4. Program Regulations

415.401: Introduction

130 CMR 415.000 establishes the requirements for the provision of services by acute inpatient hospitals under MassHealth. The word "hospital" in 130 CMR 415.000 refers specifically to an acute inpatient hospital or unit only, unless the context clearly indicates otherwise. The MassHealth agency pays for inpatient hospital services that are medically necessary and appropriately provided as defined by 130 CMR 450.204: *Medical Necessity*. The quality of such services must meet professionally recognized standards of care.

415.402: Definitions

The following terms used in 130 CMR 415.000 have the meanings given in 130 CMR 415.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 415.402 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 415.000, and in 130 CMR 410.000: *Acute Outpatient Hospital* and 450.000: *Administrative and Billing Regulations.*

Abuse – a nonaccidental physical injury to an individual inflicted by another person that causes or creates a substantial risk of death or protracted impairment of any bodily organ or function; or the commission of sex offenses against an individual, as defined in the criminal laws of Massachusetts.

Acute Inpatient Hospital – a facility that is licensed as a hospital by the Massachusetts Department of Public Health and that provides diagnosis and treatment for patients who have any of a variety of medical conditions requiring daily physician intervention as well as full-time availability of physician services; however, this does not include any facility that is licensed as a chronic disease and rehabilitation hospital, any hospital that is licensed primarily to provide mental health services, or any unit of a facility that is licensed as a nursing facility, a chronic disease unit, or a rehabilitation unit.

Administrative Day – a day of inpatient hospitalization on which a member's care needs can be provided in a setting other than an acute inpatient hospital as defined in 130 CMR 415.402 and on which a member is clinically ready for discharge.

Agent – a party designated by the MassHealth agency to act on its behalf in instances when the MassHealth agency itself does not perform the required function.

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 under the age of 21.

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.

Day of Discharge – the day on which a member leaves the hospital, regardless of the hour. The day of death is also considered the day of discharge. A leave of absence is not considered a discharge.

Discharge Planner – a registered nurse or a social worker either licensed or eligible for and in the process of applying for licensure by the Commonwealth of Massachusetts, whose primary responsibility is discharge planning.

Discharge Planning – the coordinated effort of the discharge-planning staff of a hospital to locate appropriate placement for members who no longer require hospitalization.

DMH-Licensed Bed – a bed in an acute inpatient hospital that is located in a unit licensed by the Department of Mental Health (DMH), pursuant to 104 CMR 27.00: *Licensing and Operational Standards for Mental Health Facilities.*

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

Inpatient Admission – the admission of a member to an acute inpatient hospital for the purposes of receiving inpatient services in that hospital.

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

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.

Leave-of-Absence Day – a day during which a bed in an acute inpatient hospital is reserved for a member who leaves the facility and for whom no formal discharge and readmission procedures occur.

Length of Stay – the duration of a member's inpatient hospital stay at a Medicare hospital level of care during a medical leave of absence.

Medical Leave of Absence – an inpatient hospital stay of a member who is a resident of a nursing facility for up to 10 consecutive days in a hospital at a Medicare hospital level of care. The day on which a member is transferred from a nursing facility to a hospital for an inpatient stay is the first day of the medical leave of absence from the nursing facility. The day on which a member is transferred from a hospital back to a nursing facility or is otherwise discharged to a noninstitutional setting is not a medical leave-of-absence day.

Medicare Hospital Level of Care – a level of care that meets all criteria, as determined by the Centers for Medicare and Medicaid Services or its agent, for Medicare reimbursement for hospital care.

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.

Neglect – failure by a financially able caretaker responsible for an individual to provide adequate food, clothing, shelter, education, medical care, proper supervision, or guardianship that results in the individual's present avoidable suffering. The caretaker is considered capable of adequately providing these necessities if the caretaker is financially able to do so or is offered other reasonable means to do so.

Nursing Facility – a long-term-care institution that meets the provider eligibility and certification requirements of 130 CMR 456.404: *Requirements for Provider Participation: In State*, or 456.405: *Requirements for Provider Participation: Out of State*, and the certification requirements of 130 CMR 456.406: *Medicare Certification Requirement*.

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

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

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

Reasonable Distance – generally, 25 miles from the home or usual noninstitutional residence of the member. This definition does not preclude longer distances in such instances as, but not limited to, rural areas or in cases where the member has no family or regular visitors.

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

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

Utilization Review Coordinator – an individual responsible for utilization review in a hospital.

Working Days – Monday through Friday except for legal holidays.

415.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency pays for acute inpatient hospital services only when provided to MassHealth members, subject to the restrictions and limitations described in 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 the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106: *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*.

415.404: Provider Eligibility

Payment for the services described in 130 CMR 415.000 is made only to acute inpatient hospitals participating in MassHealth as of the date of service.

(A) In-State. To participate in MassHealth, an acute inpatient hospital located in Massachusetts must

(1) be licensed as a hospital by the Massachusetts Department of Public Health;

(2) have a signed provider agreement that specifies a payment methodology with the MassHealth agency; and

(3) participate in the Medicare program.

(B) Out of State.

(1) Out-of-state acute inpatient hospital services are covered only as provided in 130 CMR 450.109: *Out-of-State Services*.

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

(a) be approved as an acute inpatient hospital by the governing or licensing agency in its state;

(b) participate in the Medicare program; and

(c) participate in that state's Medicaid Program (or equivalent).

415.405: Utilization Management Program

The MassHealth agency pays for procedures and hospital stays that are subject to the Utilization Management Program only if the requirements of the program, as described in 130 CMR 450.207: *Utilization Management Program for Acute Inpatient Hospitals* through 450.209: *Utilization Management: Prepayment for Acute Inpatient Hospitals*, are satisfied. Appendix E of the *Acute Inpatient Hospital Manual* describes the information that must be provided as part of the review process.

415.406: Payment Methodology

Payments to acute inpatient hospitals in Massachusetts for services provided to MassHealth members equals the rate established in the signed provider agreement with the MassHealth agency.

415.407: Covered Administrative Days: Payment Methodology

Payment for covered administrative days provided on or after October 1, 1991, is made in accordance with the methodology established by the signed provider agreement with the MassHealth agency. The per diem rate must be accepted by the hospital as payment in full for all days determined to be administratively necessary, in accordance with 130 CMR 415.414.

415.408: Nonpayable Services

The following are not payable:

(A) drugs and durable medical equipment prescribed for take-home use that are readily available from pharmacies or medical providers;

(B) the cost of any treatment or testing provided to a member who is an inpatient at another hospital, whether of the member or of a specimen from the member. Payment will be made to the hospital where the member is an inpatient and not to the provider where this treatment or testing occurs;

(C) leaves of absence;

(D) research or the provision of experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments;

(E) cosmetic surgery;

(F) the provision of whole blood (however, administrative and processing costs associated with the provision of blood and its derivatives are reimbursable);

(G) private hospital rooms, except when the member is being treated for an infectious disease that requires a private room, or in other circumstances in which a private room would be medically necessary; and

(H) 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.

415.409: Sterilization Services: Introduction

(A) Covered Services. The MassHealth agency pays for sterilization services performed by a licensed physician in an acute inpatient hospital for a 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 415.410, and such consent is documented in the manner described in 130 CMR 415.411.
(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, or 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 415.409(A) are met.

415.410: 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 415.410(A) and (B), and such consent is documented as specified in 130 CMR 415.411.

(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 415.410(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 415.410(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 415.410. 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
(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 415.410(A)(1).

415.411: 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. (Instructions for obtaining the Consent for Sterilization forms are located in Subchapter 5 of the *Acute Inpatient Hospital Manual*.)

(A) Required Consent Form.
(1) One of the following Consent for Sterilization forms must be used:
(a) CS-18 — for members aged 18 through 20; or
(b) CS-21 — for members aged 21 and 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 services 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 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 may also be 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 415.411(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.

(4) When more than one provider is billing the MassHealth agency under the circumstances specified in 130 CMR 415. 411(D)(2) (for example, the physician and hospital), each provider must submit a copy of the signed attachment along with the claim.

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

The MassHealth agency pays for all medically necessary acute inpatient hospital services for EPSDT-eligible members in accordance with 130 CMR 450.140 through 450.149: *EPSDT Services: Recordkeeping Requirements*, without regard to service limitations described in 130 CMR 415.000, and with prior authorization.

415.413: 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 performed by a licensed physician in an acute inpatient hospital 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 Hysterectomy Information (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 Hysterectomy Information (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 Hysterectomy Information (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 Hysterectomy Information (HI-1) form.

415.414: Utilization Review

(A) All inpatient services must be provided in accordance with 130 CMR 450.204: *Medical Necessity* or 130 CMR 415.415, and are subject, among other things, to utilization review under 130 CMR 450.207: *Utilization Management Program for Acute Inpatient Hospital* through 130 CMR 450.209: *Utilization Management: Prepayments Review for Acute Inpatient Hospitals* and to requirements governing overpayments under 130 CMR 450.235(B): *Overpayments* and 450.237: *Overpayment Determination*.

(B) (1) The MassHealth agency (or its agent) will review inpatient services provided to members to determine the medical necessity, pursuant to 130 CMR 450.204, or administrative necessity and appropriateness, pursuant to 130 CMR 415.415, of such services. Any such review may be conducted prior to, concurrently, or retrospectively following the member's inpatient admission. Reviewers consider the medical-record documentation of clinical information available to the admitting provider at the time the decision to admit was made. Reviewers do not deny admissions based on what happened to the member after the admission. However, if an admission was not medically necessary at the time of the decision to admit, but the medical record indicates that an inpatient admission later became medically necessary, the admission will be approved as long as all other MassHealth requirements are met.

(2) If, pursuant to any review, the MassHealth agency concludes that the inpatient admission was not medically or administratively necessary, the MassHealth agency will deny payment for the inpatient admission.

(3) If the MassHealth agency issues a denial notice for an acute inpatient hospital admission pursuant to 130 CMR 415.414 and 450.204: *Medical Necessity* as well as either 450.209: *Utilization Management: Prepayment for Acute Inpatient Hospitals* or 450.237: *Overpayments: Determination*, the hospital may rebill the claim as an outpatient service, as long as the MassHealth agency has determined the service would have been appropriately provided in an outpatient setting. In order for the hospital to receive payment under 130 CMR 415.414(B)(3), the outpatient claim and a copy of the denial notice must be received by the MassHealth agency within 90 days from the date of the denial notice and must comply with all applicable MassHealth requirements.

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

(1) member's medical history;
(2) member's current medical needs;
(3) severity of the signs and symptoms exhibited by the member;
(4) medical predictability of an adverse clinical event occurring with the member;
(5) results of outpatient diagnostic studies;
(6) types of facilities available to inpatients and outpatients; and
(7) MassHealth agency's Acute Inpatient Hospital Admission Guidelines in Appendix F of the *Acute Inpatient Hospital Manual* and in various appendices of other appropriate provider manuals. The MassHealth agency has developed such guidelines to help providers determine the medical necessity of an acute inpatient hospital admission. These guidelines indicate when there is generally no medical need for such an admission.

(D) If, as the result of any review, the MassHealth agency determines that any hospital inpatient admission, stay, or service provided to a member was not covered under the member's coverage type (see 130 CMR 450.105: *Coverage Types*) or was delivered without obtaining a required authorization including, where applicable, authorization from the member's primary-care provider, the MassHealth agency will not pay for that inpatient admission, stay, or service.

415.415: Reimbursable Administrative Days

(A) Administrative days as defined in 130 CMR 415.402 are reimbursable if the following conditions are met:

(1) the recipient requires an admission to a hospital or a continued stay in a hospital for reasons other than the need for services that can only be provided in an acute inpatient hospital as defined in 130 CMR 415.402 (see 130 CMR 415.415(B) for examples); and

(2) a hospital is making regular efforts to discharge the recipient to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 415.419 must be followed, but they do not preclude additional, effective discharge-planning activities.

(B) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

(1) A recipient is awaiting transfer to a chronic disease hospital, rehabilitation hospital, nursing facility, or any other institutional placement.

(2) A recipient is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).

(3) A recipient is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.

(4) A recipient with lead poisoning is awaiting deleading of his or her residence.

(5) A recipient is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.

(6)recipient in the custody of the Department of Social Services is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

(7) A recipient cannot be treated or maintained at home because the primary caregiver is absent due to medical or psychiatric crisis, and a substitute caregiver is not available.

(8) A recipient is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to:

(a) maintenance of tube feedings;

(b) ventilator management;

(c) dressings, irrigations, packing, and other wound treatments;

(d) routine administration of medications;

(e) provision of therapies (respiratory, speech, physical, occupational, etc.);

(f) insertion, irrigation, and replacement of catheters; and

(g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition.)

415.416: Nonreimbursable Administrative Days

Administrative days are not reimbursable when:

(A) a hospitalized recipient is awaiting an appropriate placement or services that are currently available but the hospital has not transferred or discharged the recipient because of the hospital's administrative or operational delays;

(B) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement or services; or

(C) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the recipient.

415.417: Notification of Denial, Reconsideration, and Appeals

(A) Notification of Denial. The Division or its agent shall notify the recipient, the hospital, and the recipient's attending physician whenever it determines as part of a concurrent review that the hospital admission or stay, or any part thereof, is not medically or administratively necessary. The Division or its agent shall notify the hospital and the recipient's attending physician whenever it determines as part of a concurrent or retrospective review that the hospital stay is or was no longer medically necessary but is or was administratively necessary. The Division or its agent shall notify the hospital and the recipient whenever it determines as part of a concurrent review that a hospital stay is no longer administratively necessary due to the refusal of an appropriate placement.

(B) Reconsideration. An agent of the Division under 130 CMR 415.000 may provide an opportunity for reconsideration of a determination made by that agent. If a reconsideration is available, notice of the agent's determination will include written notice of: the right to a reconsideration; the time within and manner in which a reconsideration must be requested; and the time within which a decision will be rendered. A hospital, a physician, or a recipient entitled to have a determination reconsidered must request and have a reconsideration determination given before requesting a hearing under 130 CMR 415.417(C).

(C) Appeals to the MassHealth Agency.

(1) A member may request a fair hearing before the MassHealth agency when the MassHealth agency or its agent determines as the result of a concurrent review that a continued stay is not administratively necessary due to the availability of an appropriate placement as described in 130 CMR 415.415.

(2) A hospital may request a fair hearing before the MassHealth agency when the MassHealth agency or its agent determines as the result of a concurrent review that an admission or a continued stay, or any part thereof, is not medically necessary but is administratively necessary.

(3) A member or a hospital may request a fair hearing before the MassHealth agency when the MassHealth agency or its agent determines as the result of a concurrent review that an admission or continued stay, or any part thereof, is not medically or administratively necessary.

(4) Written notice of the right to a fair hearing and the manner in which and time within which a hearing must be requested will be provided at the time of the initial determination or of the reconsideration decision by the MassHealth agency or its agent.

(5) A hospital may appeal the determination of the MassHealth agency or its agent as the result of a retrospective review that an admission or a continued stay, or any part thereof, was not medically necessary, was not administratively necessary, or was not medically necessary but was administratively necessary. These appeals are governed by 130 CMR 450.000.

415.418: Accident Victims

When a member is admitted to an acute inpatient hospital as the result of an accident, it is the hospital's responsibility to notify the member's local office so that assignment may be taken of the member's right to third-party coverage of claims or possible recovery of claims as the result of tort action.

415.419: Discharge-Planning Standards

(A) Staff.

(1) The hospital must assign in writing the responsibility for all patient discharge planning to one appropriate department (such as social services or continuing care). That department in turn must designate specific staff members whose primary duties are discharge planning.

(2) The discharge-planning staff must include either a registered nurse or a social worker who is licensed or eligible and applying for licensure in Massachusetts, and is under the supervision of, or in consultation with, a licensed graduate-level nurse or social worker.

(3) Unless permitted a lower ratio by the MassHealth agency, the hospital must employ one discharge planner or full-time equivalent for every 60 licensed beds, excluding maternity and special-care units. Visiting Nurse Association (VNA) or home health staff who are not employed by the hospital, but who regularly perform discharge-planning activities there, may be included in this ratio.

(4) The hospital must demonstrate to the MassHealth agency that it provides formal inservice training programs and regular case conferences for all discharge-planning staff and all other personnel who affect the discharge-planning process.

(B) Operations and Procedures.

(1) The discharge-planning staff must maintain a chronological list, updated daily, of all members on administrative day status. The list must contain the date administrative day status commenced and a recommendation for institutional or noninstitutional care upon discharge based on nursing facility medical eligibility criteria. The discharge-planning department must use this chronological list to ensure that members who have spent the longest time on administrative day status receive priority in placement attempts.

(2) The discharge-planning department must maintain up-to-date lists of the following:

(a) all licensed nursing facilities within a 25-mile minimum radius of the hospital. This list must show, for each facility, the number of beds, whether the facility is Medicare certified, whether the facility is Medicaid certified, any other notable characteristics (for example, the availability of bilingual staff), and the name of the individual who is responsible for admissions; and

(b) all community-based organizations and resources within a 25-mile minimum radius of the hospital that provide services and support to members discharged to the community. Such resources include, but are not limited to, housing for the elderly, home health agencies, homemaker services, transportation services, friendly visitor programs, and meal programs.

(3) As a routine practice, admissions data, including but not limited to age and diagnosis, must be screened by discharge-planning staff within 24 hours of admission in accordance with written criteria that identify pertinent patient characteristics and any high-risk diagnoses. Discharge-planning activities must then commence within 72 working hours of admission for every member expected to require posthospital care or services. Admissions data must be noted in the member's record in the discharge-planning department. The written criteria used to screen members must be available to the MassHealth agency.

(4) The hospital must ensure that a clinician, certified in accordance with 130 CMR 415.420, completes a CANS during the discharge planning process for those members under the age of 21 who are receiving services in a DMH-licensed bed.

(5) The hospital must have a written policy that allows discharge-planning staff access to all members and their medical records. If such access is medically contraindicated, the member's physician must sign a statement specifying the reason for the contraindication and the hospital must maintain the statement in the member's medical or discharge-planning record.

(6) The discharge-planning staff and the primary-care team must coordinate and document in writing a plan for each member who requires posthospital care that specifies the services or care expected to be required by the member, the frequency, intensity, and duration of such services, and the resources available to provide the care or services, including available family and community support. The plan must be updated if the member's condition changes significantly. If an institutional placement for the member is recommended upon discharge, the plan must state why available community resources are inadequate to meet the member's needs.

(7) Each visit to a member by a member of the discharge-planning staff must be noted in the member's discharge-planning record. The notation must include the date of the meeting, any discharge options discussed, any particular problems noted, any agreements reached with the member, and the future activities of the discharge-planning staff to address the problems raised or to continue preparation of the member for discharge.

(8) Whenever possible, the discharge-planning staff or primary-care team must contact the member's family to encourage its involvement in planning the member's discharge. To this end, family members must be informed of the discharge options and community resources available to the member and provided with lists of nursing facilities and community resources in the area. When possible, these meetings or telephone consultations with the family must be held once every two weeks until the member is discharged. The dates of these meetings and other contacts with family, matters discussed, problems identified, and agreements reached must be entered on the member's discharge-planning record.

(9) The hospital must have written procedures for arranging posthospital services for members. At a minimum, these procedures must include frequent, systematic contacts (usually, three times weekly) by telephone or in person to all nursing facilities and community-service providers within a 25-mile minimum radius of the hospital in order to

(a) determine what services at that location are or will soon become available and to ensure that the provider has current information, including medical and psychosocial status, on any member now or soon needing placement; and

(b) arrange for placement or services or both for members awaiting discharge. These member-specific contacts must be documented as to their number, frequency, and outcome, and must be made by a registered nurse or by a social worker who is licensed or eligible and applying for licensure in Massachusetts. The only exception in which such a call may be made by another person is when that person regularly works in the discharge-planning department, has received training in patient placement from a discharge planner, and consults all the relevant discharge documentation for the member when making the call. If, during the call, a question is asked that cannot be answered from the written data, it must be referred to a discharge planner.

(C) Nursing Facility Medical Eligibility Criteria.

(1) The member's physician and a registered nurse must determine eligibility for institutional or noninstitutional care required by a member upon discharge in accordance with MassHealth nursing facility medical eligibility criteria. Both the member's medical and discharge-planning records must include the specific factors that indicate the recommended care and the names of the persons who determined it.

(2) For any member on administrative day status, the recommended care must be reassessed at least once every two weeks and whenever a significant change occurs in the member's medical or psychosocial condition. The date of each reassessment and the name of the person or persons making the reassessment must be noted in both the member's medical and discharge-planning records.

(D) Cooperation with Long-Term-Care Preadmission Screening Program. In areas of the state where the MassHealth agency or its agent administers a preadmission screening program for long-term-care medical eligibility, the hospital must forward all required documentation to the MassHealth agency or its agent and must request long-term-care medical eligibility authorization before the member may be discharged. The hospital may seek the assistance of the MassHealth agency or its agent in finding placements for members on administrative day status. For those members on administrative day status, the hospital must allow the MassHealth agency or its agent access to the medical record.

(E) Reporting Discrimination Against Members. The hospital must have a formal written policy for the discharge-planning staff to use when reporting to the MassHealth agency all suspected cases of discrimination against members by MassHealth providers.

(F) Recordkeeping Requirements. The hospital must maintain a record of administrative days for four years. The hospital must maintain copies of the CANS completed in accordance with 130 CMR 415.419(B)(4) in the member's medical record.

(G) Disclosure Requirements. All written procedures and policies, lists, review criteria, discharge plans, and records used by the discharge-planning department in performing its duties must be made available for inspection by the MassHealth agency.

415.420: Child and Adolescent Needs and Strengths (CANS) Certification

The following clinicians are eligible to administer the Child and Adolescent Needs and Strengths (CANS) in acute inpatient hospitals and must be certified every two years according to the process established by the Executive Office of Health and Human Services (EOHHS):

(A) psychiatrists and psychiatric residents;

(B) psychiatric nurse mental-health clinical specialists;

(C) psychologists who have a specialization in clinical or counseling psychology;

(D) social workers who have a master's degree in social work from an accredited educational institution; and

(E) counselors who have a master's degree in counseling education, counseling psychology, or rehabilitation psychology from an accredited educational institution.

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

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

(130 CMR 415.422 through 415.424 Reserved)

415.425: Medical Leave of Absence: Responsibilities of the Hospital for the Transfer of a Member Who Is a Resident of a Nursing Facility

(A) Effective for dates of service on or after July 1, 2000, the Division will pay a nursing facility to reserve a bed during a member's medical leave of absence in accordance with the terms and conditions of 130 CMR 415.425.

(B) Whenever a member is admitted to a hospital from a nursing facility, the hospital must comply with the following requirements.

(1) Not later than the second working day of the member 's hospital stay, the hospital must:
(a) review the member 's medical record to determine the member 's estimated length of stay; and
(b) notify the nursing facility by telephone of the estimated number of days of the stay and document in the member 's medical record the date of such telephone notification to the nursing facility.

(2) When the member's estimated length of stay will be 20 consecutive days or less, the facility must reserve a bed for the same number of days and the hospital must so notify its discharge-planning unit.

(3) When the member's estimated length of stay exceeds 20 consecutive days, the facility must not reserve a bed and the hospital must so notify its discharge-planning unit.

(C) The hospital must review the member 's medical status on an ongoing basis. Whenever a change in the member 's medical status occurs before the 20th day of the hospital stay, the hospital must:

(1) review the member's medical record;
(2) revise the estimated length of stay if the member's change in medical status so requires; and
(3) immediately notify the nursing facility by telephone of the revised estimated length of stay, in accordance with 130 CMR 415.425(B).

(D) If the member is transferred within the 20-day medical leave-of-absence period to another hospital:

(1) the transferring hospital must notify the nursing facility immediately by telephone; and
(2) the receiving hospital must comply with all the requirements stated in 130 CMR 415.425.

(E) If the member is transferred within the 20-day medical leave-of-absence period to another nursing facility or noninstitutional setting, or if the member dies, the hospital must notify the original nursing facility immediately by telephone.

(F) Failure by the hospital to comply with any of the requirements set forth in 130 CMR 415.425 may result in administrative fines, in accordance with the Division's administrative and billing regulations at 130 CMR 450.237 and 450.238.

REGULATORY AUTHORITY

130 CMR 415.000: M.G.L. c. 18, § 10; M.G.L. c. 118E, § 4.