) Payment for out-of-state psychiatric hospital outpatient services will be made in accordance with the MassHealth (or equivalent) fee schedule of that state.
- (D) Payment for out-of-state psychiatric hospital outpatient services provided to an eligible Massachusetts member may be made only in the following instances:
- (1) emergency psychiatric hospital outpatient services are provided to a member;
 - (2) psychiatric hospital outpatient services are provided to a member who lives in a community near the border of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont and for whom the out-of-state hospital is nearer than one in Massachusetts providing equivalent medical services;
 - (3) prior authorization has been obtained from the MassHealth agency for nonemergency outpatient services provided to a member by the out-of-state psychiatric inpatient hospital that is more than 50 miles from the Massachusetts border.

434.408: Certification

Psychiatric inpatient hospitals must receive certification from the MassHealth agency before providing psychiatric day treatment program services (for requirements, *see* 130 CMR 434.421).

434.409: Prior Authorization

- (A) For certain outpatient services described in 130 CMR 434.000, the MassHealth agency requires that the psychiatric inpatient hospital obtain prior authorization. No payment will be made for such services unless prior authorization has been obtained from the MassHealth agency. Members participating in a MassHealth managed care plan require service authorization before certain mental health and substance abuse services are provided. For more information, *see* 130 CMR 450.124.
- (B) 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.
- (C) All requests for prior authorization must be submitted in accordance with the instructions in Subchapter 5 of the *Psychiatric Hospital Outpatient Services Manual*.
- (D) Time requirements for response from the MassHealth agency and rules that apply in determining the period within which the MassHealth agency will act on specific requests for prior authorization are set forth in the MassHealth administrative and billing regulations in 130 CMR 450.000. A service is authorized on the date the MassHealth agency transmits its decision concerning the request for prior authorization to the provider.

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(E) Written notification of the prior authorization decision will be sent to the provider and will indicate approval, deferral because additional information is necessary, modification, or denial. In the case of a denial, the member will also be notified. Notification of denial will include the reason for the decision. The member or the provider has the right to resubmit a request and furnish additional information. The member may appeal the modification or denial of a prior authorization request within 30 days after the date of the notice of denial. Procedures for such an appeal are set forth in 130 CMR 610.000.

434.410: Recordkeeping (Medical Records) Requirements

(A) Payment for any psychiatric hospital outpatient service reimbursable under MassHealth is conditioned upon its full and complete documentation in the member's medical record. If the information in the member's record is not sufficient to document the service for which payment is claimed by the provider, the MassHealth agency will not pay for the service or, if payment has been made, will consider such payment to be an overpayment subject to recovery as defined in the MassHealth administrative and billing regulations in 130 CMR 450.000. Medical record requirements as set forth in 130 CMR 434.000 constitute the standard against which the adequacy of records will be measured, as set forth in 130 CMR 450.000.

(B) The MassHealth agency may request, and the psychiatric inpatient hospital must furnish, any and all medical records (or clear photocopies of such records) corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, § 38, and 130 CMR 450.000. All components of a member's complete medical record (such as lab slips and X rays) need not be maintained in one file as long as all components are accessible to the MassHealth agency upon its request.

(C) The medical record must contain sufficient data to document fully the nature, extent, quality, and necessity of the care furnished to a member for each date of service claimed for payment, as well as any data that will update the member's medical course. The data maintained in the member's medical record must also be sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals.

(D) The medical records for hospital outpatient services provided to members must include at least the following information (basic data collected during previous visits, such as identifying data, chief complaint, or history, need not be repeated in the member's medical record for subsequent visits):

- (1) the member's name and date of birth;
- (2) the date of each service;
- (3) the reason for the visit;
- (4) the name and title of the person who performed the service;
- (5) the member's medical history;
- (6) the diagnosis or chief complaint;
- (7) a clear indication of all findings, whether positive or negative, on examination;
- (8) any tests administered and their results;
- (9) a description of any treatment given;
- (10) any medications administered or prescribed, including strength, dosage, regimen, and duration of use;
- (11) any anesthetic agent administered;
- (12) any medical goods or supplies dispensed or supplied;
- (13) recommendations and referrals for additional treatments or consultations, when applicable;
- (14) such other information as is applicable for the specific service provided, or as is otherwise required in 130 CMR 434.000; and
- (15) for members under the age of 21, the CANS that was completed at the initial behavioral-health assessment and updated at least every 90 days thereafter.

(E) When a member is referred from a private physician to the outpatient department of a psychiatric inpatient hospital exclusively for the purpose of a diagnostic test, the following information, at a minimum, must be included in the member's medical record:

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- (1) the member's name and date of birth;
- (2) the signed referral from the private physician authorizing the procedure;
- (3) the date of service;
- (4) the name and title of the person who performed the service; and
- (5) a clear indication of all findings, whether positive or negative.

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

The MassHealth agency pays for all medically necessary psychiatric outpatient hospital services for EPSDT-eligible members in accordance with 130 CMR 450.140 *et seq.*, without regard to service limitations described in 130 CMR 434.000, and with prior authorization.

434.421: Psychiatric Day Treatment Program Services

(A) A psychiatric day treatment program is a planned combination of diagnostic, treatment, and rehabilitative services provided to mentally or emotionally disturbed persons who need more active or inclusive treatment than is typically available through a weekly visit for outpatient mental health services, but who do not need full-time hospitalization or institutionalization. Such a program uses multiple, intensive, and focused activities in a supportive environment to enable these individuals to acquire more realistic and appropriate behavior patterns, attitudes, and skills for eventual independent functioning in the community.

(B) The MassHealth agency pays for services provided as part of an organized psychiatric day treatment program by the outpatient department of a psychiatric hospital. These services must be furnished in compliance with MassHealth regulations governing psychiatric day treatment program services in 130 CMR 417.000. (See Subchapter 5 of the *Psychiatric Outpatient Hospital Manual* for instructions about obtaining the *Psychiatric Day Treatment Program Manual*, which contains the necessary regulations.)

434.426: Mental Health Services: Staff Composition Requirements

(A) Provider Responsibilities.

- (1) The psychiatric inpatient hospital must have a balanced multidisciplinary staff to furnish mental health services under the direction of a licensed psychiatrist.
- (2) The psychiatric inpatient hospital must designate a professional staff member as director of clinical services and a licensed psychiatrist as medical director.
- (3) A licensed psychiatrist must be on call during all hours of operation.
- (4) Although the MassHealth agency does not require that the psychiatric inpatient hospital employ mental health professionals from all the disciplines listed in 130 CMR 434.426(B), staff members who provide services to members must be qualified as set forth in 130 CMR 434.426(B) for their respective disciplines.

(B) Qualifications of Staff by CORE Discipline.

- (1) Psychiatrist. At least one staff psychiatrist must be either currently certified by the American Board of Psychiatry and Neurology or eligible for such certification. Any additional psychiatrists must be, at the minimum, licensed physicians in their second year of a psychiatric residency program accredited by the Council on Medical Education of the American Medical Association. Such physicians must be under the direct supervision of a licensed psychiatrist. Any psychiatrist or psychiatric resident who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by the Executive Office of Health and Human Services (EOHHS).
- (2) Psychologist. At least one staff psychologist must be licensed by the Massachusetts Board of Registration of Psychologists with a specialization listed in clinical or counseling psychology or a closely related specialty. Additional staff members trained in the field of clinical or counseling psychology or a closely related specialty must
 - (a) have a minimum of a master's degree or the equivalent graduate study in clinical or counseling psychology or a closely related specialty from an accredited educational institution;

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- (b) be currently enrolled in or have completed a doctoral program in clinical or counseling psychology or a closely related specialty;
 - (c) have had two years of full-time supervised clinical experience subsequent to obtaining a master's degree in a multidisciplinary mental health setting (one year of supervised clinical work in an organized graduate internship program may be substituted for each year of experience); and
 - (d) for any psychologist who provides individual, group, or family therapy to members under the age of 21, be certified every two years to administer the CANS, according to the process established by the Executive Office of Health and Human Services (EOHHS).
- (3) Social Worker.
- (a) At least one staff social worker must be licensed or have applied for and have a license pending as an independent clinical social worker by the Massachusetts Board of Registration of Social Workers.
 - (b) Any additional social workers on the staff must provide services under the direct and continuous supervision of an independent clinical social worker. Such additional social workers must be licensed or applying for licensure as certified social workers by the Massachusetts Board of Registration of Social Workers and have received a master's degree in social work and completed two years of full-time supervised clinical work in an organized graduate internship program.
 - (c) Any social worker who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by the Executive Office of Health and Human Services (EOHHS).
- (4) Psychiatric Nurse. At least one psychiatric nurse must be currently registered by the Massachusetts Board of Registration in Nursing and must have a master's degree in nursing from an accredited National League of Nursing graduate school with two years of full-time supervised clinical experience in a multidisciplinary mental health setting and be eligible for certification as a clinical specialist in psychiatric/mental health nursing by the American Nursing Association. Any other nurses must have a bachelor's degree from an educational institution accredited by the National League of Nursing and two years of full-time supervised skilled experience in a multidisciplinary mental health setting subsequent to that degree, or a master's degree in psychiatric nursing. Any psychiatric nurse mental health clinical specialist who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by the Executive Office of Health and Human Services (EOHHS). Nurses who are not psychiatric nurse mental-health clinical specialists are not eligible to administer the CANS.
- (5) Counselor. A counselor must have a master's degree in counseling education, counseling psychology, or rehabilitation counseling from an accredited educational institution and two years of full-time supervised clinical experience in a multidisciplinary mental health setting subsequent to obtaining the master's degree (one year of supervised clinical work in an organized graduate internship program may be substituted for each year of full-time experience). Any counselor who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by the Executive Office of Health and Human Services (EOHHS).
- (6) Occupational Therapist. An occupational therapist must be currently licensed by the Massachusetts Division of Registration of Allied Health Professions and registered by the American Occupational Therapy Association and must have either
- (a) a master's degree in occupational therapy from an accredited program in occupational therapy; or
 - (b) a bachelor's degree in occupational therapy from an accredited program in occupational therapy and a master's degree in a related field such as psychology, social work, or counseling.

434.427: Mental Health Services: Operating and Treatment Procedures

- (A) A professional staff member must conduct a comprehensive evaluation of each member prior to initiation of therapy. For members under the age of 21, a CANS must be completed during the initial behavioral-health assessment before initiation of therapy and updated at least every 90 days thereafter by a CANS-certified provider, as described in 130 CMR 434.426(B).
- (B) The psychiatric inpatient hospital must accept for treatment, refer for treatment elsewhere, or both, any member for whom the intake evaluation substantiates a mental or emotional disorder.
- (C) The psychiatric inpatient hospital will ensure that one professional staff member (the primary therapist) assumes primary responsibility for each member. This responsibility includes
- (1) within four member visits, preparation of a comprehensive written treatment plan that is based on the initial evaluation, incorporates short- and long-term treatment goals, and establishes criteria for determining when termination of treatment is appropriate;
 - (2) ongoing care management;
 - (3) review of each case at termination of treatment and preparation of a termination summary that describes the course of treatment and any aftercare program or resources in which the member is expected to participate; and
 - (4) ensuring that a CANS-certified provider, as described in 130 CMR 434.426(B) completes the CANS in accordance with 130 CMR 434.427(A).
- (D) The psychiatric inpatient hospital must make provisions for responding to persons needing services on a walk-in basis.
- (E) The psychiatric inpatient hospital must take appropriate steps to facilitate uninterrupted and coordinated member care whenever it refers a member elsewhere for concurrent or subsequent treatment.
- (F) Before referring a member elsewhere, the psychiatric inpatient hospital must, with the member's consent, send a summary of or the actual record of the member to that referral provider.

434.428: Mental Health Services: Utilization Review Plan

A mental health program must have a utilization review plan that is acceptable to the MassHealth agency and that meets the following conditions.

- (A) A utilization review committee will be formed, composed of the clinical director (or a designee), a psychiatrist, and one other professional staff member from each core discipline represented who meets all the qualifications for the discipline, as outlined in 130 CMR 434.426(B).
- (B) The utilization review committee will review a representative sample of cases at least in the following circumstances:
- (1) within 90 days after initial contact;
 - (2) when a member has required more than 50 visits every 12 months and has not required hospitalization or extensive crisis intervention during that period; and
 - (3) following termination.
- (C) The utilization review committee will verify for a representative sample of cases that
- (1) the diagnosis has been adequately documented;
 - (2) the treatment plan is appropriate and specifies the methods and duration of the projected treatment program;
 - (3) the treatment plan is being or has been carried out;
 - (4) the treatment plan is being or has been modified as indicated by the member's changing status;
 - (5) there is adequate follow-up when a member misses appointments or drops out of treatment;
 - (6) there is progress toward achievement of short- and long-term goals; and

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- (7) for members under the age of 21, the CANS has been completed at the initial behavioral-health assessment and updated at least every 90 days thereafter as part of the treatment plan review.
- (D) No staff member will participate in the utilization review committee's deliberations about any member that staff member is treating directly.
- (E) The program will maintain minutes that are sufficiently detailed to show the decisions of each review and the basis on which any decisions are made so that the MassHealth agency may conduct such audits as it deems necessary.
- (F) Based on the utilization review, the director of clinical services or a designee will determine whether continuation, modification, or termination of treatment is necessary and promptly communicate this decision to the primary therapist.

434.429: Mental Health Services: Recordkeeping Requirements

- (A) The hospital outpatient department must obtain, upon the initiation of treatment, written authorization from each member or the member's legal guardian to release information obtained by the provider to hospital staff, federal and state regulatory agencies, and, when applicable, referral providers, to the extent necessary to carry out the purposes of the program and to meet regulatory requirements, including provider audits.
- (B) In addition to the information required in 130 CMR 434.410, each member's record must include the following information:
 - (1) the member's case number, address, telephone number, sex, age, marital status, next of kin, and school or employment status (or both);
 - (2) the date of initial contact and, if applicable, the referral source;
 - (3) a report of a physical examination performed within six months (if such an examination has not been performed in that period, one must be given within 30 days after the member's request for services or, if the member refuses to be examined, the record must document the reasons for the exam postponement);
 - (4) the name and address of the member's primary physician or medical clinic (a physician or medical clinic must be recommended if there is not one currently attending the member);
 - (5) a description of the nature of the member's condition;
 - (6) the relevant medical, social, educational, and vocational history;
 - (7) a comprehensive functional assessment of the member;
 - (8) the clinical impression of the member and a diagnostic formulation, including a specific diagnosis using DSM IV diagnosis codes;
 - (9) the member's treatment plan, updated as necessary, including long-range goals, short-term objectives, and the proposed schedule of therapeutic activities;
 - (10) a schedule of dates for utilization review to determine the member's progress in accomplishing goals and objectives;
 - (11) the name, qualifications, and discipline of the primary therapist;
 - (12) a written record of utilization reviews by the primary therapist;
 - (13) documentation of each visit, including the member's response to treatment, written and signed by the person providing the service, and including the therapist's discipline and degree;
 - (14) all information and correspondence regarding the member, including appropriately signed and dated consent forms;
 - (15) a medication-use profile;
 - (16) when the member is discharged, a discharge summary; and
 - (17) for members under the age of 21, a copy of the CANS completed during the initial behavioral-health assessment and updated at least every 90 days thereafter.
- (C) A brief history is acceptable for emergency or walk-in visits when the treatment plan does not call for extended care.

434.430: Mental Health Services: Service Limitations

(A) Length and Frequency of Sessions.

(1) The MassHealth agency pays for diagnostic and treatment services only when a professional staff member personally provides these services to the member or the member's family, or personally consults with a professional outside of the hospital outpatient department. The services must be provided to the member on an individual basis.

(2) The MassHealth agency pays for only one session of the types of services listed in 130 CMR 434.430(C) through (H) provided to an individual member on one date of service. Return visits on the same date of service are not reimbursable.

(B) Diagnostic Services. Payment for diagnostic services provided to a member is limited to a maximum of four hours or eight units.

(C) Individual Therapy. Payment for individual therapy is limited to a maximum of one hour per session per day.

(D) Family Therapy.

(1) Payment for family therapy is limited to a maximum of one-and-one-half hours per session per day.

(2) Payment also is limited to one payment per family therapy visit, regardless of the number of staff members or members who are present.

(E) Case Consultation.

(1) The MassHealth agency pays only for case consultation that lasts at least 30 minutes and involves a personal meeting with a professional of another agency. Payment is limited to a maximum of one hour per session.

(2) The MassHealth agency pays for case consultation only when telephone contact, written communication, and other nonreimbursable forms of communication clearly will not suffice. Such circumstances must be documented in the member's record and also in the prior authorization request, if applicable. Such circumstances are limited to situations in which both the hospital outpatient department and the other party are actively involved in treatment or management programs with the member (or family members) and where a lack of face-to-face communication would impede a coordinated treatment program.

(3) The MassHealth agency does not pay for court testimony.

(F) Family Consultation. The MassHealth agency pays for a consultation with the natural or foster parent or legal guardian of a member less than 21 years of age who lives with the child, is responsible for the child's care, and is not an eligible member, when such consultation is integral to the treatment of the member.

(G) Group Therapy.

(1) The MassHealth agency pays only for a group therapy session that has a minimum duration of one hour and a maximum duration of two hours.

(2) Payment is limited to one fee per group member with a maximum of ten members per group regardless of the number of staff members present.

(3) The MassHealth agency does not pay for group therapy when it is performed as an integral part of a psychiatric day treatment program.

(H) Psychological Testing. The MassHealth agency pays for psychological testing only when the following conditions are met.

(1) A psychologist who is licensed by the Massachusetts Board of Registration of Psychologists with a specialization listed in clinical or counseling psychology or a closely related specialty either personally administers the testing or personally supervises such testing during its administration by an unlicensed psychologist.

(2) A battery of tests is performed. These tests must meet the following standards:

(a) the tests are published, valid, and in general use, as evidenced by their presence in the current edition of the *Mental Measurement Yearbook* or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological Association;

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- (b) a personality evaluation contains the findings of at least two of the following test types or their age-appropriate equivalents: Rorschach, TAT (Thematic Apperception Test), TED (Tasks of Emotional Development), or MMPI (Minnesota Multiphasic Personality Inventory), and one or more of the following test types: figure drawing, Bender-Gestalt, or word association;
 - (c) intelligence testing includes either a full Wechsler or Stanford-Binet instrument or an equivalent; and
 - (d) assessment of brain damage contains at least the findings of a Wechsler Intelligence Scale and tests of recent memory, visual-space perception, and other functions commonly associated with brain damage.
- (3) Except as explained below, the MassHealth agency does not pay for
- (a) self-rating forms and other paper-and-pencil instruments, unless administered as part of a comprehensive battery of tests;
 - (b) group forms of intelligence tests;
 - (c) an intelligence test performed at the same time as a brain assessment;
 - (d) short-form, abbreviated, or "quick" intelligence tests administered at the same time as the Wechsler or Stanford-Binet tests; otherwise, such tests are reimbursable only at a lower rate than standard intelligence tests on an individual consideration basis; or
 - (e) a repetition of any psychological test or tests provided to the same member within the preceding six months, unless accompanied by documentation demonstrating that the purpose of the repeated testing is to ascertain changes following such special forms of treatment or intervention as electroshock therapy or psychiatric hospitalization (periodic testing to measure the member's response to psychotherapy is not reimbursable); or relating to suicidal, homicidal, toxic, traumatic, or neurological conditions. Submission of such documentation with the claim for payment is sufficient when the psychological test or tests are to be performed on the same member a second time within a six-month period. Further repetitions will be paid for by the MassHealth agency only if this documentation is submitted and prior authorization granted by the MassHealth agency prior to the testing (*see* 130 CMR 434.409).
- (4) Testing of a member requested by responsible parties, such as but not limited to physicians, clinics, hospitals, schools, courts, group homes, or state agencies, must be documented in the member's record. Such documentation must include the referral source and the reason for the referral.

(I) Medication Visits. The MassHealth agency does not pay for a medication visit as a separate service when it is performed as part of another treatment service (for example, a diagnostic assessment or individual or group therapy performed by a psychiatrist).

434.431: Child and Adolescent Needs and Strengths (CANS) Data Reporting

For each Child and Adolescent Needs and Strengths (CANS) conducted, the hospital must report data collected during the assessment to the MassHealth agency, in the manner and format specified by the MassHealth agency.

REGULATORY AUTHORITY

130 CMR 434.000: M.G.L. c. 118E, §§ 7 and 12.

NON-TEXT PAGE