450.101: Definitions

A number of common words and expressions are specifically defined here. Whenever one of them is used in 130 CMR 450.000, or in a provider contract, it will have the meaning given in the definition, unless the context clearly requires a different meaning. When appropriate, definitions may include a reference to federal and state laws and regulations.

Administrative Action — a measure taken by the MassHealth agency to correct or prevent the recurrence of an unacceptable course of action by a provider, including but not limited to the imposition of an administrative fine or other sanction.

Applicant — A person who completes and submits an application for MassHealth, and is awaiting the decision of eligibility.

Audit — an examination by the MassHealth agency of a provider’s practices by means of an on-site visit, a review of the MassHealth agency’s claim and payment records, a review of a provider’s financial, medical, and other records such as prior authorizations, invoices, and cost reports. The MassHealth agency conducts audits to ensure provider and member compliance with laws and regulations governing MassHealth.

Billing Agent — an entity that contracts with a provider to act as the provider's representative for the preparation and submission of claims.

Claim — a request by a provider for payment for a medical service or product, identified in a format approved by the MassHealth agency, that contains information including member information, date of service, and description of service provided.

Coverage Type — a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria.

Day — a calendar day unless a business day is specified.

Duals Demonstration Dual Eligible Individual — for purposes of the Duals Demonstration Program, a MassHealth member must meet all of the following criteria:

1. be 21 through 64 years of age at the time of enrollment;
2. be eligible for MassHealth Standard as defined in 130 CMR 450.105(A) or MassHealth CommonHealth as defined in 130 CMR 450.105(E);
3. be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: Definition of Terms; and
4. live in a designated service area of an integrated care organization (ICO).

Duals Demonstration Program — the MassHealth state Demonstration to Integrate Care for Duals Demonstration Dual Eligible Individuals.

Eligibility Verification System (EVS) — the member eligibility verification system accessible to providers. EVS also may be referred to as the Recipient Eligibility Verification System (REVS).
Emergency Aid to the Elderly, Disabled and Children Program (EAEDC) — a cash assistance program administered by the Department of Transitional Assistance for certain residents of Massachusetts that also covers certain medical services. The medical services component of the program is administered by the MassHealth agency.

Emergency Medical Condition — a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Emergency Services — medical services that are provided by a provider that is qualified to provide such services, and are needed to evaluate or stabilize an emergency medical condition.

Final Disposition — a written response by a health insurer to a request for payment, such as a rejection notice, an explanation of benefits (EOB), or a similar letter or form, by which the insurer either denies coverage, or acknowledges coverage and indicates the amount that the health insurer will pay.

Group Practice — a legal entity that employs or contracts with individual practitioners who have arranged for the joint use of facilities, and for payment into a common account of proceeds from the delivery of medical services by individual practitioners within the group. A sole proprietorship is not a group practice. An entity that qualifies under the MassHealth agency’s program regulations as another discreet provider type, such as a community health center, is not a group practice. A “participant” in a group practice is any owner, employee, contractor, or provider delivering services through the group practice.

Health Insurer — a private or public entity (including Medicare) that has issued a health insurance plan or policy under which it has agreed to pay for medical services provided to a member.

Individual Practitioners — physicians, dentists, psychologists, certified nurse practitioners, certified nurse midwives, physician assistants, certified registered nurse anesthetists, psychiatric clinical nurse specialists, clinical nurse specialists, and certain other licensed, registered, or certified medical practitioners.

Integrated Care Organization (ICO) — an organization with a comprehensive network of medical, behavioral-health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOS are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

Managed Care — a system of primary care and other medical services that are provided and coordinated by a MassHealth managed care provider in accordance with the provisions of 130 CMR 450.117 and 130 CMR 508.000: MassHealth: Managed Care Requirements.
Third Party — any individual, entity, or program other than MassHealth that is or may be liable to pay all or part of the costs for medical services.

Transitional Aid to Families with Dependent Children (TAFDC) — a federally funded program administered by the Massachusetts Department of Transitional Assistance that provides cash assistance to certain low-income families.

Urgent Care — medical services that are not primary care, and are needed to treat a medical condition that is not an emergency medical condition.

### 450.102: Purpose of 130 CMR 400.000 through 499.000

130 CMR 400.000 through 499.000 contain the MassHealth agency’s regulations specific to provider participation in, and the medical services and benefits available under, MassHealth and the Emergency Aid to the Elderly, Disabled and Children Program. 130 CMR 450.000 applies to all MassHealth providers and services. The MassHealth agency also promulgates other regulations, and publishes other documents affecting these programs, including other chapters in 130 CMR, statements of policy and procedure, conditions of participation, guidelines, billing instructions, provider bulletins, and other documents referenced in 130 CMR. In addition, the regulations in 130 CMR frequently refer to federal regulations, to regulations of the Massachusetts Department of Public Health and other agencies, and to rates and fee schedules established by the Massachusetts Division of Health Care Finance and Policy or the MassHealth agency.

### 450.103: Promulgation of Regulations

(A) All regulations of the MassHealth agency are promulgated in accordance with M.G.L. c. 30A. In the event of any conflict between the MassHealth agency’s regulations and applicable federal laws and regulations, the MassHealth agency’s regulations shall be construed so far as possible to make them consistent with such federal laws and regulations.

(B) Without limiting the generality of 130 CMR 450.103(A), the MassHealth agency’s regulations shall be construed so far as possible to make them consistent with the federal Health Insurance Portability and Accountability Act (HIPAA), including federal regulations promulgated thereunder. To implement and comply with HIPAA, the MassHealth agency, may issue billing instructions, provider bulletins, companion guides, or other materials, which shall be effective and controlling notwithstanding any MassHealth agency regulations to the contrary.

(130 CMR 450.104 Reserved)
### 450.105: Coverage Types

A member is eligible for services and benefits according to the member’s coverage type. Each coverage type is described below. Payment for the covered services listed in 130 CMR 450.105 is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment. See individual program regulations for information on covered services and specific service limitations, including age restrictions applicable to certain services.

(A) **MassHealth Standard.**

(1) **Covered Services.** The following services are covered for MassHealth Standard members (see 130 CMR 505.002: *MassHealth Standard* and 519.002: *MassHealth Standard*).

- abortion services;
- acute inpatient hospital services;
- adult day health services;
- adult foster care services;
- ambulance services;
- ambulatory surgery services;
- audiologist services;
- behavioral health (mental health and substance abuse) services;
- certified nurse midwife services;
- certified nurse practitioner services;
- certified registered nurse anesthetist services;
- Chapter 766: home assessments and participation in team meetings;
- chiropractor services;
- chronic disease and rehabilitation inpatient hospital services;
- clinical nurse specialist services;
- community health center services;
- day habilitation services;
- dental services;
- durable medical equipment and supplies;
- early intervention services;
- family planning services;
- hearing aid services;
- home health services;
- hospice services;
- laboratory services;
- nurse midwife services;
- nurse practitioner services;
- nursing facility services;
- orthotic services;
- outpatient hospital services;
- oxygen and respiratory therapy equipment;
- personal care services;
- pharmacy services;
- physician services;
- physician assistant services;
(eehh) podiatrist services;
(ffeei) private duty nursing services;
(eggiij) prosthetic services;
(kk) psychiatric clinical nurse specialist services;
(hhhlll) rehabilitation services;
(iimmnn) renal dialysis services;
(jinn) speech and hearing services;
(kkoo) therapy services: physical, occupational, and speech/language;
(llpp) transportation services;
(mmmqqq) vision care; and
(nnrrrr) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Standard members must enroll with a MassHealth managed care provider unless excluded from participation in managed care. (See 130 CMR 450.117 and 508.000: MassHealth: Managed Care Requirements.)

(3) Managed Care Organizations. For MassHealth Standard members who are enrolled in a MassHealth MCO, the following rules apply.
   (a) The MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency’s contract with the MCO, except for family planning services that were not provided or arranged for by the MCO. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency’s contract with the MCO.
   (b) The MassHealth agency pays providers other than the MCO for those services listed in 130 CMR 450.105(A)(1) that are not covered by the MassHealth agency’s contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Behavioral-health Services.
   (a) MassHealth Standard members enrolled in the PCC Plan receive behavioral-health services only through the MassHealth behavioral-health contractor. (See 130 CMR 450.124.)
   (b) MassHealth Standard members enrolled in an MCO receive behavioral-health services only through the MCO. (See 130 CMR 450.117.)
   (c) MassHealth Standard members who are excluded from participating in managed care under 130 CMR 508.002: MassHealth Members Excluded from Participation in Managed Care or who have not enrolled in an MCO or with the MassHealth behavioral-health contractor may receive behavioral-health services from any participating MassHealth provider of such services.
   (d) 1. MassHealth Standard members who participate in a senior care organization receive all behavioral-health services only through the senior care organization.
      2. MassHealth Standard members who participate in an integrated care organization receive all behavioral-health services through the integrated care organization.
   (e) MassHealth Standard members who are younger than 21 years old and who are excluded from participating in a MassHealth-contracted MCO under 130 CMR 508.002(A)(1) or (2) or the PCC Plan under 130 CMR 508.002(B)(1) or (2) must enroll with the MassHealth behavioral-health contractor.
(f) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): The Kaileigh Mulligan Program, or who are enrolled in a home- and community-based services waiver may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(g) MassHealth members who are receiving services from the Department of Children and Families (DCF) or the Department of Youth Services (DYS) may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO must enroll with the MassHealth behavioral-health contractor.

(h) MassHealth members who receive Title IV-E adoption assistance described in 130 CMR 522.003: Adoption Assistance and Foster Care Maintenance may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth Standard members, with the exception of members described at 130 CMR 505.002(F): Individuals with Breast or Cervical Cancer, if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(A)(1) that are not available through the member’s third-party health insurer.

(6) Senior Care Organizations. MassHealth Standard members 65 years of age and older may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008: Senior Care Organizations. The MassHealth agency does not pay a provider other than a SCO for any services that are provided to the MassHealth member while the member is enrolled in a SCO.

(7) Integrated Care Organizations. MassHealth Standard members 21 through 64 years of age who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level defined in 130 CMR 501.001: Definition of Terms may voluntarily enroll in integrated care organization (ICO) in accordance with the requirements at 130 CMR 508.007: Integrated Care Organizations. While enrolled in an ICO, MassHealth members who turn 65 years of age and are eligible for MassHealth Standard may remain in an ICO after 65 years of age. The MassHealth agency does not pay a provider other than the ICO for any services that are provided by an ICO while the member is enrolled in the ICO, except for family planning services that were not provided or arranged for by the ICO. It is the responsibility of the provider of services to determine if a MassHealth member is enrolled in an ICO. Upon request, the ICO must inform providers and enrollees of ICO-covered benefits. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.
(B) MassHealth CarePlus.

(1) Covered Services. The following services are covered for MassHealth CarePlus members (see 130 CMR 505.008: MassHealth CarePlus):

(a) abortion services;  
(b) acute inpatient hospital services;  
(c) ambulance services;  
(d) ambulatory surgery services;  
(e) audiologist services;  
(f) behavioral health (mental health and substance abuse) services;  
(g) certified nurse midwife services;  
(h) certified nurse practitioner services;  
(i) certified registered nurse anesthetist services;  
(j) chiropractor services;  
(k) chronic disease and rehabilitation inpatient hospital services;  
(l) clinical nurse specialist services;  
(m) community health center services;  
(n) dental services;  
(o) durable medical equipment and supplies;  
(p) family planning services;  
(q) hearing aid services;  
(r) home health services;  
(s) hospice services;  
(t) laboratory services;  
(u) nurse midwife services;  
(v) nurse practitioner services;  
(w) nursing facility services;  
(x) orthotic services;  
(y) outpatient hospital services;  
(z) oxygen and respiratory therapy equipment;  
(a) pharmacy services;  
(b) physician services;  
(c) physician assistant services;  
(d) podiatrist services;  
(e) prosthetic services;  
(f) psychiatric clinical nurse specialist services;  
(g) rehabilitation services;  
(h) renal dialysis services;  
(i) speech and hearing services;  
(j) therapy services: physical, occupational, and speech/language;  
(k) transportation services;  
(l) vision care; and  
(m) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth CarePlus members must enroll with a MassHealth managed care provider in accordance with 130 CMR 508.001: MassHealth Member Participation in Managed Care. (See also 130 CMR 450.117.)

(3) Managed Care Organizations. For MassHealth CarePlus members who are enrolled in a MassHealth-contracted MCO, the following rules apply.

(a) The MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency’s contract with the MCO, except for family planning services that were not provided or arranged for by the MCO. It is the
responsibility of the provider to verify the scope of services covered by the MassHealth agency’s contract with the MCO.
(b) The MassHealth agency pays providers other than the MCO for those services listed in 130 CMR 450.105(B)(1) that are not covered by the MassHealth agency’s contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Behavioral-health Services.
   (a) MassHealth CarePlus members enrolled in the PCC Plan receive behavioral-health services only through the MassHealth behavioral health contractor. (See 130 CMR 450.124.)
   (b) MassHealth CarePlus members enrolled in an MCO receive behavioral-health services only through the MCO. (See 130 CMR 450.117.)
   (c) MassHealth CarePlus members who are excluded from participating in managed care under 130 CMR 508.002: MassHealth Members Excluded from Participation in Managed Care or who have not enrolled in an MCO or the PCC Plan may receive behavioral-health services from any participating MassHealth provider of such services.

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth CarePlus members, with the exception of members described at 130 CMR 505.002(F): Individuals with Breast or Cervical Cancer, if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(B)(1) that are not available through the member’s third-party health insurer.

(C) MassHealth Buy-In.
   (1) For a MassHealth Buy-In member who is 65 years of age or older or is institutionalized (see 130 CMR 519.011: MassHealth Buy-In), the MassHealth agency pays all of the member’s Medicare Part B premium. The MassHealth agency does not pay for any other benefit for these members.
   (2) MassHealth Buy-In members are responsible for payment of copayments, coinsurance, and deductibles. MassHealth Buy-In members are also responsible for payment for any services that are not covered by the member's insurance.
   (3) The MassHealth agency does not pay providers directly for any services provided to any MassHealth Buy-In member, and therefore does not issue a MassHealth card to MassHealth Buy-In members.
   (4) MassHealth Buy-In members are excluded from participation in any of the MassHealth agency's managed care options pursuant to 130 CMR 508.002: MassHealth Members Excluded from Participation in Managed Care.

(D) MassHealth Senior Buy-In.
   (1) Covered Services. For MassHealth Senior Buy-In members (see 130 CMR 519.010: MassHealth Senior Buy-In), the MassHealth agency pays the member's Medicare Part B premiums, and where applicable, Medicare Part A premiums. The MassHealth agency also pays for coinsurance and deductibles under Medicare Parts A and B.
   (2) Managed Care Member Participation. MassHealth Senior Buy-In members are excluded from participation in managed care pursuant to 130 CMR 508.002: MassHealth Members Excluded from Participation in Managed Care.

(1) Covered Services. The following services are covered for MassHealth CommonHealth members (see 130 CMR 505.004: MassHealth CommonHealth and 519.012: MassHealth CommonHealth.):

(a) abortion services;
(b) acute inpatient hospital services;
(c) adult day health services;
(d) adult foster care services;
(e) ambulance services;
(f) ambulatory surgery services;
(g) audiologist services;
(h) behavioral-health (mental health and substance abuse) services;
(i) certified nurse midwife services;
(j) certified nurse practitioner services;
(k) certified registered nurse anesthetist services;
(l) Chapter 766: home assessments and participation in team meetings;
(m) chiropractor services;
(n) chronic disease and rehabilitation inpatient hospital services;
(o) clinical nurse specialist services;
(p) community health center services;
(q) day habilitation services;
(r) dental services;
(s) durable medical equipment and supplies;
(t) early intervention services;
(u) family planning services;
(v) hearing aid services;
(w) home health services;
(x) hospice services;
(y) laboratory services;
(z) nurse midwife services;
(aa) nurse practitioner services;
(bb) nursing facility services;
(cc) orthotic services;
(dd) outpatient hospital services;
(ee) oxygen and respiratory therapy equipment;
(ff) personal care services;
(gg) pharmacy services;
(hh) physician services;
(ii) physician assistant services;
(jj) podiatrist services;
(kk) private duty nursing services;
(ll) prosthetic services;
(mm) psychiatric clinical nurse specialist services;
(nn) rehabilitation services;
(oo) renal dialysis services;
(pp) speech and hearing services;
(qq) therapy services: physical, occupational, and speech/language;
(rr) transportation services;
(ss) vision care; and
(tt) X-ray/radiology services.
(2) **Managed Care Member Participation.**
   (a) MassHealth CommonHealth members must enroll with a MassHealth managed care provider unless excluded from participation in managed care. *(See 130 CMR 450.117 and 508.000: Managed Care Requirements.)*
   (b) MassHealth CommonHealth members who are younger than 21 years old and who are excluded from participation in a MassHealth-contracted MCO under 130 CMR 508.002(A)(1) or (2) or in the PCC Plan under 130 CMR 508.002(B) (1) or (2) must enroll with the MassHealth behavioral-health contractor.

(3) **Purchase of Health Insurance.** The MassHealth agency may purchase third-party health insurance for any MassHealth CommonHealth member if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(E)(1) that are not available through the member’s third-party health insurer.

(4) **Integrated Care Organizations.** MassHealth CommonHealth members 21 through 64 years of age who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level defined in 130 CMR 501.001: *Definition of Terms* may voluntarily enroll in an integrated care organization (ICO) in accordance with the requirements at 130 CMR 508.007: *Integrated Care Organizations.* The MassHealth agency does not pay a provider other than the ICO for any services that are provided by an ICO while the member is enrolled in the ICO, except for family planning services that were not provided or arranged for by the ICO. It is the responsibility of the provider of services to determine if a MassHealth member is enrolled in an ICO. Upon request, the ICO must inform providers and enrollees of ICO-covered benefits. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

(F) **MassHealth Limited.**
   (1) **Covered Services.** For MassHealth Limited members *(see 130 CMR 505.006: MassHealth Limited and 519.009: MassHealth Limited)*, the MassHealth agency pays only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in
      (a) placing the member’s health in serious jeopardy;
      (b) serious impairment to bodily functions; or
      (c) serious dysfunction of any bodily organ or part.
   (2) **Organ Transplants.** Pursuant to 42 U.S.C. 1396b(v)(2), the MassHealth agency does not pay for an organ-transplant procedure, or for care and services related to that procedure, for MassHealth Limited members, regardless of whether such procedure would otherwise meet the requirements of 130 CMR 450.105(F)(1).
   (3) **Managed Care Member Participation.** MassHealth Limited members are excluded from participation in managed care pursuant to 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care.*
(G) MassHealth Family Assistance.

(1) Premium Assistance. The MassHealth agency provides benefits for MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B), (C), or (D).

(a) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B) and (C), the only benefit the MassHealth agency provides is partial payment of the member's employer-sponsored health insurance, except as provided in 130 CMR 450.105(H).

(b) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B): Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household greater than 150 and less than or Equal to 300% of the Federal Poverty Level, the MassHealth agency provides dental services as described in 130 CMR 420.000: Dental Services.

(c) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(D): Eligibility Requirements for Adults and Young Adults Aged 19 and 20 Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 300% of the Federal Poverty Level, the MassHealth agency issues a MassHealth card and provides

1. full payment of the member's private health-insurance premium; and
2. coverage of any services listed in 130 CMR 450.105(H) not covered by the member's private health insurance. Coverage includes payment of copayments, coinsurance, and deductibles required by the member's private health insurance.

(2) Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance.

(a) For children who meet the requirements of 130 CMR 505.005(B): Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household greater than 150 and less than or equal to 300 Percent of the Federal Poverty Level, the MassHealth agency pays providers directly, or reimburses the member, for

1. copayments, coinsurance, and deductibles relating to well-baby and well-child care; and
2. copayments, coinsurance, and deductibles for services covered under the member’s employer-sponsored health insurance once the member’s family has incurred and paid copayments, coinsurance, and deductibles for eligible members that equal or exceed five percent of the family group’s annual gross income.

(b) Providers should check the Eligibility Verification System (EVS) to determine whether the MassHealth agency will pay a provider directly for a copayment, coinsurance, or deductible for a specific MassHealth Family Assistance member.
(3) Covered Services for Members Who Are Not Receiving Premium Assistance. For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B), (E), (F), or (G), the following services are covered:

(a) abortion services;
(b) acute inpatient hospital services;
(c) ambulance services (emergency only);
(d) ambulatory surgery services;
(e) audiologist services;
(f) behavioral-health (mental health and substance abuse) services;
(g) certified nurse midwife services;
(h) certified nurse practitioner services;
(i) certified registered nurse anesthetist services;
(j) Chapter 766: home assessments and participation in team meetings;
(k) chiropractor services;
(l) chronic disease and rehabilitation inpatient hospital services;
(m) clinical nurse specialist services;
(n) community health center services;
(o) dental services;
(p) durable medical equipment and supplies;
(q) early intervention services;
(r) family planning services;
(s) hearing aid services;
(t) home health services;
(u) hospice services;
(v) laboratory services;
(w) nurse midwife services;
(x) nurse practitioner services;
(y) orthotic services;
(z) outpatient hospital services;
(aa) oxygen and respiratory therapy equipment;
(bb) pharmacy services;
(cc) physician services;
(dd) physician assistant services;
(ee) podiatrist services;
(ff) prosthetic services;
(gg) psychiatric clinical nurse specialist services;
(hh) rehabilitation services;
(ii) renal dialysis services;
(jj) speech and hearing services;
(kk) therapy services: physical, occupational, and speech/language;
(ll) vision care; and
(mm) X-ray/radiology services.

(4) Managed Care Participation.
(a) MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(E): Eligibility Requirement for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or equal to 200 Percent of the Federal Poverty Level, must enroll with a Primary Care Clinician (PCC) or a MassHealth-contracted managed care organization (MCO). (See 130 CMR 450.117.)
(b) If the managed care entity determines that all administrative and other practices were
in compliance with relevant requirements of the Federal Mental Health Parity Law during
the calendar year, the certification will affirmatively state that all relevant administrative
and other practices were in compliance with Federal Mental Health Parity Law.
(c) If the managed care entity determines that any administrative or other practices were
not in compliance with relevant requirements of the Federal Mental Health Parity Law
during the prior calendar year, the certification will state that not all practices were in
compliance with Federal Mental Health Parity Law, and will include a list of the practices
not in compliance, and the steps the managed care entity has taken to bring these practices
into compliance.

(2) A member enrolled in any of these managed care entities may file a grievance with
MassHealth if the member believes that services are provided in a way that is not consistent
with applicable Federal Mental Health Parity laws, regulations or federal guidance. Member
grievances may be communicated for resolution verbally or in writing to MassHealth’s
customer services contractor.

(K) MassHealth managed care options include an integrated care organization (ICO) for
MassHealth Standard and CommonHealth members who also meet the requirements for eligibility
set forth under 130 CMR 508.007: Integrated Care Organizations.
(1) Members who participate in an ICO must choose or be assigned a primary care provider.
(2) Members who participate in an ICO obtain all covered services through the ICO.
(3) Members who enroll in the Duals Demonstration Program may continue to receive
services from their current providers who accept current Medicare or Medicaid fee-for-service
provider rates during a continuity-of-care period. A continuity-of-care period is a period
beginning on the date of enrollment into the Duals Demonstration Program and extends to
either of the following:
   (a) up to 90 days, unless the comprehensive assessment and the individualized-care plan
      are completed sooner and the enrollee agrees to the shorter time period; or
   (b) until the comprehensive assessment and the individualized-care plan are complete.
(4) Members who are enrolled in an ICO are identified on EVS (see 130 CMR 450.107). For
a MassHealth member enrolled with an ICO, EVS will identify the name and telephone
number of the ICO. The MassHealth agency will not pay an entity other than an ICO for any
services that are provided to the MassHealth member while the member is enrolled in an ICO,
except for family planning services that were not provided or arranged for by the ICO.
450.118: Primary Care Clinician (PCC) Plan

(A) Role of Primary Care Clinician. The PCC is the principal source of care for members who are enrolled in the PCC Plan. All services for which such a member is eligible, except those listed in 130 CMR 450.118(J), are payable only when provided by the member's PCC, or when the PCC has referred the member to another MassHealth provider.

(B) Provider Eligibility. Providers who wish to enroll as PCCs must be participating providers in MassHealth, or physician assistants participating pursuant to 130 CMR 433.434, must complete a PCC provider application, which is subject to approval by the MassHealth agency, and must meet the requirements of the PCC provider contract. The following provider types may apply to the MassHealth agency to become PCCs:

1. Individual physicians who have current admitting privileges to at least one MassHealth-participating Massachusetts acute hospital in the physician's service area that participates in MassHealth or who meet 130 CMR 450.118(F)(1), and who are board-eligible or board-certified in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology, or who meet 130 CMR 450.118(F)(2).
2. An independent certified nurse practitioner with one of the following licenses:
   a) A physician specialist must agree to provide primary care services to PCC Plan enrollees;
   b) A physician specialist must agree to provide primary care services to PCC Plan enrollees.

3. Community health centers (freestanding or hospital-licensed) with at least one physician on staff who meets the criteria of 130 CMR 450.118(B)(1); and
4. Acute hospital outpatient departments with at least one physician on staff who meets the criteria of 130 CMR 450.118(B)(1); and
5. Group practices with at least one physician or independent certified nurse practitioner who
   a) is enrolled and approved by the MassHealth agency as a participating provider in that
   b) meets the requirements of 130 CMR 450.118(B)(1) or (2); and
   c) has signed the PCC contract.

6. Physician assistants employed by a group practice, if the group practice also employs at least one physician who supervises the physician assistant and meets the requirements of 130 CMR 450.118(B)(5). The supervisory arrangement must comply with 130 CMR 433.434(D) and 263 CMR 5.00.

(C) Community Health Center Participation. When a community health center participates as a PCC, it must assign each enrollee to an individual practitioner who meets the requirements of 130 CMR 450.118(B)(1) or (2), or to a physician assistant who is supervised by a physician who meets the requirements of 130 CMR 450.118(B)(1).

(D) Hospital Outpatient Department Participation. When a hospital outpatient department participates as a PCC, it must assign each enrollee to an attending physician who meets the requirements of 130 CMR 450.118(B)(1).

(E) Group Practice Participation. When a group practice participates as a PCC, the group practice (1) may claim an enhanced fee only for services provided by those individual practitioners within the group who meet the requirements of 130 CMR 450.118(B)(1) or (2); and
(2) must assign each enrollee to an individual practitioner who meets the criteria under 130 CMR 450.118(B)(1), or (2), or (6).
(l) obstetric services for pregnant and postpartum members provided up to to the end of the month in which the 60-day period following the termination of pregnancy ends;
(m) oxygen and respiratory therapy equipment;
(n) pharmacy services (prescription and over-the-counter drugs);
(o) radiology and other imaging services with the exception of magnetic resonance imaging (MRI) computed tomography (CT) scans, positron emission tomography (PET) scans, and imaging services conducted at an independent diagnostic testing facility (IDTF), which do require a referral;
(p) services delivered by a behavioral health (mental health and substance abuse) provider (including inpatient and outpatient psychiatric services);
(q) services delivered by a dentist;
(r) services delivered by a family planning service provider, for members of child-bearing age;
(s) services delivered by a hospice provider;
(t) services delivered by a limited service clinic;
(u) services delivered in a nursing facility;
(v) services delivered by an anesthesiologist or a certified registered nurse anesthetist;
(w) services delivered in an intermediate care facility for the mentally retarded (ICF-MR);
(x) services delivered to a homeless member outside of the PCC office pursuant to 130 CMR 450.118(K);
(y) services delivered to diagnose and treat sexually transmitted diseases;
(z) services delivered to treat an emergency condition;
(aa) services provided under a home- and community-based waiver;
(bb) sterilization services when performed for family planning services;
(cc) surgical pathology services;
(dd) tobacco-cessation counseling services;
(ee) transportation to covered care;
(ff) vision care in the following categories (see Subchapter 6 of the Vision Care Manual): visual analysis frames, single-vision prescriptions, bifocal prescriptions, and repairs; and
(gg) additional services provided to members whose PCC participates in an Accountable Care Organization (ACO) subject to bulletins and other issuances more particularly describing applicable referral requirements.

(K) Services to Homeless Members. To provide services to homeless members according to 130 CMR 450.118(J)(5)(cc), the provider must furnish written evidence of demonstrated experience in delivering medical care in a nonmedical setting, and request, in writing, designation from the MassHealth agency that the PCC is approved to provide services to homeless members. The MassHealth agency retains the right to approve or disapprove such a request or revoke an approval of such a request at any time.
(L) **Recordkeeping and Reporting.**

1. **PCC Recordkeeping Requirement.** The PCC must document all referrals in the member's medical record by recording the following:
   
   (a) the date of the referral;
   
   (b) the name of the provider to whom the member was referred;
   
   (c) the reason for the referral;
   
   (d) number of visits authorized; and
   
   (e) copies of the reports required by 130 CMR 450.118(L)(2).

2. **Reporting Requirements.** The PCC who made the referral must obtain from the provider who furnished the service the results of the referred visit by telephone and in writing whenever legally possible.

(M) **Other Program Requirements.** Payment for services provided to members enrolled with a MassHealth managed care provider is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(N) **PCC Contracts.** Providers that are PCCs are bound by and liable for compliance with the terms of the most recent PCC contract issued by the MassHealth agency, including amendments to the contract, as of the effective date specified in the PCC contract or amendment.

(130 CMR 450.119 through 450.123 Reserved)
450.140: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction

(A) Legal Basis.
   (1) In accordance with federal law at 42 U.S.C. 1396d(a)(4)(b) and (r) and 42 CFR 441.50, and notwithstanding any limitations implied or expressed elsewhere in MassHealth regulations or other publications, the MassHealth agency has established a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for MassHealth Standard and MassHealth CommonHealth members younger than 21 years old, including those who are parents.
   (2) Any qualified MassHealth provider may deliver EPSDT services. However, in delivering well-child care, providers must follow the EPSDT Medical Protocol and Periodicity Schedule.
   (3) EPSDT screening services include among other things, health, vision, dental, hearing, behavioral health, developmental and immunization status screening services.
   (4) The regulations governing the EPSDT program are set forth in 130 CMR 450.140 through 450.149.

(B) Program Objectives. The objectives of the EPSDT program are
   (1) to provide comprehensive and continuous health care designed to prevent illness and disability;
   (2) to foster early detection and prompt treatment of health problems before they become chronic or cause irreversible damage;
   (3) to create an awareness of the availability and value of preventive well-child care services; and
   (4) to create an awareness of the services available under the EPSDT program, and where and how to obtain those services.

450.141: EPSDT Services: Definitions

Dental Care — dental services customarily furnished by or through dental providers as defined in 130 CMR 420.000: Dental Services, to the extent the furnishing of those services is authorized by the MassHealth agency.

EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule) — a schedule (see Appendix W of all MassHealth provider manuals) developed and periodically updated by the MassHealth agency in consultation with recognized medical and dental organizations involved in child health care. The Dental Schedule consists of screening and treatment procedures arranged according to the intervals or age levels at which each procedure is to be provided.

EPSDT Medical Protocol and Periodicity Schedule (the Medical Schedule) — a schedule (see Appendix W of all MassHealth provider manuals) developed and periodically updated by the MassHealth agency in consultation with recognized medical and dental organizations involved in child health care. The Medical Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.
Interperiodic Visit — the provision of screening procedures or treatment services at an age other than those indicated on the Medical or the Dental Schedule. Interperiodic visits may be:

1. screenings that are medically necessary to determine the existence of a suspected illness or condition, or a change in or complication of a preexisting condition;
2. the provision of the full-range of EPSDT screening or treatment services delivered at an age other than one listed on the Medical or Dental Schedule to update the member's care according to the Medical or Dental Schedule; or
3. additional screening or treatment services provided to a member whose care is already up-to-date according to the Medical or Dental Schedule.

Periodic Visit — the provision of screening procedures appropriate to the member's age and medical history, as prescribed by the Medical Schedule or the Dental Schedule.

Primary Care — health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, independent certified nurse practitioner, or independent certified nurse midwife, or physician assistant to the extent the furnishing of those services is legally authorized in the Commonwealth. Primary care does not include emergency or poststabilization services provided in a hospital or other setting.

Primary Care Providers — a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, independent-certified nurse practitioner, or independent certified nurse midwife, or physician assistant.

450.142: EPSDT Services: Medical Protocol and Periodicity Schedule and Dental Protocol and Periodicity Schedule

(A) Providers of Periodic and Interperiodic Visits.

1. Primary care providers must offer to conduct periodic and medically necessary interperiodic visits to screen all members under age 21 (except members enrolled in MassHealth Limited) in accordance with the Medical Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.

2. Hospitals and community health centers that provide primary care services must offer to conduct periodic and medically necessary interperiodic visits to screen all members under age 21 (except members enrolled in MassHealth Limited) in accordance with the Medical Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.

3. The health assessments described in the Medical Schedule are payable when provided by a physician, independent-certified nurse practitioner, independent-certified nurse midwife, hospital, community health center, nurse practitioner, or physician assistant under a physician's supervision.
(B) **Providers of Dental Services.**

1. Dental care providers must offer to provide services listed in Appendix W of all MassHealth provider manuals to all members under age 21 (except members enrolled in MassHealth Limited) in accordance with the Dental Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.

2. The dental services described in the Dental Schedule are payable when provided by dental providers as described in 130 CMR 420.000: *Dental Services.*

(C) **Explanation of Procedures.**

1. The Medical Schedule outlines the procedures for comprehensive preventive care that help to identify members who may require further diagnosis of suspected or actual health problems, treatment of these problems, or both.

2. The Medical Schedule explains procedures that must be documented in the medical record.

3. The Dental Schedule is a tool to help dental providers identify members with suspected or actual dental problems that may require additional investigations, diagnosis, or treatment.

450.143: EPSDT Services: Description of Medical Protocol and Periodicity Schedule Visits (EPSDT Visits)

(A) **Initial EPSDT Visit.**

1. An initial EPSDT visit must be provided for every
   
   a. new member;
   
   b. member previously seen only for sick care; and
   
   c. newborn previously seen only in the hospital.

2. An initial EPSDT visit includes the recording of
   
   a. family, medical, behavioral health, developmental, and immunization history;
   
   b. a review of all systems;
   
   c. a comprehensive physical examination; and
   
   d. all exams, assessments, screening, and laboratory work indicated on the Medical Schedule as appropriate for the member's age.

(B) **EPSDT Periodic Visit.**

1. An EPSDT periodic visit consists of all exams, assessments, screenings, and laboratory work indicated on the Medical Schedule as appropriate for the member's age.

2. A provider may claim payment for an EPSDT periodic visit only when all the screening procedures on the Medical Schedule that correspond to the member's age have been delivered to the member.
   
   a. While the screening procedures are based upon a presumption of regular contact with health-care providers, many members will need additional screening procedures to bring them up to date.
   
   b. It is the provider's responsibility to provide those additional screening procedures necessary to bring the member up to date with his or her preventive health care according to the Medical Schedule.
(3) If the provider is unequipped to perform a test (for example, if he or she does not have an audiometer and an audiometric test is required), the provider must make a screening referral to another provider. However, in every case, for the referring provider to claim payment for an EPSDT periodic visit
   (a) all required screening procedures must be performed; and
   (b) the referring provider must receive and document all results in the member’s medical record.

(C) EPSDT Interperiodic Visit. An EPSDT interperiodic visit is any visit not indicated on the Medical Schedule. Such visits may be either
   (1) preventive health-care visits provided at an age or age interval not indicated on the Medical Schedule; or
   (2) a screening that is medically necessary to determine the existence of a suspected illness or condition, or a change in or complication of a preexisting condition.

450.144: EPSDT Services: Diagnosis and Treatment

(A) (1) EPSDT diagnosis and treatment services consist of all medically necessary services listed in 1905(a) of the Social Security Act (42 U.S.C. 1396d(a) and (r)) that are
   (a) needed to correct or ameliorate physical or mental illnesses and conditions discovered by a screening, whether or not such services are covered under the State Plan; and
   (b) payable for MassHealth Standard and MassHealth CommonHealth members under age 21 years, if the service is determined by the MassHealth agency to be medically necessary.

(2) To receive payment for any service described in 130 CMR 450.144(A)(1) that is not specifically included as a covered service under any MassHealth regulation, service code list, or contract, the requester must submit a request for prior authorization in accordance with 130 CMR 450.303. This request must include, without limitation, a letter and supporting documentation from a MassHealth-enrolled physician, physician assistant, certified nurse practitioner, nurse certified midwife, or certified clinical nurse specialist, documenting the medical need for the requested service. If the MassHealth agency approves such a request for service for which there is no established payment rate, the MassHealth agency will establish the appropriate payment rate for such service on an individual-consideration basis in accordance with 130 CMR 450.271. If the request is for a member who is enrolled in a MassHealth-contracted managed care organization, as defined in 130 CMR 508.000; MassHealth: Managed Care Requirements, the requestor must submit the request to the managed care organization according to the managed care organization’s prior-authorization process. If the request is for a behavioral health service for a member who is enrolled with MassHealth’s behavioral health contractor, as defined in 130 CMR 508.000, the requestor must submit the request to the behavioral health contractor according to the behavioral health contractor’s prior authorization process.
(B) For any condition that requires further assessment, diagnosis or treatment after the periodic or interperiodic visit, the provider must inform the member how and where to obtain further assessment, diagnosis, or treatment, and must either
   (1) request that the member return for another appointment as soon as possible; or
   (2) make a referral to another provider who can provide the appropriate assessment, diagnosis, or treatment as soon as the referring provider determines that a referral is needed.

(C) When making a referral to another provider, the referring provider must give the name and address of an appropriate provider to the member or to the member's parent or guardian.

(D) The referring provider must obtain a report of the results of assessment, diagnosis, and treatment from the provider of the referred service and document this information in the member's medical record.

450.145: EPSDT Services: Claims for Visits

(A) Initial EPSDT Visit. A provider may bill for only one initial EPSDT visit per member.

(B) Periodic Visits.
   (1) For each member from birth through two years of age, a provider may bill for only one periodic visit per age level listed in the Medical Schedule.
   (2) For each member aged two years through 20 years, a provider may bill for only one periodic visit every year.

(C) Interperiodic Visits. There is no limit on the number of medically necessary interperiodic visits that may be billed. Only interperiodic visits, at which the full range of EPSDT screening services are delivered, are payable as EPSDT periodic visits, subject to the limitations in 130 CMR 450.145(B). Any other interperiodic visit is payable according to the visit service codes and descriptions in Subchapter 6 of the screening provider's MassHealth provider manual.

(D) Newborn Visits. (Physician, Physician Assistant, Certified Independent Nurse Practitioner, Independent-Certified Nurse Midwife, and Community Health Center Providers Only)
   (1) To be paid for an EPSDT periodic visit of a newborn, the provider must have visited the newborn at least twice before the newborn leaves the hospital.
      (a) The first visit, for an initial history and physical examination, is payable as newborn care and not as an EPSDT periodic visit.
      (b) The second visit, for a discharge history, physical examination, and all other screens required for the newborn, is payable as an EPSDT periodic visit.
   (2) Additional hospital visits for ill newborns are payable according to the service codes and descriptions for hospital visits.
   (3) The newborn EPSDT periodic visit may occur at the provider's office if the infant's length of stay in the hospital is not long enough for the provider to visit the infant twice before the infant is discharged from the hospital.
(E) Reporting Requirement. To claim payment for an EPSDT initial, periodic, or interperiodic visit, a provider must submit a completed claim according to the MassHealth’s billing and claims submission requirements instructions in Subchapter 5 of the applicable MassHealth provider manual.

450.146: EPSDT Services: Claims for Laboratory Services, Audiometric Hearing Tests, Vision Tests, and Behavioral Health Screening (Physician, Physician Assistant, Certified Independent Nurse Practitioner, Independent-Certified Nurse Midwife, Certified Clinical Nurse Specialist, and Community Health Center Providers Only)

(A) Laboratory Services. The laboratory services that are listed in Appendix Z of all MassHealth provider manuals and included in the Schedule are payable, in addition to the initial, periodic, or interperiodic visit, when they are performed and interpreted in the office of the provider who performed the initial, periodic, or interperiodic visit.

(B) Audiometric Hearing and Vision Tests. Payments for the audiometric hearing tests and the bilateral quantitative screening test of visual acuity that are listed in Appendix Z of all MassHealth provider manuals and included in the Medical Schedule, is not included in the fee for an initial, periodic, or interperiodic visit. Payment for these tests may be claimed separately.

(C) Behavioral Health Screening. Payment for the administration and scoring of one of the standardized behavioral health screening tools that is listed in Appendix Z of all MassHealth provider manuals and set forth in the Medical Schedule is not included in the fee for an initial, periodic, or interperiodic visit.

(130 CMR 450.147 Reserved)
450.148: EPSDT Services: Payment for Transportation

Transportation may be available to members accessing EPSDT services. Providers must ask members if they need transportation assistance, and refer those members who do to MassHealth Customer Service for additional information about transportation.

450.149: EPSDT Services: Recordkeeping Requirements

(A) Medical Records.
   (1) A provider must create and maintain a record for every member receiving EPSDT services, in accordance with MassHealth regulations governing medical records at 130 CMR 450.205.
   (2) In addition, the medical record for each member receiving EPSDT services must contain documentation of the screening procedures listed in Appendix W as well as the following:
      (a) the results of all laboratory tests;
      (b) the name of each referral provider; and
      (c) the results of any component of the Medical Schedule that was delivered by another provider.

(B) Determination of Compliance with Medical Standards. The MassHealth agency may review the medical records of members receiving EPSDT services to determine the necessity and quality of the medical services provided. Any such determinations will be made in accordance with 130 CMR 450.204 and 450.206.
450.150: Preventive Pediatric Health-Care Screening and Diagnosis (PPHSD) Services for Certain MassHealth Members

(A) MassHealth has established a program of preventive pediatric health-care screening and diagnosis services for MassHealth members younger than 21 years old who are enrolled in MassHealth Family Assistance. MassHealth Standard and MassHealth CommonHealth members are entitled to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services pursuant to 130 CMR 450.140.

(B) Any qualified MassHealth provider may deliver preventive pediatric health-care screening and diagnosis services.

1. In delivering preventive pediatric health-care screening and diagnosis services, providers must
   (a) follow the procedures listed in the Medical Schedule; and
   (b) comply with the regulations at 130 CMR 450.140 through 450.150.

2. Preventive pediatric health-care screening and diagnosis services include health, vision, dental, hearing, behavioral health, developmental, and immunization status screening services.

3. To interpret the applicable EPSDT regulations for children enrolled in MassHealth Family Assistance, providers should substitute the term, preventive pediatric health-care diagnosis and treatment services, for the term, Early and Periodic Screening, Diagnosis and Treatment Services, wherever it appears.

(C) Providers delivering preventive pediatric health-care screening and diagnosis services should provide members with, or refer members for, additional diagnosis and treatment services according to 130 CMR 450.105.

(130 CMR 450.151 through 450.199 Reserved)