

130 CMR: DIVISION OF MEDICAL ASSISTANCE

130 CMR 433.000: PHYSICIAN SERVICES

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433.401: Definitions

The following terms used in 130 CMR 433.000 have the meanings given in 130 CMR 433.401 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 433.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 433.000 and in 130 CMR 450.000: *Administrative and Billing Regulations*.

Acupuncture — the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, with or without the application of an electric current, and with or without the application of heat to the needles, skin, or both.

Child and Adolescent Needs and Strengths (CANS) — 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 younger than 21 years old.

Consultant — a licensed physician whose practice is limited to a specialty and whose written advice or opinion is requested by another physician or agency in the evaluation or treatment of a member's illness or disability.

Consultation — a visit made at the request of another physician.

Controlled Substance — a drug listed in Schedule II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

Cosmetic Surgery — a surgical procedure that is performed for the exclusive purpose of altering appearance and is unrelated to disease or physical defect, or traumatic injury.

Couple Therapy — therapeutic services provided to a couple for whom the disruption of their marriage, family, or relationship is the primary reason for seeking treatment.

Diagnostic Radiology Service — a radiology service intended to identify an injury or illness.

Domiciliary — for use in the member's place of residence, including a long-term-care facility.

Drug — a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

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 individual, as further defined in § 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

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

Family Planning — any medically approved means, including diagnosis, treatment, and related counseling, that helps individuals of childbearing age, including sexually active minors, to determine the number and spacing of their children.

Family Therapy — a session for simultaneous treatment of two or more members of a family.

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

High-risk Newborn Care — care of a full-term newborn with a critical medical condition or of a premature newborn requiring intensive care.

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Home or Nursing Facility Visit — a visit by a physician to a member at a residence, nursing facility, extended care facility, or convalescent or rest home.

Hospital-licensed Health Center (HLHC) — a facility that

- (1) operates under a hospital's license but is not physically attached to the hospital;
- (2) is subject to the fiscal, administrative, and clinical management of the hospital;
- (3) provides services to patients solely on an outpatient basis;
- (4) demonstrates CMS provider-based status in accordance with 42 CFR 413.65;
- (5) meets all regulatory requirements for participation in MassHealth as a hospital-licensed health center; and
- (6) is enrolled with the MassHealth agency as a hospital-licensed health center.

Hospital Visit — a bedside visit by a physician to a hospitalized member, except for routine preoperative and postoperative care.

Hysterectomy — a medical procedure or operation for the purpose of removing the uterus.

Independent Diagnostic Testing Facility (IDTF) — a Medicare-certified diagnostic imaging center, freestanding MRI center, portable x-ray, sleep center, or mammography van in a fixed location or mobile entity independent of a hospital or physician's office, that performs diagnostic tests and meets the requirements of 130 CMR 431.000: *Independent Diagnostic Testing Services*.

Individual Psychotherapy — private therapeutic services provided to a member to lessen or resolve emotional problems, conflicts, and disturbances.

Institutionalized Individual — an individual who is

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

Intensive Care Services — the services of a physician other than the attending physician, provided for a continuous period of hours (rather than days), required for the treatment of an unusual aspect or complication of an illness, injury, or pregnancy.

Interchangeable Drug Product — a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A-rated") by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

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

MassHealth Drug List — a list of commonly prescribed drugs and therapeutic class tables published by the MassHealth agency. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 433.443(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 433.000.

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

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Midlevel Practitioner — a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, clinical nurse specialist, psychiatric clinical nurse specialist, and physician assistant. In general, subject to compliance with state and federal law, the requirements and limitations in 130 CMR 433.000 that apply to a physician, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage, also apply to midlevel practitioners.

Multiple-source Drug — a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Non-drug Product List — a section of the MassHealth Drug List comprised of those products not classified as drugs (*i.e.*, blood testing supplies) that are payable by the MassHealth agency through the Pharmacy Program. Payment for these items is in accordance with rates published in 114.3 CMR 22.00: *Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment* and 101 CMR 317.00: *Medicine*. The MassHealth Non-drug Product List also specifies which of the included products require prior authorization.

Over-the-counter Drug — any drug for which no prescription is required by federal or state law. These drugs are sometimes referred to as nonlegend drugs. The MassHealth agency requires a prescription for both prescription drugs and over-the-counter drugs (*see* 130 CMR 433.441(A)).

Not Otherwise Classified — a term used for service codes that should be used when no other service code is appropriate for the service provided.

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

Oxygen — gaseous or liquid medical-grade oxygen that conforms to United States Pharmacopoeia Standards.

Pharmacy Online Processing System (POPS) — the online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

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

Prescription Drug — any drug for which a prescription is required by applicable federal or state law or regulation, other than MassHealth regulations. These drugs are sometimes referred to as legend drugs.

Reconstructive Surgery — a surgical procedure performed to correct, repair, or ameliorate the physical effects of disease or physical defect (for example, correction of cleft palate), or traumatic injury.

Referral — the transfer of the total or specific care of a member from one physician to another. For the purposes of 130 CMR 433.000, a referral is not a consultation.

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Respiratory Therapy Equipment — a product that

- (1) is fabricated primarily and customarily for use in the domiciliary treatment of pulmonary insufficiencies for its therapeutic and remedial effect;
- (2) is of proven quality and dependability; and
- (3) conforms to all applicable federal and state product standards.

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

Sterilization — any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Therapeutic Radiology Service — a radiology service used to treat an injury or illness.

Therapy Visit — a personal contact provided as an office visit or outpatient visit for the purpose of providing a covered physical or occupational therapy service by a physician or licensed physical or occupational therapist employed by the physician. Additionally, speech therapy services provided by a physician as an office or outpatient visit is considered a therapy visit.

Unit-dose Distribution System — a means of packaging or distributing drugs, or both, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit-dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken.

433.402: Eligible Members

- (A)(1) MassHealth Members. The MassHealth agency pays for physician services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the MassHealth regulations. 130 CMR 450.105: *Coverage Types* specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.
- (2) Recipients of 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: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

433.403: Provider Eligibility

- (A) Participating Providers.
 - (1) 130 CMR 433.000 applies to medical, radiology, laboratory, anesthesia, and surgery services provided to members by physicians participating in MassHealth as of the date of service.
 - (2) To be eligible for payment, a physician must be physically present and actively involved in the treatment of the member. Time periods specified in the service descriptions refer to the amount of time the physician personally spends with the member, except in the instances noted where the service can be performed under the direct supervision of the physician. For surgery, the physician must be scrubbed and must be present in the operating room during the major portion of an operation.
 - (3) Provider participation requirements for certified nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, psychiatric clinical nurse specialists, and physician assistants are also addressed in 130 CMR 433.000.

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(B) In-state. An in-state physician is a physician who is licensed by the Massachusetts Board of Registration in Medicine.

(C) Out-of-state. An out-of-state physician must be licensed to practice in his or her state. The MassHealth agency pays an out-of-state physician for providing covered services to a MassHealth member only under the following circumstances.

(1) The physician practices in a community of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont that is within 50 miles of the Massachusetts border and provides services to a member who resides in a Massachusetts community near the border of that physician's state.

(2) The physician provides services to a member who is authorized to reside out-of-state by the Massachusetts Department of Children and Families.

(3) The physician practices outside a 50-mile radius of the Massachusetts border and provides emergency services to a member.

(4) The physician practices outside a 50-mile radius of the Massachusetts border and obtains prior authorization from the MassHealth agency before providing a nonemergency service. Prior authorization will be granted only for services that are not available from comparable resources in Massachusetts, that are generally accepted medical practice, and that can be expected to benefit the member significantly. To request prior authorization, the out-of-state physician or the referring physician must send the MassHealth agency a written request detailing the proposed treatment and naming the treatment facility (see the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*). The MassHealth agency will notify the member, the physician, and the proposed treatment facility of its decision. If the request is approved, the MassHealth agency will assist in any arrangements needed for transportation.

433.404: Nonpayable Circumstances

(A) The MassHealth agency does not pay a physician for services provided under any of the following circumstances.

(1) The services were provided by a physician who individually or through a group practice has contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution that involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to member care.

(2) The services were provided by a physician who is an attending, visiting, or supervising physician in an acute, chronic, or rehabilitation hospital but who is not legally responsible for the management of the member's case with respect to medical, surgery, anesthesia, laboratory, or radiology services.

(3) The services were provided by a physician who is a salaried intern, resident, fellow, or house officer. 130 CMR 433.404 does not apply to a salaried physician when the physician supplements his or her income by providing services during off-duty hours on premises other than those of the institution that pays the physician a salary, or through which the physician rotates as part of his or her training.

(4) The services were provided in a state institution by a state-employed physician or physician consultant.

(5) Under comparable circumstances, the physician does not customarily bill private patients who do not have health insurance.

(B) The MassHealth agency does not pay a physician for performing, administering, or dispensing any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment.

(C) The MassHealth agency does not pay a physician for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does pay a physician for the diagnosis of male or female infertility.

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(D) The MassHealth agency does not pay a physician for otherwise payable service codes when those codes are used to bill for circumstances that are not payable pursuant to 130 CMR 433.404.

433.405: Maximum Allowable Fees

The MassHealth agency pays for physician services with rates set by the Executive Office of Health and Human Services (EOHHS), subject to the conditions, exclusions, and limitations set forth in 130 CMR 433.000. EOHHS fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations:

- (A) 101 CMR 315.00: *Vision Care Services and Ophthalmic Services*
- (B) 101 CMR 316.00: *Surgery and Anesthesia Services*
- (C) 101 CMR 317.00: *Medicine*
- (D) 101 CMR 318.00: *Radiology*
- (E) 101 CMR 320.00: *Clinical Laboratory Services*

433.406: Individual Consideration

(A) The MassHealth agency has designated certain services in Subchapter 6 of the *Physician Manual* as requiring individual consideration. This means that the MassHealth agency will establish the appropriate rate for these services based on the standards and criteria set forth in 130 CMR 433.406(B). Providers claiming payment for any service requiring individual consideration must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that may include, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The MassHealth agency does not pay claims for services requiring individual consideration unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim. See 130 CMR 433.410 for report requirements.

(B) The MassHealth agency determines the appropriate payment for a service requiring individual consideration in accordance with the following standards and criteria:

- (1) the amount of time required to perform the service;
- (2) the degree of skill required to perform the service;
- (3) the severity and complexity of the member's disease, disorder, or disability;
- (4) any applicable relative-value studies;
- (5) any complications or other circumstances that the MassHealth agency deems relevant;
- (6) the policies, procedures, and practices of other third-party insurers;
- (7) the payment rate for drugs as set forth in the MassHealth pharmacy regulations at 130 CMR 406.000: *Pharmacy*; and
- (8) for drugs or supplies, a copy of the invoice from the supplier showing the actual acquisition cost.

433.407: Service Limitations: Professional and Technical Components of Services and Procedures

Additional limitations are set forth in 130 CMR 433.413 and 433.437.

(A) Definitions.

- (1) Professional Component — the component of a service or procedure representing the physician's work interpreting or performing the service or procedure.
- (2) Technical Component — the component of a service or procedure representing the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses of the service or procedure, excluding the physician's professional component.

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(B) Payment. A physician may bill for the professional component of a service or procedure or, subject to the conditions of payment set forth in 130 CMR 433.407(C), both the professional and technical components of the service or procedure. The MassHealth agency does not pay a physician for providing the technical component only of a service or procedure.

(C) Conditions of Payment for the Provision of Both the Professional and Technical Components of a Service or Procedure. Only the physician providing the professional component of the service or procedure may bill for both the professional and technical components. This constitutes a limited exception to 130 CMR 450.301: *Claims*. A physician may bill for providing both the professional and technical components of a service or procedure in the physician's office when the physician owns or leases the equipment used to perform the service or procedure, provides the technical component (either directly or by employing a technician), and provides the professional component.

433.408: Prior Authorization, Orders, Referrals, and Prescriptions

(A) Introduction.

- (1) Subchapter 6 of the *Physician Manual* lists codes that require prior authorization as a prerequisite for payment. The MassHealth agency does not pay for services if billed under any of these codes, unless the provider has obtained prior authorization from the MassHealth agency before providing the service.
- (2) A 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.

(B) Requesting Prior Authorization. All prior authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Physician Manual*.

(C) Physician Services Requiring Prior Authorization. Services requiring prior authorization include, but are not limited to, the following:

- (1) certain surgery services, including reconstructive surgery and gender affirming surgery;
- (2) nonemergency services provided to a member by an out-of-state physician who practices outside a 50-mile radius of the Massachusetts border;
- (3) certain vision care services; and
- (4) certain behavioral health services.

(D) Mental Health and Substance Abuse Services Requiring Prior Authorization. Members enrolled with the MassHealth behavioral health contractor require service authorization before certain mental health and substance abuse services are provided. For more information, see 130 CMR 450.124: *Behavioral Health Services*.

(E) Therapy Services Requiring Prior Authorization. Prior authorization is required for the following therapy services provided by any MassHealth provider to eligible MassHealth members.

- (1) more than 20 occupational-therapy visits or 20 physical-therapy visits, including group-therapy visits, for a member within a 12-month period; and
- (2) more than 35 speech/language therapy visits, including group-therapy visits, for a member within a 12-month period.

(F) Other Services Requiring Prior Authorization, Orders, Referrals, or Prescriptions. Many other services require prior authorization, or must first be ordered, referred, prescribed, or otherwise have their need substantiated by a physician or other practitioner before the MassHealth agency will cover the service. When such a service is medically necessary for an eligible MassHealth member, a treating physician or other practitioner shall provide such orders, referrals, prescriptions, medical necessity documentation, certifications, plans of care, examinations, or take such other actions that the MassHealth agency requires as a condition of payment for the service. Coverage requirements for particular MassHealth services are contained in the applicable MassHealth program regulations and guidance and are found in the MassHealth Provider Library.

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These services include, but are not limited to, the following:

- (1) transportation;
- (2) drugs;
- (3) home health services;
- (4) nursing facility services;
- (5) durable medical equipment; and
- (6) therapy services.

433.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any service listed in 130 CMR 433.000 is conditioned upon its full and complete documentation in the member's medical record. Payment for maintaining the member's medical record is included in the fee for the service.

(B) In order for a medical record to document completely a service or services to a member, that record must set forth the nature, extent, quality, and necessity of care provided to the member. When the information contained in a member's medical record is not sufficient to document the service for which payment is claimed by the provider, the MassHealth agency will disallow payment for the claimed service.

(C) The MassHealth agency may at its discretion request, and upon such request the physician must provide, any and all medical records of members corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, § 38, and 130 CMR 450.205: *Recordkeeping and Disclosure*. The MassHealth agency may produce, or at its option may require the physician to produce, photocopies of medical records instead of actual records when compliance with 130 CMR 433.409(C) would otherwise result in removal of medical records from the physician's office or other place of practice.

(D) (1) Medical records corresponding to office, home, nursing facility, hospital outpatient department, and emergency department services provided to members must include the reason for the visit and the data upon which the diagnostic impression or statement of the member's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, these medical records must include, but may not be limited to, the following:

- (a) the member's name and date of birth;
- (b) the date of each service;
- (c) the name and title of the person performing the service, if the service is performed by someone other than the physician claiming payment for the service;
- (d) the member's medical history;
- (e) the diagnosis or chief complaint;
- (f) clear indication of all findings, whether positive or negative, on examination;
- (g) any medications administered or prescribed, including strength, dosage, and regimen;
- (h) a description of any treatment given;
- (i) recommendations for additional treatments or consultations, when applicable;
- (j) any medical goods or supplies dispensed or prescribed;
- (k) any tests administered and their results; and
- (l) for members younger than 21 years old who are being treated by a physician or psychiatric clinical nurse specialist, a CANS completed during the initial behavioral-health assessment and updated at least once every 90 days thereafter.

(2) When additional information is necessary to document the reason for the visit, the basis for diagnosis, or the justification for future diagnostic procedures, treatments, or recommendations for return visits or materials, such information must also be contained in the medical record. Basic data collected during previous visits (for example, identifying data, chief complaint, or history) need not be repeated in the member's medical record for subsequent visits. However, data that fully document the nature, extent, quality, and necessity of care provided to a member must be included for each date of service or service code claimed for payment, along with any data that update the member's medical course.

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(E) For inpatient visit services provided in acute, chronic, or rehabilitation hospitals, there must be an entry in the hospital medical record corresponding to and substantiating each hospital visit claimed for payment. An inpatient medical record will be deemed to document services provided to members and billed to the MassHealth agency if it conforms to and satisfies the medical record requirements set forth in 105 CMR 130.000: *Licensure of Hospitals*. The physician claiming payment for any hospital inpatient visit service is responsible for the adequacy of the medical record documenting such service. The physician claiming payment for an initial hospital visit must sign the entry in the hospital medical record that documents the findings of the comprehensive history and physical examination.

(F) Additional medical record requirements for radiology, psychiatry, and other services can be found in the applicable sections of 130 CMR 433.000.

(G) Compliance with the medical record requirements set forth in, referred to in, or deemed applicable to 130 CMR 433.000 will be determined by a peer-review group designated by the MassHealth agency as set forth in 130 CMR 450.206: *Determination of Compliance with Medical Standards*. The MassHealth agency will refuse to pay or, if payment has been made, will consider such payment to be an overpayment as defined in 130 CMR 450.235: *Overpayments* subject to recovery, for any claim that does not comply with the medical record requirements established or referred to in 130 CMR 433.000. Such medical record requirements constitute the standard against which the adequacy of records will be measured for physician services, as set forth in 130 CMR 450.205(B).

433.410: Report Requirements

(A) General Report. A general written report or a discharge summary must accompany the physician's claim for payment for any service that is listed in Subchapter 6 of the *Physician Manual* as requiring a report or individual consideration (I.C.), or if the code is for an unlisted service. This report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of the service.

(B) Operative Report. For surgery procedures designated in Subchapter 6 of the *Physician Manual* as requiring individual consideration, the provider must attach operative notes to the claim. An operative report must state the operation performed, the name of the member, the date of the operation, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and surgical assistants, and the technical procedures performed.

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

For each Child and Adolescent Needs and Strengths (CANS) conducted as described in 130 CMR 433.429, the physician or psychiatric clinical nurse specialist must report data collected during the assessment to the MassHealth agency, in the manner and format specified by the MassHealth agency.

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

The MassHealth agency pays for all medically necessary physician services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction*, without regard to service limitations described in 130 CMR 433.000, and with prior authorization.

433.413: Office Visits: Payment Limitations

(A) Time Limit. Payment for office visits is limited to one visit per day per member per physician.

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(B) Office Visit and Treatment/Procedure. The physician may bill for either an office visit or a treatment/procedure, but may not bill for both an office visit and a treatment/procedure for the same member on the same date when the office visit and the treatment/procedure are performed in the same location. This limit does not apply to a significant, separately identifiable office visit provided by the same physician on the same day as the treatment/procedure. This limitation does not apply to tobacco cessation counseling services provided by a physician or a qualified staff member under the supervision of a physician on the same day as a visit. This limitation does not apply to a treatment/procedure that is performed as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit (*see* 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction*); in such a case, the physician may bill for both an EPSDT visit and a treatment/procedure. Examples of treatment/procedures are suturing, suture removal, aspiration of a joint, and cast application or removal. X-rays, laboratory tests, and certain diagnostic tests may be billed for in addition to an office visit.

(C) Immunization or Injection.

(1) The physician may bill for either an office visit or vaccine administration, but may not bill for both an office visit and vaccine administration for the same member on the same date when the office visit and the vaccine administration are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same physician on the same day as the vaccine was administered.

(2) The MassHealth agency pays for the cost of the injectable material unless the Massachusetts Department of Public Health distributes the injectable material free of charge.

(D) Family Planning Office Visits. The MassHealth agency pays for office visits provided for the purposes of family planning. The MassHealth agency pays for any family planning supplies and medications dispensed by the physician at the physician's acquisition cost. To receive payment for the supplies and medications, the provider must attach to the claim a copy of the actual invoice from the supplier.

433.414: Outpatient Hospital Services: Payment

(A) Time Limit. Payment for outpatient hospital visits is limited to one outpatient hospital visit per day per member per physician.

(B) Visit and Treatment/Procedure.

(1) The physician may bill for either a hospital outpatient visit, or for a treatment/procedure during a hospital outpatient visit, but may not bill for both a visit and a treatment/procedure for the same member on the same date at the same hospital. This limitation does not apply to a significant, separately identifiable outpatient hospital visit provided by the same physician on the same day as the procedure or other service.

(2) The MassHealth agency pays either a physician or an outpatient hospital, but not both, for physician services provided in an outpatient hospital setting. The MassHealth agency does not separately pay a hospital for other professional services provided in an outpatient hospital setting.

(3) An outpatient hospital setting includes a hospital's outpatient department, emergency department, HLHC, and any other satellite of the hospital. A hospital outpatient visit includes a visit to any outpatient hospital setting.

433.415: Inpatient Hospital Services: Service Limitations and Screening Requirements

(A) Hospital inpatient visit fees apply to visits by physicians to members hospitalized in acute, chronic, or rehabilitation hospitals. Payment is limited to one visit per day per member for the length of the member's hospitalization.

(B) The MassHealth agency does not routinely pay for visits to members who have undergone or who are expected to undergo surgery, since the allowable surgical fees include payment for the provision of routine inpatient preoperative and postoperative care. In unusual circumstances, however, the MassHealth agency does pay for such visits.

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(C) The MassHealth agency pays only the attending physician for inpatient hospital visits, with the following exceptions.

(1) The MassHealth agency pays for a consultation by a physician other than the attending physician. (*See* 130 CMR 433.418 for regulations about consultations.)

(2) If it is necessary for a physician other than the attending physician to treat a hospitalized member, the other physician's services are payable. An explanation of the necessity of such visits must be attached to the claim. The MassHealth agency will review the claim and determine appropriate payment to the other physician.

(D) The MassHealth agency pays either a physician or an inpatient hospital, but not both, for physician services provided in an inpatient hospital setting. The MassHealth agency does not separately pay a hospital for other professional services provided in an inpatient hospital setting.

433.416: Nursing Facility Visits: Service Limitations

(A) Requirement for Approval of Admission. The MassHealth agency seeks to ensure that a MassHealth member receives nursing facility services only when available alternatives do not meet the member's need, and that every member receiving nursing facility services is placed appropriately according to the medical eligibility criteria, in accordance with 130 CMR 456.409 through 456.411.

(B) Service Limitations. Payment for a visit by a physician to members in nursing facilities or rest homes is limited to one visit per member per month, except in an emergency. Any medically necessary care required for the follow-up of a condition during the month must be billed as subsequent nursing facility care.

433.417: Home Visits: Service Limitations

Payment for a visit by a physician to a member's home is limited to one visit per member per day.

433.418: Consultations: Service Limitations

The MassHealth agency pays for only one initial consultation per member per case episode. Additional consultation visits per episode are payable as follow-up consultations.

433.419: Certified Nurse Midwife Services

(A) General. 130 CMR 433.419 applies specifically to certified nurse midwives (also known as nurse midwives). In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to certified nurse midwives, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(B) Conditions of Payment. The MassHealth agency pays a certified nurse midwife or group practice for certified nurse midwife services when

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(2) the certified nurse midwife or group practice is not an employee of the hospital or other facility in which the certified nurse midwife services were performed, or is not otherwise paid by the hospital or facility for the service;

(3) the certified nurse midwife participates in MassHealth pursuant to the requirements of 130 CMR 433.419(C)); and

(4) for an out-of-state certified nurse midwife the requirements of 130 CMR 433.403(C) are met.

(C) Certified Nurse Midwife Provider Eligibility. Any certified nurse midwife applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she

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- (1) is licensed to practice as a certified nurse midwife by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the certified nurse midwife services are provided; and
- (2) is a member of a group practice or is in a solo private practice;

(D) Consultation Between a Certified Nurse Midwife and Physician. The MassHealth agency does not pay for a consultation between a certified nurse midwife and a physician as a separate service.

433.420: Obstetric Services: Introduction

The MassHealth agency offers two methods of payment for obstetric services: the fee-for-service method and the global-fee method. Fee for service requires submission of claims for services as they are performed and is available to a provider for all covered obstetric services. The global fee is available only when the conditions specified in 130 CMR 433.421 are met.

433.421: Obstetric Services: Global-fee Method of Payment

(A) Definitions.

- (1) Coverage Provider. a physician, certified nurse midwife, physician assistant, or certified nurse practitioner that is either a member of the same group practice as the Primary Provider, or who is in a separate practice from the Primary Provider and has a back-up coverage arrangement with the Primary Provider.
- (2) Global Fee. a single inclusive fee for all prenatal and postpartum visits, and the delivery. The global fee is available only when the conditions in 130 CMR 433.421 are met.
- (3) Non-coverage Provider. any provider that has no employment, contractual, or practice-coverage relationship with the Primary Provider, or his or her practice.
- (4) Primary Provider. a physician or certified nurse midwife who has assumed responsibility for performing or coordinating a minimum of six prenatal visits, the delivery, and a minimum of one postpartum visit for a member.

(B) Conditions for Global Fee.

- (1) Primary Provider Responsibilities. In order to qualify for payment of the global fee, the primary provider must perform, or coordinate a coverage provider's performance of, a minimum of six prenatal visits, the delivery, and a minimum of one postpartum visit for the member, and must also satisfy all other requirements in 130 CMR 433.421. The primary provider is the only clinician that may claim payment of the global fee. As an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A), the primary provider is not required to perform all components of the obstetric global service directly. All global-fee claims must use the delivery date as the date of service.
- (2) Standards of Practice. All of the components of the obstetric global service must be provided at a level of quality consistent with the standards of practice of the American College of Obstetrics and Gynecology.
- (3) Coordinated Medical Management. The primary provider or coverage provider must coordinate the medical and support services necessary for a healthy pregnancy and delivery. This includes the following:
 - (a) tracking and follow-up of the patient's activity to ensure completion of the patient care plan, with the appropriate number of visits;
 - (b) coordination of medical management with necessary referral to other medical specialties and dental services; and
 - (c) referral to WIC (the Special Supplemental Food Program for Women, Infants, and Children), counseling, and social work as needed.
- (4) Health-care Counseling. In conjunction with providing prenatal care, the primary provider or coverage provider must provide health-care counseling to the woman over the course of the pregnancy. Topics covered must include, but are not limited to, the following:
 - (a) EPSDT screening for teenage pregnant individuals;
 - (b) smoking and substance abuse;
 - (c) hygiene and nutrition during pregnancy;
 - (d) care of breasts and plans for infant feeding;

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- (e) obstetrical anesthesia and analgesia;
 - (f) the physiology of labor and the delivery process, including detection of signs of early labor;
 - (g) plans for transportation to the hospital;
 - (h) plans for assistance in the home during the postpartum period;
 - (i) plans for pediatric care for the infant; and
 - (j) family planning.
- (5) Obstetrical-risk Assessment and Monitoring. The primary provider or coverage provider must manage the member's obstetrical risk assessment and monitoring. Medical management requires monitoring the woman's care and coordinating diagnostic evaluations and services as appropriate. The professional and technical components of these services are paid separately from the global fee and should be billed for by the servicing provider on a fee for service basis. Such services may include, but are not limited to, the following:
- (a) counseling specific to high risk patients (for example, antepartum genetic counseling);
 - (b) evaluation and testing (for example, amniocentesis); and
 - (c) specialized care (for example, treatment of premature labor).
- (C) Multiple Providers. When more than one provider is involved in prenatal, delivery, and postpartum services for the same member, the following conditions apply.
- (1) The global fee may be claimed only by the primary provider and only if the required services (minimum of six prenatal visits, a delivery, and a minimum of one postpartum visit) are provided directly by the primary provider, or a coverage provider. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).)
 - (2) If the primary provider bills for the global fee, no coverage provider may claim payment from the MassHealth agency. Payment of the global fee constitutes payment in full both to the primary provider and to all coverage providers who provided components of the obstetric global service.
 - (3) If the primary provider bills for the global fee, any non-coverage provider who performed prenatal visits or postpartum visits for the member may claim payment for such services only on a fee-for-service basis. If the primary provider bills for the global fee, no non-coverage provider may claim payment for the delivery.
 - (4) If the primary provider bills on a fee-for-service basis and does not bill a global fee, any other coverage or non-coverage provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services they provided to the same member.
- (D) Recordkeeping for Global Fee. The primary provider is responsible for documenting, in accordance with 130 CMR 433.409, all the service components of a global fee. This includes services performed by the primary provider and any coverage providers. All hospital and ambulatory services, including risk assessment and medical visits, must be clearly documented in each member's record in a way that allows for easy review of her obstetrical history.

433.424: Obstetric Services: Fee-for-service Method of Payment

The fee-for-service method of payment is always available to a provider for obstetric services covered by the MassHealth agency as an alternative to the global fee referenced in 130 CMR 433.421. If the global-fee requirements in 130 CMR 433.421 are not met, the provider or providers may claim payment from the MassHealth agency only on a fee-for-service basis, as specified in 130 CMR 433.424(A) through (D).

- (A) When there is no primary provider for the obstetric services performed for the member, each provider may claim payment only on a fee-for-service basis.
- (B) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the member may claim payment only on a fee-for-service basis.
- (C) When a certified nurse-midwife is the primary provider and a physician performs a cesarean section, the certified nurse-midwife may claim payment for the prenatal visits only on a fee-for-service basis. The operating physician may claim payment for the cesarean section only on a fee-for-service basis.

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(D) When additional services (for example, ultrasound or special tests) are performed, the provider may claim payment for these only on a fee-for-service basis.

433.425: Ophthalmology Services

The MassHealth agency pays for ophthalmic materials in accordance with the vision care regulations at 130 CMR 402.000: *Vision Care Services*. The MassHealth agency pays for eye examinations subject to the following limitations.

(A) Comprehensive Eye Examinations.

(1) The MassHealth agency does not pay for a comprehensive eye examination if the service has been provided

- (a) within the preceding 12 months, for a member younger than 21 years old; or
- (b) within the preceding 24 months, for a member 21 years of age or older.

(2) The restrictions at 130 CMR 433.425(A)(1) do not apply if one of the following complaints or conditions is documented in the member's medical record:

- (a) blurred vision;
- (b) evidence of headaches;
- (c) systemic diseases, such as diabetes, hyperthyroidism, or HIV;
- (d) cataracts;
- (e) pain;
- (f) redness; or
- (g) infection.

(B) Consultation Service. The MassHealth agency pays for a consultation service only if it is provided independently of a comprehensive eye examination.

(C) Screening Services. The MassHealth agency does not pay for a screening service if two screening services have been furnished to the member within the preceding 12 months.

(D) Comprehensive Eye Examinations and Screening Services. A comprehensive eye examination includes a screening service. If the provider performs both a screening service and a comprehensive eye examination for the same member, the MassHealth agency pays for only the comprehensive eye exam.

(E) Tonometry. The MassHealth agency does not pay for a tonometry as a separate service when it is performed as part of a comprehensive eye examination, consultation, or screening service. When a tonometry is performed as a separate service to monitor a member who has glaucoma, the provider must use the appropriate service code.

433.426: Audiology Services: Service Limitations

The MassHealth agency pays for audiology services only when they are provided either by a physician, or by an audiologist licensed or certified in accordance with 130 CMR 426.404: *Provider Eligibility* who is employed by a physician. This limitation does not apply to an audiometric hearing test, pure-tone, air only.

433.427: Allergy Testing: Service Limitations

(A) The MassHealth agency pays for allergy testing only when performed by or under the direction of a physician, certified nurse practitioner or clinical nurse specialist, or by a physician assistant under a physician's supervision. All fees include payment for physician observation and interpretation of the tests in relation to the member's history and physical examination. An initial consultation and allergy testing for a member may be billed by the same provider on the same date of service.

(B) The MassHealth agency does not pay for more than three blood tests and pulmonary function tests (such as spirometry and expiogram) used only for diagnosis and periodic evaluation per member per year.

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(C) Immunotherapy and desensitization (extracts) are covered services. The provider must indicate the amount and anticipated duration of the supply for immunotherapy and desensitization (extracts) on the claim form.

(D) The MassHealth agency pays for follow-up office visits for injections and reevaluation as office visits.

(E) The MassHealth agency pays for sensitivity tests only once per member per year, regardless of the type of tests performed or the number of visits required.

433.428: Psychiatric Services: Introduction

(A) Covered Services. The MassHealth agency pays a physician or a psychiatric clinical nurse specialist (PCNS) for the psychiatry services described in 130 CMR 433.428 and 130 CMR 433.429.

(B) Non-covered Services.

(1) Nonphysician and Non-PCNS Services. Except as permitted in Section 603 of Subchapter 6 of the *Physician Manual*, the MassHealth agency does not pay a physician or PCNS for services provided by a social worker, psychologist, or other nonphysician mental health professional employed or supervised by the physician or PCNS.

(2) Research and Experimental Treatment. The MassHealth agency does not pay for research or experimental treatment. This includes, but is not limited to, any method not generally accepted or widely used in the field, or any session conducted for research rather than for a member's clinical need.

(3) Nonmedical Services. The MassHealth agency does not pay a physician or PCNS for nonmedical services including, but not limited to, the following:

(a) vocational rehabilitation services;

(b) educational services;

(c) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is payable);

(d) street-worker services (information, referral, and advocacy to certain age populations; liaison with other agencies; role modeling; and community organization);

(e) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and

(f) biofeedback.

(4) Nonmedical Programs. The MassHealth agency does not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other non-covered services. Such programs include freestanding alcohol or drug detoxification programs, freestanding methadone maintenance programs, residential programs, day activity programs, drop-in centers, and educational programs.

(5) Psychological Testing. The MassHealth agency does not pay for psychological testing provided by a physician or a PCNS.

(C) Services Provided by a Psychiatric Clinical Nurse Specialist (PCNS).

(1) General. 130 CMR 433.428 and 130 CMR 433.429 apply specifically to physicians and psychiatric clinical nurse specialists. In general however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to a physician, also apply to a psychiatric clinical nurse specialist (PCNS), such as service and payment limitations, recordkeeping and reporting requirements, and prior authorization and other conditions of coverage.

(2) Conditions of Payment. The MassHealth agency pays a PCNS or group practice for PCNS services when

(a) the services are limited to the scope of practice authorized by state law or regulation (including, but not limited to, 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

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- (b) the PCNS or group practice is not an employee of the hospital or other facility in which the PCNS services were performed, or is not otherwise paid by the hospital or facility for the service;
 - (c) the PCNS participates in MassHealth pursuant to the requirements of 130 CMR 433.428(C)(3); and
 - (d) for an out-of-state PCNS, the requirements of 130 CMR 433.403(C) are met.
 - (3) PCNS Provider Eligibility. Any PCNS applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she
 - (a) is licensed to practice as a PCNS by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the PCNS services are provided; and
 - (b) is a member of a group practice or is in a solo private practice.
 - (4) Consultation Between a PCNS and a Physician. The MassHealth agency does not pay for a consultation between a PCNS and a physician as a separate service.
- (D) Record Keeping (Medical Records) Requirements. In addition to the provisions in 130 CMR 433.409, the following specific information must be included in the medical record for each member receiving psychiatric services:
- (1) the condition or reason for which psychiatric services are provided;
 - (2) the member's diagnosis;
 - (3) the member's medical history;
 - (4) the member's social and occupational history;
 - (5) the treatment plan;
 - (6) the physician's or PCNS's short- and long-range goals for the member;
 - (7) the member's response to treatment; and
 - (8) if applicable, a copy of the signed consent for electroconvulsive therapy.

433.429: Psychiatric Services: Scope of Services

130 CMR 433.429 describes the services that a physician or a psychiatric clinical nurse specialist (PCNS) may provide, including the limitations imposed on those services by the MassHealth agency. For all psychotherapeutic services, the majority of time must be spent as personal interaction with the member; a minimal amount of time must be spent for the recording of data.

(A) Individual Psychotherapy. The MassHealth agency pays a physician or PCNS for individual psychotherapy provided to a member only when the physician or PCNS treats the member. This service includes diagnostics.

(B) Family and Couple Therapy. The MassHealth agency pays for therapy provided simultaneously in the same session to more than one member of the same family or to a couple whose primary complaint is the disruption of their marriage, family, or relationship. Payment is limited to one fee per session, regardless of the number of family members present or the presence of a co-therapist.

(C) Group Psychotherapy.

- (1) Payment is limited to one fee per group member with a maximum of 12 members per group regardless of the number of staff members present.
- (2) The MassHealth agency does not pay for group therapy when it is performed as an integral part of a psychiatric day treatment program.

(D) Multiple-family Group Psychotherapy.

- (1) 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.
- (2) The MassHealth agency does not pay for multiple-family group psychotherapy when it is performed as an integral part of a psychiatric day treatment program.

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(E) Diagnostic Services. The MassHealth agency pays for the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan. This service includes an initial medication evaluation.

(F) Reevaluation. The MassHealth agency pays for the reevaluation of a member who has been out of treatment for at least six months. A provider may bill for a maximum of two one hour units per member per calendar year for the purpose of designing a treatment plan.

(G) Long-term Therapy. The MassHealth Agency defines long-term therapy as a combination of diagnostics and individual, couple, family, and group therapy planned to extend more than 12 sessions.

(H) Short-term Therapy. The MassHealth agency defines short-term therapy as a combination of diagnostics and individual, couple, family, and group therapy planned to terminate within 12 sessions.

(I) Medication Review. The MassHealth agency pays for a member visit specifically for the prescription, review, and monitoring of psychotropic medication by a psychiatrist, or PCNS, or administration of prescribed intramuscular medication by a physician or a PCNS. If this service is not combined with psychotherapy, it must be billed as a minimal office visit. The MassHealth agency does not pay separately for medication review if it is performed on the same day as another service, except for psychotherapy for crisis.

(J) Case Consultation.

(1) The MassHealth agency pays only for a case consultation that involves a personal meeting with a professional of another entity.

(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. Such circumstances are limited to situations in which both the physician or PCNS 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.

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

(L) Psychotherapy for Crisis Services. The MassHealth agency pays for psychotherapy for crisis as defined as an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma.

(1) This service is limited to face-to-face contacts with the member; psychotherapy for crisis service *via* telephone contact is not a reimbursable service.

(2) The need for psychotherapy for crisis services must be fully documented in the member's record for each date of psychotherapy for crisis services.

(3) This service is limited to one initial unit of service and up to three add-on units of service per date of service.

(M) Electroconvulsive Therapy. The MassHealth agency pays for electroconvulsive therapy only when it is provided in a hospital setting by a physician or PCNS and only when the physician or PCNS as well as the facility meet the standards set by the Massachusetts Department of Mental Health, including those relative to informed consent.

(N) After-hours Telephone Service. The physician or PCNS must provide telephone coverage during the hours when the physician or PCNS is unavailable, for members who are in a crisis state.

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(O) Acute Hospital Inpatient Visit. A visit to a hospitalized member in an acute hospital is payable only as a hospital visit (*see* 130 CMR 433.415) unless at least 15 minutes of psychotherapy is provided. Payment will be made for only one visit per member per day.

(P) Frequency of Treatment. The MassHealth agency pays a physician or a PCNS for only one session of a single type of service provided to an individual member on a single date of service. Return visits on the same date of service are not reimbursable except for the provision of psychotherapy for crisis services, as described in 130 CMR 433.429(L). The MassHealth agency pays a physician or a PCNS for more than one mode of therapy provided to a member during one week only if clinically justified; that is, when any single approach has been shown to be necessary but insufficient. The need for additional modes of treatment must be documented in the member's record.

(Q) Child and Adolescent Needs and Strengths (CANS). Any physician or PCNS who provides individual, group, or family therapy to members younger than 21 years old must be certified every two years according to the process established by the Executive Office of Health and Human Services (EOHHS) to administer the CANS, must use the CANS during initial behavioral-health assessments before the initiation of therapy, and must update the CANS at least every 90 days thereafter during the treatment review process.

433.430: Dialysis: Service Limitations

(A) Medicare Coverage. Medicare is the primary source of payment for medical care to persons of any age who have chronic renal disease and who require hemodialysis or a kidney transplant. Members being treated for chronic renal disease must be referred to a MassHealth Enrollment Center or their Social Security Administration office to determine Medicare eligibility.

(B) Service Limitations. The MassHealth agency pays for hemodialysis only to hospitalized members who are

- (1) being dialyzed for acute renal failure;
- (2) receiving initial dialysis for chronic renal failure prior to continuing chronic maintenance dialysis; or
- (3) receiving dialysis for complications of chronic maintenance dialysis.

433.431: Physical Medicine: Service Limitations

(A) The services listed in 130 CMR 433.431 are payable only when the physician prescribes the needed therapy, and the services are provided by the physician or by a licensed physical or occupational therapist employed by the physician, subject to all general conditions of payment including the requirement to obtain prior authorization as described in 130 CMR 433.408.

(B) Physical medicine services include, but are not limited to, superficial or deep-heat modalities, therapeutic exercise, traction, hydrotherapy, prosthetics and orthotics training, activities of daily living and ambulation training, range of motion, and manual muscle strength assessment. Other restorative services are covered by MassHealth in accordance with 130 CMR 430.000: *Rehabilitation Center Services* and 432.000: *Therapist Services*.

(C)(1) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 433.431(C)(2).

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

433.432: Other Medical Procedures

- (A) Cardiovascular and Other Vascular Studies. Fees for cardiovascular services and other vascular studies include payment for laboratory procedures, interpretations, and physician services (except surgery and anesthesia services), unless otherwise stated. These services may be billed for in addition to an office visit.
- (B) Cardiac Catheterization. Fees for cardiac catheterization are for the physician's services only and include payment for the usual preassessment of the cardiac problem and the recording of intracardiac pressure.
- (C) Pulmonary Procedures. Fees for pulmonary procedures include payment for laboratory procedures, interpretations, and physician's services. These services may be billed for in addition to an office visit.
- (D) Dermatological Special Procedures. These services may be billed for in addition to an office visit.
- (E) Unlisted Procedures. Providers may bill for unlisted procedures only if there is no "Not otherwise classified" code.

433.433: Certified Nurse Practitioner Services

- (A) General. 130 CMR 433.433 applies specifically to certified nurse practitioners (also known as nurse practitioners). In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to certified nurse practitioners, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.
- (B) Conditions of Payment. The MassHealth agency pays either an independent certified nurse practitioner or group practice (in accordance with 130 CMR 433.433(C)), or the physician employer of a nonindependent certified nurse practitioner (in accordance with 130 CMR 433.433(E)), for certified nurse practitioner services when:
 - (1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);
 - (2) the certified nurse practitioner or group practice is not an employee of the hospital or other facility in which the certified nurse practitioner services were performed, or is not otherwise paid by the hospital or facility for the service;
 - (3) (a) in the case of payment claimed by an independent certified nurse practitioner, or a group practice, the certified nurse practitioner participates in MassHealth pursuant to the requirements of 130 CMR 433.433(C); or
 - (b) in the case of payment claimed by a physician employer of a nonindependent certified nurse practitioner, the conditions of 130 CMR 433.433(E) are met; and
 - (4) for an out-of-state certified nurse practitioner the requirements of 130 CMR 433.403(C) are met.
- (C) Independent Certified Nurse Practitioner Provider Eligibility: Submission Requirements. Only a certified nurse practitioner who meets the following requirements may enroll in MassHealth as an independent certified nurse practitioner:
 - (1) is licensed to practice as a certified nurse practitioner by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the certified nurse practitioner services are provided; and
 - (2) is a member of a group practice or is in a solo private practice.
 - (3) any certified nurse practitioner applying to participate as an independent provider in MassHealth must submit documentation satisfactory to the MassHealth agency that he or she meets these requirements.
- (D) Consultation Between Certified Nurse Practitioner and Physician. The MassHealth agency does not pay for a consultation between a certified nurse practitioner and a physician as a separate service.

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(E) Submitting Claims for Nonindependent Certified Nurse Practitioners. Any certified nurse practitioner who does not meet the requirements of 130 CMR 433.433(C) is a nonindependent certified nurse practitioner and is not eligible to submit claims to MassHealth. As an exception to 130 CMR 450.301: *Claims*, an individual physician (who is neither practicing as a professional corporation nor a member of a group practice) who employs a nonindependent certified nurse practitioner may submit claims for services provided by a nonindependent certified nurse practitioner employee, but only if:

- (1) the nonindependent certified nurse practitioner is licensed to practice as a certified nurse practitioner by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the certified nurse practitioner services are performed;
- (2) such services are provided in accordance with 130 CMR 433.433(B); and
- (3) payment is claimed by the physician employer in accordance with 130 CMR 450.301(B). (Refer to Subchapter 6 of the *Physician Manual* for appropriate modifiers.)

433.434: Physician Assistant Services

(A) General. 130 CMR 433.434 applies specifically to physician assistants. In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to physician assistants, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage. Services provided by a physician assistant must be limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR 5.00: *Scope and Practice and Employment of Physician Assistants*).

(B) Conditions of Payment. In accordance with 263 CMR: *Board of Registration of Physician Assistants*, the MassHealth agency does not pay physician assistants directly. The MassHealth agency pays a group practice employer of a physician assistant for physician assistant services. Physician assistant services are payable when:

- (1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR: *Board of Registration of Physician Assistants* or of the state licensing agency of another state in which the services are provided);
- (2) the physician assistant or group practice is not an employee of the hospital or other facility in which the physician assistant services were performed, or is not otherwise paid by the hospital or facility for the service;
- (3) the services are provided pursuant to a formal supervisory arrangement with a physician, as further described in 263 CMR 5.00: *Scope and Practice and Employment of Physician Assistants* and 130 CMR 433.434(D);
- (4) the physician assistant participates in MassHealth pursuant to the requirements of 130 CMR 433.434(C); and
- (5) for an out-of-state physician assistant the requirements of 130 CMR 433.403(C) are met.

(C) Physician Assistant Provider Eligibility. Any physician assistant applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she

- (1) is licensed to practice as a physician assistant by the Massachusetts Board of Registration of Physician Assistants or by the licensing agency of another state in which the physician assistant services are provided; and
- (2) is a member of a group practice comprising at least one physician.

(D) Supervisory Arrangement Requirements.

- (1) The services of a physician assistant must be performed under the supervision of a physician in accordance with 263 CMR 5.00: *Scope and Practice and Employment of Physician Assistants*.
- (2) Physician supervision of or consultation with a physician assistant is not payable as a separate service.

433.435: Tobacco Cessation Services

(A) Introduction. MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 433.435(B) and pharmacotherapy treatment, including nicotine replacement therapy (NRT), in accordance with 130 CMR 406.000: *Pharmacy Services*.

(B) Tobacco Cessation Counseling Services.

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

(a) Individual counseling consists of face-to-face tobacco cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobacco cessation services as set forth in 130 CMR 433.435(B) and (C).

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

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

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

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

1. a review of the health consequences of tobacco use and the benefits of quitting;
2. a description of how tobacco dependence develops and an explanation of the biological, psychological, and social causes of tobacco dependence; and
3. a review of evidence-based treatment strategies and the advantages and disadvantages of each strategy;

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

1. identification of personal risk factors for relapse and incorporation into the treatment plan;
2. strategies and coping skills to reduce relapse risk;
3. a plan for continued aftercare following initial treatment; and

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

1. the correct use, efficacy, adverse events, contraindications, known side effects, and exclusions for all tobacco dependence medications; and
2. the possible adverse reactions and complications related to the use of pharmacotherapy for tobacco dependence.

(C) Provider Qualifications for Tobacco Cessation Counseling Services.

(1) Qualified Providers.

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

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

(2) Supervision of Tobacco Cessation Counseling Services. A physician must supervise all registered nurses and other individuals who qualify under 130 CMR 433.435(C)(1)(b) who are providers of tobacco cessation counseling services for whom the physician will submit claims.

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(D) Tobacco Cessation Services: Claims Submission.

(1) Physicians, independent certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, and clinical nurse specialists, or group practice employers of such clinicians may submit claims for tobacco cessation services when those clinicians provide tobacco cessation services directly to MassHealth members. A group practice employer of a physician assistant may submit claims for tobacco cessation services provided by the physician assistant. *See* Subchapter 6 of the *Physician Manual* for service code descriptions.

(2) As an exception to 130 CMR 450.301(A), a physician that is an employer of a non-independent certified nurse practitioner, registered nurse, or individual who qualifies under 130 CMR 433.435(C)(1)(b), may submit claims for tobacco cessation services provided by that employee, but only if such services are provided in accordance with 130 CMR 433.435(B) and (C) and payment is claimed in accordance with 130 CMR 450.301(B).

433.436: Radiology Services: Introduction

The MassHealth agency pays for radiology services only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Services Provided by an Independent Diagnostic Testing Facility (IDTF). The MassHealth agency pays an IDTF as defined in 130 CMR 433.401 for applicable diagnostic tests in accordance with the independent diagnostic testing facility regulations at 130 CMR 431.000: *Independent Diagnostic Testing Services*.

(B) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (*see* 130 CMR 433.409), the physician must keep suitable records of radiology services performed. All X-rays must be labeled adequately with the following:

- (1) the member's name;
- (2) the date of the examination;
- (3) the nature of the examination; and
- (4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

See also the general limitations described at 130 CMR 433.407.

(A) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays for those services in accordance with the EOHHS fee schedule. The MassHealth agency does not pay for the interpretation of an X-ray that was previously read and taken in the same hospital. However, the MassHealth agency does pay a physician for interpreting an X-ray that was previously read and taken in a different hospital.

(B) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays for those services in accordance with the EOHHS fee schedule.

(C) Surgical Introductions and Interpretations. The MassHealth agency pays a physician for performing surgical introductions and interpretations of films performed in a hospital inpatient or outpatient setting, with the following restrictions.

- (1) Only one surgical introduction per operative session is payable in accordance with the EOHHS fee schedule.
- (2) In a single operative session:
 - (a) no more than three additional surgical introductions using the same puncture site are payable, each in accordance with the EOHHS fee schedule; and
 - (b) no more than three additional selective vascular studies using the same puncture site are payable, each at the maximum allowable fee.

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(3) Interpretations are payable in accordance with the EOHHS fee schedule, up to a maximum of three.

(D) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a member by one or more physicians are payable only if sufficient documentation for each is shown in the member's medical record.

(E) Interventional Radiology. If interventional radiology services are performed by two providers, the professional component is divided equally into surgical and interpretative components.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a member are payable under MassHealth.

(A) Provider Eligibility. The MassHealth agency pays for laboratory tests only when they are performed on a member by a physician, certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, psychiatric clinical nurse specialist, clinical nurse specialist, or physician assistant, or by an independent clinical laboratory certified by Medicare.

(B) Payment. The MassHealth agency pays a physician, certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, psychiatric clinical nurse specialist, clinical nurse specialist, or group practice employer of such practitioners or of a physician assistant only for laboratory tests performed in the practitioner's office. If an independent clinical laboratory performs laboratory tests for a member, the MassHealth agency pays only the laboratory for those services.

(C) Information with Specimen. A physician who sends a specimen to an independent clinical laboratory participating in MassHealth must also send the following.

- (1) a signed request for the laboratory services to be performed;
- (2) the member's MassHealth identification number; and
- (3) the physician's name, address and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The MassHealth agency does not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue).

(B) Professional Component of Laboratory Services. The MassHealth agency does not pay a physician for the professional component of a clinical laboratory service. The MassHealth agency pays a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The MassHealth agency does not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. Payment for laboratory services includes payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests.

- (1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics.
 - (a) The group of tests is designated as a profile or panel by the physician performing the tests.
 - (b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.

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(2) In no event may a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

(E) Forensic Services. The MassHealth agency does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438 including, but not limited to:

- (1) tests performed to establish paternity;
- (2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and
- (3) postmortem examinations.

433.440: Acupuncture

(A) Introduction. MassHealth members are eligible to receive acupuncture for the treatment of pain as described in 130 CMR 433.440(C), for use as an anesthetic as described in 130 CMR 433.454(C), and for use for detoxification as described in 130 CMR 418.406(C)(3): *Substance Abuse Treatment: Acupuncture Detoxification*.

(B) General. 130 CMR 433.440 applies specifically to physicians and midlevel practitioners who are licensed practitioners of acupuncture.

(C) Acupuncture for the Treatment of Pain. MassHealth provides a total of 20 sessions of acupuncture for the treatment of pain per member per year without prior authorization. If the member's condition, treatment, or diagnosis changes, the member may receive more sessions of medically-necessary acupuncture treatment with prior authorization.

(D) Provider Qualifications for Acupuncture. MassHealth pays for acupuncture services only when the provider rendering the service is:

- (1) a physician; or
- (2) a midlevel practitioner who is licensed in acupuncture by the Massachusetts Board of Registration in Medicine under 243 CMR 5.00: *The Practice of Acupuncture*.

(E) Conditions of Payment. The MassHealth agency pays providers qualified to render acupuncture services in accordance with 130 CMR 433.440(D) for acupuncture services only when

- (1) the services are limited to the scope of practice authorized by state law or regulation (such as 243 CMR 5.00: *The Practice of Acupuncture*); and
- (2) the provider has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine.

(F) Acupuncture Claims Submissions.

(1) Providers eligible to render acupuncture services in accordance with 130 CMR 433.440(D) may submit claims for acupuncture services when they provide those services directly to MassHealth members. *See* Subchapter 6 of the *Physician Manual* for service code descriptions and billing requirements.

(2) For MassHealth members receiving services under any of the acupuncture codes on the same date of service as an office visit, the provider may bill for either an office visit or the acupuncture code, but may not bill for both an office visit and the acupuncture code for the same member on the same date when the office visit and the acupuncture services are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same provider on the same day of the acupuncture service.

433.441: Pharmacy Services: Drugs Dispensed in Pharmacies

Coverage of drugs and medical supplies dispensed to MassHealth members by MassHealth pharmacy providers, and related prescription requirements for prescribing prescribers, are governed by 130 CMR 406.000: *Pharmacy Services*.

433.447: Drugs Administered in the Office (Provider-administered Drugs)

(A) Drugs and biologicals dispensed in the office are payable, subject to the exclusions and service limitations at 130 CMR 433.404, 433.406, and 130 CMR 406.413(B): *Drug Exclusions* and (C): *Service Limitations*.

(B) The MassHealth agency does not pay a provider separately for drugs that are considered routine and integral to the delivery of a provider's professional services in the course of diagnosis or treatment. Such drugs are commonly provided without charge or are included in the provider's fee for the service.

(C) The MassHealth agency does not pay separately for any oral drugs dispensed in the office for which the provider has not requested and received prior authorization from the MassHealth agency, with the exception of oral vaccines and oral radiopharmaceuticals, which do not require prior authorization.

(D) Claims for drugs and biologicals that are listed in Subchapter 6 of the *Physician Manual* must include the name of the drug or biological, strength, dosage, and number of HCPCS units dispensed, NDC code, NDC units and NDC unit of measurement. In addition, for drugs and/or biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Physician Manual*, a copy of the invoice showing the actual acquisition cost must be attached to the claim. Claims without this information are denied.

(E) The MassHealth agency pays only for prescription drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8. Payment is calculated in accordance with 101 CMR 331.00: *Prescribed Drugs*.

(F) The MassHealth agency does not pay for a biological if the Massachusetts Department of Public Health distributes the biological free of charge.

(G) Payment for drugs may be claimed in addition to an office visit.

433.449: Fluoride Varnish Services

(A) Eligible Members. Members must be younger than 21 years old to be eligible for the application of fluoride varnish.

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

(C) Fluoride Varnish Services: Claim Submission.

(1) A provider may bill for an office visit, in addition to the fluoride varnish application, only if fluoride varnish was not the sole service, treatment, or procedure provided during the visit.

(2) Physicians, independent certified nurse practitioners, and clinical nurse specialists or group practice employers of such clinicians, may submit claims for fluoride varnish services when those clinicians provide fluoride varnish services directly to MassHealth members. A group practice employer of a physician assistant may submit claims for fluoride varnish services provided by the physician assistant. See Subchapter 6 of the *Physician Manual* for service code descriptions.

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(3) As an exception to 130 CMR 450.301(A), a physician that is an employer of a non-independent certified nurse practitioner, registered nurse, licensed practical nurse, or medical assistant, may submit claims for fluoride varnish services provided by that employee, but only if such services are provided in accordance with 130 CMR 433.449(A) and (B), and payment is claimed in accordance with 130 CMR 450.301(B).

433.451: Surgery Services: Introduction

(A) Provider Eligibility. The MassHealth agency pays a physician for surgery only if the physician is scrubbed and present in the operating room during the major portion of the operation. (See 130 CMR 433.421(B)(2) for the single exception to this requirement.)

(B) Nonpayable Services. The MassHealth agency does not pay for

- (1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment;
- (2) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does pay for the diagnosis of male or female infertility;
- (3) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the physical effects of disease or physical defect, or traumatic injury;
- (4) services billed under codes listed in Subchapter 6 of the *Physician Manual* as not payable;
- (5) services otherwise identified in the MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable; and
- (6) services billed with otherwise covered service codes when such codes are used to bill for nonpayable circumstances as described in 130 CMR 433.404.

(C) Definitions. The following terms have the meanings given for purposes of 130 CMR 433.451 and 433.452, unless otherwise indicated.

- (1) Complications Following Surgery - all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications that do not require additional trips to the operating room.
- (2) Evaluation and Management (E/M) Services - visits and consultations furnished by physicians in various settings and of various complexities as defined in the Evaluation and Management section of the American Medical Association's *Current Procedural Terminology (CPT)* code book.
- (3) Intraoperative Services - intraoperative services that are normally a usual and necessary part of a surgical procedure.
- (4) Major Surgery - a surgery for which the Centers for Medicare & Medicaid Services (CMS) determines the preoperative period is one day and the postoperative period is 90 days.
- (5) Minor Surgery - a surgery for which CMS determines the preoperative period is zero days and the postoperative period is zero or ten days.
- (6) Postoperative Period -
 - (a) The postoperative period for major surgery is 90 days.
 - (b) The postoperative period for minor surgery and endoscopies is zero or ten days.
- (7) Postoperative Visits - follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery.
- (8) Postsurgical Pain Management - postsurgical pain management by the surgeon, including supplies.
- (9) Preoperative Period -
 - (a) The preoperative period for major surgery is one day.
 - (b) The preoperative period for minor surgery is zero days.
- (10) Preoperative Visits - preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.

433.452: Surgery Services: Payment

Surgical services and other invasive procedures are listed in the surgery and medicine section of the American Medical Association's *Current Procedural Terminology (CPT)* code book. The MassHealth agency pays for all medicine and surgery CPT codes in effect at the time of service, except for those codes listed in Section 602 of Subchapter 6 of the *Physician Manual*, subject to all conditions and limitations described in MassHealth regulations at 130 CMR 433.000 and 450.000: *Administrative and Billing Regulations*.

(A) Visit and Treatment/Procedure on Same Day in Same Location. The MassHealth agency pays a provider for either a visit or a treatment/procedure, whichever fee is greater. The MassHealth agency does not pay for both a preoperative evaluation and management visit, and a treatment/procedure provided to a member on the same day when they are performed in the same location. For minor surgeries and endoscopies, the MassHealth agency does not pay separately for an evaluation and management service on the same day as the surgery or endoscopy. The limitations in 130 CMR 433.452(A) do not apply to a significant, separately identifiable evaluation and management service provided by the same provider on the same day of the procedure or other services. For payment information about obstetrical care, refer to 130 CMR 433.421.

(B) Payment for Global Surgical Package. The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The services are included in the global surgical package regardless of setting including, but not limited to, hospitals, ambulatory surgical centers, and office settings.

(1) The following services are included in the payment for a global surgery when furnished by the provider who performs the surgery:

- (a) preoperative visits;
- (b) intraoperative visits;
- (c) complications following surgery;
- (d) postoperative visits;
- (e) postsurgical pain management;
- (f) miscellaneous services related to surgery including, but not limited to, dressing changes; local incisional care; removal of operative pack, cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes; and changes and removal of tracheostomy tubes; and
- (g) visits related to the surgery to a patient in an intensive care or critical care unit, if made by the surgeon. Intensive or critical care visits unrelated to surgery are not included in the global surgical package.

(2) The following services are not included in the payment for a global surgery and are separately payable by MassHealth. See 130 CMR 433.600 for a listing of modifiers, where applicable.

- (a) the initial consultation or evaluation of the problem by the surgeon to determine the need for surgery;
- (b) services of other physicians except where the surgeon and the other physician or physicians agree on the transfer of care during the global period. Such transfer agreement must be in writing and a copy of the written transfer agreement must be kept in the member's medical record;
- (c) visits unrelated to the diagnosis for which the surgical procedure is performed;
- (d) treatment for the underlying condition or an added course of treatment that is not part of the normal recovery from the surgery;
- (e) diagnostic tests and procedures, including diagnostic radiological procedures;
- (f) clearly distinct surgical procedures during the postoperative period that are not reoperations or treatment for complications resulting from the surgery. A new postoperative period begins with the subsequent surgical procedure. This exception includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure;

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- (g) treatment for postoperative complications that require a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical that there would be insufficient time for transportation to an OR);
- (h) a second, more extensive procedure required because the initial, less extensive procedure did not produce the desired outcome;
- (i) immunotherapy management for organ transplants; and
- (j) critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance by the physician.

(C) Payment for Multiple Surgeries. Multiple surgeries are separate procedures performed by a provider on the same patient at the same operative session or on the same day. Multiple surgeries are distinguished from intraoperative services and surgeries that are incidental to or components of a primary surgery (that is, bundled services). Bundled services are not paid separately. When two or more related procedures are performed on a patient during a single session or visit, the MassHealth agency pays the provider for the comprehensive code and denies or adjusts the component, incidental, or mutually exclusive procedure performed during the same session. The bundling guidelines that MassHealth applies are based upon generally accepted industry guidelines including, but not limited, to the National Correct Coding Initiative administered through the Centers for Medicare & Medicaid Services (CMS) and the *American Medical Association's Current Procedural Terminology* (CPT) code book. To receive payment for multiple surgeries, the provider must bill with the multiple surgery modifier. Additionally, the provider must use NCCI-related modifiers to receive payment, when appropriate, for two medically necessary, separately identifiable procedures performed on a member on the same date of service (*see* Subchapter 6 of the *Physician Manual* for a listing of allowed modifiers).

(D) Payment for Multiple Endoscopy Procedures. When multiple procedures are performed through the same endoscope, payment is made for the highest valued endoscopy procedure plus the difference between the next highest endoscopy procedure and the base endoscopy procedure. The base endoscopy procedure is included in the code for each of the multiple procedures. When two related endoscopies and an unrelated endoscopy are performed, the endoscopic payment rule stated above applies to the related endoscopies. Unrelated endoscopic procedures are treated as separate surgeries and paid as multiple surgeries pursuant to 130 CMR 433.452(C).

(E) Payment for Add-on Surgical Procedures. The Centers for Medicare & Medicaid Services (CMS) has identified certain procedures as add-on procedures that are always billed with another procedure. Add-on codes are identified in the CPT code book. By definition, these services do not stand alone and must be provided in conjunction with a primary surgical procedure or qualifying service. Both the service code for the primary procedure and add-on code are paid separately. The global surgery package provisions at 130 CMR 455.451 and 455.452 apply to the service code for the primary procedure.

(F) Payment for Bilateral Procedures. Bilateral surgeries are defined as procedures performed on both sides of the body during the same operative session or on the same day. To receive payment, the surgeon must use the bilateral surgery modifier with the appropriate service code. The provider must not use the bilateral surgery modifier with service codes containing the terms “bilateral” or “unilateral or bilateral” in their definitions, since the terminology of the code identifies the service as one whose payment accounts for any additional work required for bilateral surgery.

(G) Surgical Assistants. Some surgical procedures require a primary surgeon and an assistant surgeon. To receive payment, the assistant surgeon must use the appropriate modifier. Surgical codes that accept the surgical assistant modifiers are indicated in The Centers for Medicare & Medicaid Services *Correct Coding Initiative Guide*. In addition, the MassHealth agency does not pay for a surgical assistant if

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- (1) any component of the surgery is billed using a team surgery modifier pursuant to 130 CMR 433.452(H) or a two-surgeon modifier pursuant to 130 CMR 433.452(I);
- (2) the surgery services were provided in a teaching hospital that has an approved training program related to the medical specialty required for the surgical procedure and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the MassHealth agency pays for a surgical assistant if the member's medical record documents that a qualified resident was unavailable at the time of the surgery; or
- (3) the surgical procedure does not require the services of more than one surgeon.

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

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

433.454: Anesthesia Services(A) Payment.

(1) Payment Determination. The MassHealth agency pays an anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA) for anesthesia services as described in 101 CMR 316.00: *Surgery and Anesthesia*, and 130 CMR 433.454. Payment for anesthesia services is determined using a system of base anesthesia units and time anesthesia units.

(2) Base Anesthesia Units. Providers must report the administration of anesthesia on the claim by using the applicable five-digit anesthesia procedure code (00100-01999), and any applicable modifier. The anesthesia procedure code determines the number of base anesthesia units that correspond to the procedure. If a base anesthesia unit is not established for a service, the MassHealth agency pays using time anesthesia units only. When anesthesia is administered for multiple surgery procedures, only the base anesthesia units corresponding to the procedure with the largest number of units is used to determine payment. The number of base anesthesia units does not vary based on the type of anesthesia that is administered.

(3) Time Anesthesia Units.

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

(b) Reporting Time Anesthesia Units. A provider must report only payable time anesthesia units in the number of units field on the claim. The provider must not include base anesthesia units or units that exceed the criteria set forth in 130 CMR 433.454(A)(3)(a) in the number of units field. Time anesthesia units are measured in minutes. One unit equals one minute.

(4) Personally Performed Anesthesia Services. Anesthesia procedures that are personally performed alone by either an anesthesiologist, or a CRNA not employed by the facility in which the anesthesia services are provided, are payable by MassHealth. For a CRNA, personally performed anesthesia services are those that a CRNA performs alone without medical direction of an anesthesiologist. Payment for personally performed anesthesia services may be claimed by appending the appropriate anesthesia modifier to the anesthesia procedure code. If a CRNA is employed by the facility in which the personally performed anesthesia services are provided, there is no separate payment for the CRNA's services. Refer to subchapter 6 of the *Physician Manual* for appropriate modifiers.

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(5) Medical Direction and Medical Supervision. The MassHealth agency pays for medical direction as described in 101 CMR 316.00: *Surgery and Anesthesia* and 130 CMR 433.454(C). Refer to Subchapter 6 of the *Physician Manual* for appropriate modifiers. The MassHealth agency does not pay for medical supervision as further described in 130 CMR 433.454(D).

(B) Services Provided by a Certified Registered Nurse-anesthetist (CRNA).

(1) General. 130 CMR 433.454 applies specifically to physicians and CRNAs. In general however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians, also apply to CRNAs, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(2) Conditions of Payment. The MassHealth agency pays a CRNA or group practice for CRNA services when

- (a) the services are limited to the scope of practice authorized by state law or regulation (including, but not limited to, 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);
- (b) the CRNA or group practice is not an employee of the hospital or other facility in which the CRNA services were performed, or is not otherwise paid by the hospital or facility for the service;
- (c) the CRNA participates in MassHealth pursuant to the requirements of 130 CMR 433.454(B)(3);
- (d) the services of the CRNA are provided under the supervision of a physician such that the operating physician or an anesthesiologist is immediately available if needed; and
- (e) for an out of state CRNA the requirements of 130 CMR 433.403(C) are met.

(3) CRNA Provider Eligibility. A CRNA may enroll in MassHealth as a provider. Any CRNA applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she

- (a) is licensed to practice as a CRNA by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the CRNA services are provided; and
- (b) is a member of a group practice or is in a solo private practice.

(C) Medical Direction of Anesthesia Services. The MassHealth agency pays an anesthesiologist for medical direction of a CRNA as follows. The term medical direction is used in 130 CMR 433.454(C) for payment purposes only.

(1) Medical direction of anesthesia services occurs when an anesthesiologist is involved in no more than four concurrent anesthesia procedures and provides all of the following seven services to a patient:

- (a) perform a pre-anesthetic examination and evaluation;
- (b) prescribe the anesthesia plan;
- (c) personally participate in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence;
- (d) ensure that any procedures in the certified registered nurse anesthesia plan that he or she does not perform, are performed by a qualified anesthetist;
- (e) monitor the course of anesthesia administration at frequent intervals;
- (f) remain physically present and available for immediate diagnosis and treatment of emergencies; and
- (g) provide the indicated post-anesthesia care.

(2) If one or more of the above services in 130 CMR 433.454(C)(1)(a) through (1)(g) are not performed by the anesthesiologist, the service is not considered medical direction.

(3) Ordinarily, the anesthesiologist should not furnish additional services to other patients while concurrently directing the administration of anesthesia. The anesthesiologist can, however, provide any of the following services to other patients while medically directing the administration of anesthesia without affecting the anesthesiologist's ability to provide medical direction.

- (a) addressing an emergency of short duration in the immediate area;
- (b) administering an epidural or caudal anesthetic to ease labor pain;
- (c) periodic rather than continuous monitoring of an obstetrical patient;

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- (d) receiving patients entering the operating suite for the next surgery;
 - (e) checking on or discharging patients from the post anesthesia care unit; and
 - (f) coordinating scheduling matters.
- (4) Payment for medical direction of a CRNA may be claimed by appending the appropriate anesthesia modifier to the anesthesia procedure code.
- (a) If an anesthesiologist provides medical direction of a CRNA who participates in MassHealth in accordance with 130 CMR 433.454(B)(3), and is not employed by the facility in which the anesthesia services are performed, the anesthesiologist receives 50% of the fee and the CNRA receives 50% of the fee.
 - (b) If an anesthesiologist provides medical direction of a CRNA employed by a facility in which the anesthesia service is performed, the anesthesiologist receives 50% of the fee, but no separate payment is made for the CRNA's services.
 - (c) Anesthesiologists and CRNAs should refer to subchapter 6 of the *Physician Manual* for appropriate modifiers.
- (D) Medical Supervision of Anesthesia Services. The MassHealth agency does not pay a physician for medical supervision of a CRNA. The term medical supervision is used in this section for payment purposes only.
- (1) Medical supervision of anesthesia services occurs when an anesthesiologist is involved in five or more concurrent anesthesia procedures and when the anesthesiologist provides some, but not all of the seven required services under medical direction in 130 CMR 433.454(C)(1)(a) through (1)(g).
 - (2) Medical supervision also occurs when the seven required services under medical direction in 130 CMR 433.454(C)(1)(a) through (1)(g) are not performed by an anesthesiologist. This might occur in cases when the anesthesiologist:
 - (a) left the immediate area of the operating suite for more than a short duration;
 - (b) devotes extensive time to an emergency case; or
 - (c) was otherwise not available to respond to the immediate needs of the surgical patients.
- (E) Acupuncture as an Anesthetic. The MassHealth agency pays for acupuncture as a substitute for conventional surgical anesthesia (*see* 130 CMR 433.440).

433.455: Abortion Services

- (A) Payable Services.
- (1) The MassHealth agency pays for an abortion service if both of the following conditions are met:
 - (a) the abortion is a medically necessary abortion, or the abortion is performed upon a victim of rape or incest when such rape or incest has been reported to a law enforcement agency or public health service within 60 days of the incident; and
 - (b) the abortion is performed in accordance with law.
 - (2) For the purposes of 130 CMR 433.455, a medically necessary abortion is one which, according to the medical judgment of a licensed physician, or, consistent with M.G.L. c. 112, § 12M and the time limitations established therein a physician assistant, certified nurse practitioner, or certified nurse midwife, is necessary in light of all factors affecting the pregnant individual's health.
 - (3) Unless otherwise indicated, all abortions referred to in 130 CMR 433.455 are payable abortions as defined in 130 CMR 433.455(A)(1) and (2).
- (B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of abortion services. The MassHealth agency, any provider, any agent or employee of a provider must not mislead any member into believing that a decision to have or not to have an abortion will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of member records for abortion services as well as for all other medical services covered by MassHealth.

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(C) Certification for Payable Abortion Form. All providers (*i.e.*, physicians, physician assistants, nurse practitioners, or nurse midwives) must complete a Certification for Payable Abortion (CPA 2) form and retain the form in the member's record. (Instructions for obtaining the CPA-2 form are in Appendix A of all provider manuals.) To identify those abortions that meet federal reimbursement standards, the MassHealth agency must secure on the CPA 2 form the certifications described in 130 CMR 433.455(C)(1), (2), and (3), when applicable. For all medically necessary abortions not included in 130 CMR 433.455(C)(1), (2), or (3), the certification described in 130 CMR 433.455(C)(4) is required on the CPA 2 form. The provider must indicate on the CPA-2 form which of the following circumstances is applicable, and must complete that portion of the form with the appropriate signatures.

(1) Life of the Pregnant Individual Would Be Endangered. The attending provider must certify that, in their professional judgment, the life of the pregnant individual would be endangered if the pregnancy were carried to term.

(2) Severe and Long-lasting Damage to Pregnant Individual's Physical Health. The attending provider and another provider must each certify that, in their professional judgment, severe and long-lasting damage to the pregnant individual's physical health would result if the pregnancy were carried to term. At least one of the providers must also certify that they are not an "interested provider," defined herein as one whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or who is the spouse of, or another relative who lives with, a provider whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(3) Victim of Rape or Incest. The provider is responsible for submitting with the claim form signed documentation from a law enforcement agency or public health service certifying that the person upon whom the procedure was performed was a victim of rape or incest that was reported to the agency or service within 60 days of the incident. (A public health service is defined as either an agency of the federal, state, or local government that provides health or medical services, or a rural health clinic, provided that the agency's principal function is not the performance of abortions.) The documentation must include the date of the incident, the date the report was made, the name and address of the victim and of the person who made the report (if different from the victim), and a statement that the report included the signature of the person who made the report.

(4) Other Medically Necessary Abortions. The attending provider must certify that, in their medical judgment, for reasons other than those described in 130 CMR 433.455(C)(1), (2), and (3), the abortion performed was necessary in light of all factors affecting the pregnant individual's health.

433.456: Sterilization Services: Introduction

(A) Covered Services. The MassHealth agency pays for a sterilization service provided to an eligible member only if all of the following conditions are met.

(1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 433.457, and such consent is documented in the manner described in 130 CMR 433.458.

(2) The member is at least 18 years old at the time consent is obtained.

(3) The member is not a mentally incompetent individual or an institutionalized individual.

(B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of sterilization services. The MassHealth agency, any provider, any agent or employee of a provider must not mislead any member into believing that a decision to have or not have a sterilization will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of member records for sterilization services as well as for all other medical services covered by MassHealth.

(C) Retroactive Eligibility. The MassHealth agency does not pay for a sterilization performed during the period of a member's retroactive eligibility unless all conditions for payment listed in 130 CMR 433.456(A) are met.

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(D) Locations in Which Sterilizations May Be Performed.

- (1) Male sterilization must be performed by a licensed physician in a physician's office, hospital, or sterilization clinic.
- (2) Female sterilization must be performed by a licensed physician in a hospital, freestanding ambulatory surgery center, or sterilization clinic.
- (3) A hospital, freestanding ambulatory surgery center, or sterilization clinic in which a sterilization is performed must be licensed in compliance 105 CMR 130.000: *Hospital Licensure* or 105 CMR 140.000: *Licensure of Clinics*, as applicable.

433.457: Sterilization Services: Informed Consent

A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained in accordance with the requirements specified in 130 CMR 433.457(A) and (B), and such consent is documented as specified in 130 CMR 433.458.

(A) Informed Consent Requirements.

- (1) The person who obtains consent (a physician, nurse, or counselor, for example) must orally provide all of the following information and advice to the member requesting sterilization:
 - (a) advice that the member is free to withhold or withdraw consent for the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss of any federal- or state-funded program benefits to which the member otherwise might be entitled;
 - (b) a description of available alternative methods of family planning and birth control;
 - (c) advice that the sterilization procedure is considered irreversible;
 - (d) a thorough explanation of the specific sterilization procedure to be performed;
 - (e) a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
 - (f) a full description of the benefits or advantages that may be expected as a result of the sterilization; and
 - (g) advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in 130 CMR 433.457(B)(1).
- (2) The person who obtains consent must also:
 - (a) offer to answer any questions the member may have about the sterilization procedure;
 - (b) give the member a copy of the consent form;
 - (c) make suitable arrangements to ensure that the information and advice required by 130 CMR 433.457(A)(1) are effectively communicated to any member who is blind, deaf, or otherwise handicapped;
 - (d) provide an interpreter if the member does not understand the language used on the consent form or the language used by the person obtaining consent; and
 - (e) allow the member to have a witness of the member's choice present when consent is obtained.

(B) When Informed Consent Must Be Obtained.

- (1) A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member gave informed consent for the sterilization in the manner specified in 130 CMR 433.457. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
- (2) A member's consent for sterilization will not be considered informed or voluntary if such consent is obtained or given while the member requesting sterilization is
 - (a) in labor or childbirth;
 - (b) seeking to obtain or obtaining an abortion; or

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- (c) under the influence of alcohol or other substances that affect the individual's state of awareness.
- (3) Shortly before the performance of the sterilization procedure, the physician performing the procedure must orally inform the member of all of the information and advice specified in 130 CMR 433.457(A)(1).

433.458: Sterilization Services: Consent Form Requirements

Informed consent for sterilization must be documented by the completion of the MassHealth agency's Consent for Sterilization form in accordance with the following requirements.

(A) Required Consent Form.

- (1) One of the following Consent for Sterilization forms must be used:
 - (a) CS-18 — for members 18 through 20 years of age; or
 - (b) CS-21 — for members 21 years of age or older.
- (2) Under no circumstances will the MassHealth agency accept any other consent for sterilization form.

(B) Required Signatures. The member, the interpreter (if one was required), and the person who obtained the consent for sterilization must all sign and date the Consent for Sterilization form (CS-18 or CS-21) at the time of consent. After performing the sterilization procedure, the physician must sign and date the form.

(C) Required Distribution of the Consent Form. The Consent for Sterilization form (CS-18 or CS-21) must be completed and distributed as follows:

- (1) the original must be given to the member at the time of consent; and
- (2) a copy must be included in the member's permanent medical record at the site where the sterilization is performed.

(D) Provider Billing and Required Submissions.

- (1) All providers must bill with the appropriate sterilization diagnosis and service codes, and must attach a copy of the completed Consent for Sterilization form (CS-18 or CS-21) to each claim made to the MassHealth agency for sterilization services. This provision applies to any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. When more than one provider is billing the MassHealth agency (for example, the physician and the hospital), each provider must submit a copy of the completed sterilization consent form with the claim.
- (2) A provider does not need to submit a Consent for Sterilization form (CS-18 or CS-21) with a claim for a medical procedure, treatment, or operation that is not for the purpose of rendering an individual permanently incapable of reproducing. If the appropriate service code used to bill for such a medical procedure, treatment, or operation is also used to bill for a sterilization, the claim will be denied unless at least one of the following justifications is present and documented on an attachment signed by the physician and attached to the claim.
 - (a) The medical procedure, treatment, or operation was a unilateral procedure and did not result in sterilization.
 - (b) The medical procedure, treatment, or operation was unilateral or bilateral, but the patient was previously sterile as indicated in the operative notes.
 - (c) The medical procedure, treatment, or operation was medically necessary for treatment of an existing illness or injury and was not performed for the purpose of sterilization; or
 - (d) The medical procedure, treatment, or operation was medically necessary for treatment of a life-threatening emergency situation and was not performed for the purpose of sterilization, and it was not possible to inform the member in advance that it would or could result in sterilization. Include the nature and date of the life-threatening emergency.
- (3) In the circumstances set forth in 130 CMR 433.458(D)(2)(a) and (c), the medical records must also document that the member consented to the medical procedure, treatment, or operation after being informed that it would or could result in sterilization.

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- (4) When more than one provider is billing the MassHealth agency under the circumstances specified in 130 CMR 433.458(D)(2) (for example, the physician and the hospital), each provider must submit a copy of the signed attachment along with the claim.

433.459: Hysterectomy Services

(A) Nonpayable Services. The MassHealth agency does not pay for a hysterectomy provided to a member under the following conditions.

- (1) The hysterectomy was performed solely for the purpose of sterilizing the member.
- (2) If there was more than one purpose for the procedure, the hysterectomy would not have been performed but for the purpose of sterilizing the member.

(B) Hysterectomy Information Form. The MassHealth agency pays for a hysterectomy only when the appropriate section of the Hysterectomy Information (HI-1) form is completed, signed, and dated as specified below.

- (1) Prior Acknowledgment. Except under the circumstances specified below, the member and her representative, if any, must be informed orally and in writing before the hysterectomy operation that the hysterectomy will make her permanently incapable of reproducing. (Delivery in hand of the Hysterectomy Information (HI-1) form will fulfill the written requirement, but not the oral requirement.) Section (B) of the Hysterectomy Information (HI-1) form must be signed and dated by the member or her representative before the operation is performed, as acknowledgment of receipt of this information. Whenever any surgery that includes the possibility of a hysterectomy is scheduled, the member must be informed of the consequences of a hysterectomy, and must sign and date section (B) of the Hysterectomy Information (HI-1) form before surgery.
- (2) Prior Sterility. If the member is sterile prior to the hysterectomy operation, the physician who performs the operation must so certify, describe the cause of sterility, and sign and date section (C)(1) of the Hysterectomy Information (HI-1) form.
- (3) Emergency Surgery. If the hysterectomy is performed in an emergency, under circumstances that immediately threaten the member's life, and if the physician determines that obtaining the member's prior acknowledgment is not possible, the physician who performs the hysterectomy must so certify, describe the nature of the emergency, and sign and date section (C)(2) of the Hysterectomy Information (HI-1) form.
- (4) Retroactive Eligibility. If the hysterectomy was performed during the period of a member's retroactive eligibility, the physician who performed the hysterectomy must certify that one of the following circumstances existed at the time of the operation:
 - (a) the woman was informed before the operation that the hysterectomy would make her sterile (the physician must sign and date section (D)(1) of the HI-1 form);
 - (b) the woman was sterile before the hysterectomy was performed (the physician must sign, date, and describe the cause of sterility in section (D)(2) of the HI-1 form); or
 - (c) the hysterectomy was performed in an emergency that immediately threatened the woman's life and the physician determined that it was not possible to obtain her prior acknowledgment (the physician must sign, date, and describe the nature of the emergency in section (D)(3) of the HI-1 form).

(C) Submission of the Hysterectomy Information Form. Each provider must attach a copy of the completed Hysterectomy Information (HI-1) form to each claim form submitted to the MassHealth agency for hysterectomy services. When more than one provider is billing the MassHealth agency for the same hysterectomy, each provider must submit a copy of the completed HI-1 form.

433.473: Clinical Nurse Specialist (CNS) Services

(A) General. 130 CMR 433.473 applies specifically to clinical nurse specialists. In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to a physician also apply to a clinical nurse specialist (CNS), such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

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(B) Conditions of Payment. The MassHealth agency pays a CNS or group practice for CNS services when

- (1) the services are limited to the scope of practice authorized by state law or regulation (including, but not limited to, 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);
- (2) the CNS or group practice is not an employee or contractor of the hospital or other facility in which the CNS services were performed, or is not otherwise paid by the hospital or facility for their services;
- (3) the CNS participates in MassHealth pursuant to the requirements of 130 CMR 433.473(C); and
- (4) for an out-of-state CNS the requirements of 130 CMR 433.403(C) are met.

(C) Clinical Nurse Specialist Provider Eligibility. A CNS may enroll as a MassHealth provider. Any CNS applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency that he or she

- (1) is licensed to practice as a CNS by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the CNS services are provided; and
- (2) is a member of a group practice or is in a solo private practice.

(D) Consultation Between A Clinical Nurse Specialist and Physician. The MassHealth agency does not pay for a consultation between a CNS and a physician as a separate service.

433.485: CARES Program Services

(A) Introduction. The MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support for Kids program (CARES program) is a Targeted Case Management (TCM) service rendered by CARES program providers certified in accordance with 130 CMR 433.485(D) to members younger than 21 years old who satisfy the eligibility criteria in 130 CMR 433.485(C). The MassHealth agency pays for CARES program services provided by CARES program providers subject to restrictions and limitations in 130 CMR 433.485(A) through 433.485(H) and Appendix M.

(B) Definitions. The following terms used in 130 CMR 433.485(A) through 433.485(H) have the meanings given in 130 CMR 433.485(B), unless the context clearly requires a different meaning.

Comprehensive Assessment - a systematic, timely, and clearly documented screening process that provides the foundation for care coordination and the individual care plan. The assessment includes information and data from multiple sources and reflects key information about the member and their parent/guardian's needs and priorities.

Individual Care Plan (ICP) - a plan that specifies the goals and actions to address the medical, educational, social, behavioral, or other services needed by the member and their parent/guardian.

Local Education Agency - a public authority legally constituted by the state as an administrative agency to provide control of and direction for kindergarten through grade 12 public educational institutions.

Medical Complexity - a combination of multiorgan system involvement from chronic health condition(s) that often result in functional limitations, ongoing use of medical technology, and high resource need and use.

Natural Supports - include family, friends, neighbors, and self-help groups intentionally identified to support the member. This support system is an active component of the ICP to support the member and their parent/guardian.

Subspecialist - a provider who specializes in a narrow field of professional knowledge/skills within a medical specialty, such as pediatric congenital heart disease within the broad specialty of cardiology.

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(C) Clinical Eligibility Criteria. To receive CARES program services, a member must:

- (1) be younger than 21 years old;
- (2) not reside in a nursing facility or other inpatient facility for longer than six consecutive months at the time of seeking CARES program services; and
- (3) satisfy:
 - (a) all of the eligibility criteria in 130 CMR 433.485(C)(3)(b)(1); and
 - (b) all of the eligibility criteria in either 130 CMR 433.485(C)(3)(b)(2) or 130 CMR 433.485(C)(3)(b)(3), as follows:
 1. The member is a child or youth with special health needs who requires ongoing medical management by at least two pediatric subspecialists. At least one of the specialists must treat a medical condition that results in all of the following:
 - a. functional impairment (*e.g.*, need for assistance with activities of daily living) that substantially interferes with or limits the member's role/functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the member in achieving or maintaining developmentally appropriate, social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.
 - b. at least one condition must be:
 - i. progressive, associated with persistent deteriorating health; or
 - ii. a chronic medical condition, expected to last at least a year and expected to be episodically or continuously debilitating and require ongoing treatment for control of the condition that will use health care resources above the level of a healthy child; or
 - iii. a progressive or metastatic malignancy.
 2. At the time the member begins receiving CARES program services, the member is at high risk for adverse health outcomes due to both of the following:
 - a. Demonstrated inability to coordinate multiple medical, social, and other services impacting medical condition, as evidenced by:
 - i. two or more unplanned emergency department visits within the past 180 days; or
 - ii. a documented pattern of multiple missed primary care physician (PCP) or subspecialty appointments; or
 - iii. chronic school absenteeism directly related to the member's medical conditions.
 - b. Demonstrated health-related social needs impacting the management of the member's medical condition. Social complexity/health-related social needs are defined by at least one of the following:
 - i. experiencing homelessness or housing insecurity;
 - ii. experiencing food insecurity;
 - iii. parent/caregiver experiencing employment instability;
 - iv. lacking access to basic resources such as heat, electricity, internet, transportation, education, and social connections; or
 - v. living in unsafe or violent conditions.
 3. The member requires more than two continuous hours of skilled nursing services to remain safely at home.

(D) Provider Requirements.

- (1) Payment for services described in 130 CMR 433.485(A) through 433.485(H) will be made only to group practices participating in MassHealth on the date of service that are also certified by the MassHealth agency for the provision of CARES program services at that location on the date of service.
- (2) A group practice seeking to provide CARES program services must meet the requirements listed in 130 CMR 433.485(A) through 433.485(H). A separate application for certification as a CARES program provider must be submitted for each group practice that seeks to render such services. The application must be made on the form provided by the MassHealth agency and must be submitted to the MassHealth agency's physician program. The MassHealth agency may request additional information from the applicant to evaluate the applicant's compliance with 130 CMR 433.485(A) through 433.485(H). Through this certification, the applicant must, among other things:

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- (a) agree to enter into a written agreement with the MassHealth agency in which the applicant agrees to satisfy all of the requirements in 130 CMR 433.485(A) through 433.485(H);
 - (b) agree to establish, maintain, and comply with written policies and procedures to satisfy all the requirements in 130 CMR 433.485(A) through 433.485(H);
 - (c) agree to assess and annually reassess each member in its care in accordance with 130 CMR 433.485(E)(3)(a) and 130 CMR 433.485(F)(1)(a) to ensure that each such member satisfies, and continues to satisfy, the clinical eligibility criteria for receipt of CARES program services;
 - (d) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 433.485(A) through 433.485(H);
 - (e) submit a written description of:
 - 1. CARES program services offered by the applicant and its care objectives, and
 - 2. how the applicant will fulfill the staffing requirements in 130 CMR 433.485(E);
 - (f) agree to participate in any CARES program provider orientation required by EOHHS;
 - (g) attest that it:
 - 1. actively provides covered services to MassHealth members younger than 21 years old with medical complexities; and
 - 2. has the capacity to provide on-call care coordination to members assigned to the applicant 24 hours per day, 365 days per year;
 - (h) agree to provide any documentation, data, and reports as required by EOHHS;
 - (i) agree to subscribe to and participate in the statewide ENS (Event Notification Service) Framework described in 101 CMR 20.11: *Statewide Event Notification Service Framework*, including having the capacity to receive and send admission, discharge, and transfer messages, as that term is defined in 101 CMR 20.04: *Admission, Discharge, and Transfer Messages (ADTs)*;
 - (j) agree to establish and implement policies and procedures to increase the technological capabilities to share information among providers involved in members' care, including increasing Health Information Exchange (HIE) connections and enhancing digital systems interoperability;
 - (k) agree to use CMS required CEHRT (Certified Electronic Health Record Technology) criteria (2015 edition or subsequent editions) and updates to said criteria, to document and communicate clinical care information;
 - (l) agree to comply with the Office of the National Coordinator for Health Information Technology (ONC) guidance on USCDI (United States Core Data for Interoperability) for standardized health data exchange, or such other guidance and standards for health data exchange as specified by EOHHS;
 - (m) agree to submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the CARES program provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 433.485(A) through 433.485(H); and
 - (n) agree to participate in any quality management and program integrity processes as required by the MassHealth agency.
- (3) The MassHealth agency requires documentation from providers seeking to become CARES program providers. All required application documentation will be specified by the MassHealth agency and must be submitted and approved prior to participating as a CARES program provider in MassHealth.
- (4) Based on the information provided in the certification application, the MassHealth agency will determine whether the applicant is certifiable as a CARES program provider. If the MassHealth agency determines that the applicant is not certifiable, the notice will contain a statement of the reasons for that determination and recommendations for corrective action so that the applicant may reapply for certification once corrective action has been taken.
- (5) The certification is valid only for the group practice described in the application and is not transferable to any other provider. Any additional location established by the applicant at a satellite facility must obtain separate certification from the MassHealth agency in order to receive payment.

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(E) CARES Team.

(1) The CARES program provider must establish a CARES team to meet the care coordination needs of members, including on call after-hours availability to assist as needed and to triage medical crises and emergencies. The CARES team must include a program director, senior care manager, care coordinator, and family support staff which may include a community health worker or peer, each of whom must satisfy the staff composition requirements specified in Appendix M. The CARES team must satisfy any other staff composition requirements specified in Appendix M. CARES team members may serve multiple roles for which they are qualified as long as the staffing responsibilities and programmatic requirements are met. In addition, care managers and supervisors serving on the CARES team must complete trainings as outlined in Appendix M. CARES program providers must establish policies and procedures relating to such trainings to ensure the completion of such trainings. CARES program providers must document compliance with training requirements for care managers and supervisors within three months of starting in that role.

(2) The CARES team is responsible for ensuring that needed medical, social, educational, and other CARES program services are accessed, coordinated, and delivered in a strength-based, individualized, member-driven, culturally informed, linguistically appropriate, and accessible manner. The CARES team must establish referral relationships with members' pediatric specialty providers, primary care providers, behavioral health providers, MassHealth managed care entities, and any other entity, agency, system, or provider as needed for the treatment of a member in the provider's care, as determined by the member's CARES team.

(3) The CARES team must:

(a) conduct a comprehensive assessment of each member seeking CARES program services from the provider in order to determine that the member is clinically eligible to receive such services. The CARES team will conduct this comprehensive assessment in accordance with 130 CMR 433.485(F) and Appendix M.

(b) make referrals for and coordinate services on- and off-site. These services include, but are not limited to, making referrals for and coordinating the following services:

1. medical and behavioral health care.
2. home and community long-term services and supports, such as Durable Medical Equipment (DME) and Continuous Skilled Nursing (CSN) services. For members enrolled in the Community Case Management (CCM) program, the CARES team will serve as the lead care coordination entity and will work directly with the CCM case manager to coordinate DME, CSN, and other home health services.
3. health-related social needs, goods, and services, including, but not limited to, housing stabilization and support services, utility assistance, and nutritional assistance.
4. educational services and entitlements.
5. any state agency services for which the member may be eligible.

(c) have standardized processes for referrals to ensure continuity of care, exchange of relevant health information, such as test results and records, and avoidance of service duplication. This process must also contain follow-up provisions to ensure that the referral is completed successfully.

(d) establish and maintain relationships with the member's health plan and any state or local agencies with which the member is involved, including, but not limited to, the Department of Children and Families (DCF), the Department of Developmental Services (DDS), the Department of Mental Health (DMH), the Department of Public Health (DPH), the Department of Transitional Assistance (DTA), the Department of Youth Services (DYS), and any Local Education Agency (LEA).

(e) support care coordination and facilitate collaboration through the establishment of regular case review meetings as specified in Appendix M.

(f) provide all CARES program services.

(F) Scope of Services. The CARES program provider must ensure that CARES program services are provided only by individuals serving on the CARES team who are qualified to render such services. Detailed service components are outlined in Appendix M.

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- (1) CARES program services must include at a minimum:
 - (a) a comprehensive assessment of the member at least once a year. These assessment activities include, but are not limited to:
 1. taking the member's history, which must capture the full spectrum of medical, social, educational, and emotional needs;
 2. identifying the member's needs and completing related documentation; and
 3. gathering information from other sources such as the parent/guardian, medical providers, state agencies, social services providers, and educators, to complete the assessment or reassessment of the member.
 - (b) development of an ICP, which must be driven by the member and their parent/guardian, authorized health care decision maker, and other relevant providers, and it must be shared and included in transition of care communication with relevant providers, state agencies, and members of the care management team. The ICP must be in a form and format specified by the MassHealth agency and include:
 1. goals and actions to address the medical, social, educational, and other services needed by the member;
 2. a course of action to respond to the assessed needs of the member; and
 3. an emergency plan;
 - (c) care coordination and family support activities such as, but not limited to:
 1. having a designated CARES team member (either a care coordinator or a senior care manager) serve as the primary and "first line" contact for the member and their parent/guardian. The care manager must provide regular contact with the member and their parent/guardian (either face-to-face or by telehealth, in accordance with the preferences of the member and their parent/guardian);
 2. providing a phone number and on-call capacity 24 hours per day, 365 days per year to respond to and triage any medical and care coordination related questions;
 3. helping the parent/guardian/caregiver advocate for and access resources and services to meet the family's needs;
 4. maintaining effective, coordinated, and communicative relationships with designees from the member's care team, such as primary care physicians, health systems, specialty providers, dental providers, behavioral health providers, CCM, and CSN supports, and other state agencies, in order to facilitate coordination;
 5. coordinating with early intervention providers and school and early childhood education providers;
 6. coordinating access to DME, home care needs, scheduling appointments, referrals to providers for needed medical services, and assistance with prior authorization;
 7. coordinating goods and services related to health-related social needs;
 8. providing ongoing support in maintaining MassHealth eligibility, accessing any eligible benefits through state agencies, and coordinating with primary insurance for members who have third-party coverage;
 9. providing intensive support for transitions of care between different health and community settings and the member's home; and
 10. performing any other activities as detailed in Appendix M.
 - (d) appropriate services to address identified needs and achieve goals specified in the ICP;
 - (e) intensive support for member transitions into adult care, beginning once the member reaches 16 years old; and
 - (f) all monitoring and follow-up activities necessary to ensure that the ICP is implemented and adequately addresses the member's needs.
- (2) A CARES program provider is responsible for providing any and all of the CARES program services described above to each member receiving CARES program services from that provider when medically necessary.

(G) Assignment and Removal of Assignment Procedures.

- (1) To promote effective provision of targeted case management services and prevent duplication, a member seeking CARES program services may receive such services from only one CARES program provider at a time. To facilitate this requirement, a CARES program provider must, prior to rendering CARES program services to a member, check the Eligibility Verification System to determine whether the member has been assigned to another CARES program provider, in accordance with the process in Appendix M.

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- (a) If the member is assigned to another CARES program provider, the provider from whom the member seeks CARES program services must decline to provide such services to the member and refer the member to the CARES program to which they are assigned.
- (b) If the member is not assigned to another CARES program provider, and if the member agrees to receive CARES program from the CARES program provider, the CARES program provider must assign the member to the CARES program provider in accordance with the process in Appendix M, including determining clinical eligibility and other education and information-sharing activities with the eligible member and parent/guardian.
- (2) Removal of Assignment. If a member no longer needs or is no longer eligible for CARES program services provided by the CARES program provider, the CARES program must follow the removal of assignment procedures as specified in Appendix M, including convening a meeting with the member and their family to develop an aftercare/transition plan.
- (H) Payment.
 - (1) The MassHealth agency pays a CARES program provider for CARES program services only if the member receiving CARES program services is eligible to receive such services under 130 CMR 433.485(C).
 - (2) The MassHealth agency pays a CARES program provider for services in accordance with the applicable payment methodology and rate schedule established by EOHHS. Rates of payment for CARES program services include only those services described in 130 CMR 433.485(F), and do not cover or include any direct medical care.
 - (3) The MassHealth agency makes a single monthly payment for all CARES program services rendered by a CARES program provider to a member during that calendar month. In order to qualify for payment of the monthly fee, the CARES program provider must provide at least two of the CARES program services described above to that member during that calendar month, with at least one of those services including live interaction between the provider and the member and their parent/guardian, whether in person or via telehealth. A CARES program provider may not bill MassHealth the monthly fee for any calendar month in which the provider renders only one of the services described above to the member.
 - (4) Payment for the CARES program is subject to the conditions, exclusions, and limitations in 130 CMR 433.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.
 - (5) The MassHealth agency does not pay for CARES program services rendered to a member by a CARES program provider during any period of time in which the member is assigned to another CARES program provider.
 - (6) If the member assigned to a CARES program provider is admitted to a nursing facility or other inpatient facility during the period of assignment, the MassHealth agency pays for CARES program services rendered by that CARES program provider to that member for up to six consecutive months from the date of admission, subject to compliance with all applicable requirements in 130 CMR 433.485(A) through 433.485(H) and Appendix M. MassHealth will not pay for CARES program services rendered to any member who has resided in a nursing facility or other inpatient facility for more than six consecutive months.

REGULATORY AUTHORITY

130 CMR 433.000: M.G.L. c. 118E, §§ 7 and 12.

(PAGES 477 AND 488 ARE RESERVED FOR FUTURE USE.)