

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> Table of Contents	<b>Page</b> iv
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

4. Program Regulations

130 CMR 410.000: *Outpatient Hospital Services*

410.401: Introduction .....	4-1
410.402: Definitions .....	4-1
410.403: Eligible Members .....	4-5
410.404: Provider Eligibility .....	4-5
410.405: Noncovered Services .....	4-6
410.406: Payment .....	4-7
410.407: Certification.....	4-8
410.408: Prior Authorization.....	4-8
410.409: Recordkeeping (Medical Records) Requirements .....	4-9
410.410: Assurance of Member Rights .....	4-11
410.411: Emergency Services .....	4-11
410.412: Utilization Management Program and Mental Health and Substance Abuse Admission Screening Requirements .....	4-11
410.413: Medical Services Required on Site at a Hospital-Licensed Health Center.....	4-11
410.414: Observation Services.....	4-12
410.415: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services .....	4-13
(130 CMR 410.416 through 410.419 Reserved)	
410.420: Tobacco Cessation Services .....	4-14
(130 CMR 410.421 through 410.430 Reserved)	
410.431: Sterilization Services: Introduction .....	4-16
410.432: Sterilization Services: Informed Consent .....	4-16
410.433: Sterilization Services: Consent Form Requirements .....	4-17
410.434: Abortion Services: Reimbursable Services .....	4-18
410.435: Abortion Services: Certification for Payable Abortion Form.....	4-18
410.436: Abortion Services: Out-of-state Abortions.....	4-19
410.437: Family Planning Services .....	4-20
410.438: Acupuncture .....	4-20
(130 CMR 410.439 through 410.440 Reserved)	
410.441: Early Intervention Program Services.....	4-22
410.442: Home Health Agency Services.....	4-22
410.443: Adult Day Health Program Services .....	4-22
410.444: Adult Foster Care Services .....	4-23
410.445: Psychiatric Day Treatment Program Services .....	4-23
410.446: Dental Services.....	4-23
(130 CMR 410.447 through 410.450 Reserved)	
410.451: Therapist Services: Covered Services .....	4-24
410.452: Therapist Services: Service Limitations .....	4-25
410.453: Therapist Services: Recordkeeping Requirements .....	4-25
(130 CMR 410.454 Reserved)	

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> Table of Contents	<b>Page</b> iv-a
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

4. Program Regulations (cont.)

410.455: Laboratory Services: Introduction.....	4-26
410.456: Laboratory Services: Payment.....	4-26
410.457: Laboratory Services: Request for Services.....	4-27
410.458: Laboratory Services: Recordkeeping Requirements .....	4-27
410.459: Laboratory Services: Specimen Referral.....	4-27
(130 CMR 410.460 Reserved)	
410.461: Pharmacy Services: Drugs Dispensed in Pharmacies Including but not Limited to Hospital-based Pharmacies .....	4-28
(130 CMR 410.062 through 410.067 Reserved)	
410.468: Participation in the 340B Drug-pricing Program for Pharmacy Services .....	4-29
(130 CMR 410.469 and 410.470 Reserved)	
410.471: Mental Health Services: Introduction.....	4-30
410.472: Mental Health Services: Noncovered Services .....	4-30
(130 CMR 410.473 Reserved)	
410.474: Mental Health Services: Definitions .....	4-31
410.475: Mental Health Services: Staffing Requirements .....	4-32
410.476: Mental Health Services: Treatment Procedures .....	4-33
410.477: Mental Health Services: Utilization Review Plan .....	4-34
410.478: Mental Health Services: Recordkeeping Requirements .....	4-35
410.479: Mental Health Services: Service Limitations .....	4-36
410.480: Mental Health Services: Child and Adolescent Needs and Strengths (CANS) Data Reporting.....	4-37
410.481: Vision Care Services .....	4-38
410.482: CARES Program Services.....	4-38

<b>Commonwealth of Massachusetts</b> <b>MassHealth</b> <b>Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b>  4. Program Regulations (130 CMR 410.000)	<b>Page</b>  4-1
	<b>Transmittal Letter</b>  AOH-52	<b>Date</b>  06/10/22

410.401: Introduction

130 CMR 410.000 establishes the requirements for the provision of services by hospital outpatient departments, hospital-licensed health centers, and other hospital satellite clinics under MassHealth. For the purposes of 130 CMR 410.000, "hospital outpatient department" may also refer to hospital-licensed health centers, and other hospital satellite clinics. MassHealth pays for outpatient hospital visits and ancillary services (such as radiographic views, laboratory tests, medical supplies, and drugs) that are medically necessary and appropriately provided, as defined at 130 CMR 450.204: *Medical Necessity*. The quality of such services must meet professionally recognized standards of care.

410.402: Definitions

The following terms used in 130 CMR 410.000 have the meanings given in 130 CMR 410.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 410.402 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 410.000, and in 130 CMR 415.000: *Acute Inpatient Hospital Services* and 450.000: *Administrative and Billing Regulations*.

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

340B Drug Pricing Program – a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992.

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.

Acute Hospital – a facility that (i) is licensed as a hospital by the Massachusetts Department of Public Health (DPH) under M.G.L. c. 111, §51 (if in-state) or by the governing or licensing agency in its state (if out-of-state); (ii) is Medicare-certified and participates in the Medicare program; (iii) has more than 50% of its beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (obstetrics), or neonatal intensive care beds (Level III) as determined by DPH (or if out-of-state, the governing or licensing agency in its state, and as determined by MassHealth) and; (iv) utilizes more than 50% of its beds exclusively as either medical / surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (obstetrics), or neonatal intensive care beds (Level III), as determined by MassHealth. An acute hospital is not a chronic disease and rehabilitation hospital or a hospital licensed primarily to provide mental health services, or any unit of a facility that is licensed as a nursing facility, chronic disease unit, or rehabilitation unit.

Acute Inpatient Hospital – an acute hospital that provides diagnosis and treatment on an inpatient basis 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 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, chronic disease unit, or a rehabilitation unit.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-2
	<b>Transmittal Letter</b> AOH-52	<b>Date</b> 06/10/22
Acute Outpatient Hospital Manual		

Chronic Disease and Rehabilitation Hospital (CDR) – a hospital licensed by the Massachusetts Department of Public Health (DPH) under M.G.L. c.111, §51 (or by the governing or licensing agency in its state (if out-of-state)), with a majority of its beds licensed to provide chronic care services, or comprehensive rehabilitation services, or both, to patients with appropriate medical needs, or that is operated by DPH’s Bureau of Public Health Facilities. This definition includes such a hospital licensed with a pediatric specialty. Hospitals with 50% or more of their beds licensed as medical/surgical, intensive care, coronary care, burn, maternal (obstetrics) and neonatal intensive care beds (Level III) possess acute hospital licensure and do not meet the definition of a chronic disease and rehabilitation hospital.

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.

Drug – a substance as defined by the Food, Drug, and Cosmetic Act, 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 assists individuals of childbearing age, including sexually active minors, in determining the number and spacing of their children.

Functional Level – the degree to which an individual can function in the community. Progressive levels of impaired functioning are evaluated using a MassHealth-approved scale that has specific criteria for emotional stability, vocational/educational productivity, social relations, and self-care.

Functional Maintenance Program – a planned combination of social, vocational, and recreational services designed for individuals disabled by a chronic mental illness who need continuing services to maintain skills that allow them to function within the community but who do not require the more intensive care of inpatient or day treatment programs.

Gross Cost Per Utilizer Per Year – Annual cost per utilizer projected by EOHHS based on factors including actual or expected utilization, dosing information, duration of therapy, and the National Average Drug Acquisition Cost (NADAC) or Wholesale Acquisition Cost (WAC) (when NADAC is not available) of the covered drug prior to any federal or supplemental rebate.

Hospital – a facility that is licensed or operated as a hospital by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health and that provides diagnosis and treatment on an outpatient basis for patients who have any of a variety of medical conditions.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-3
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

Hospital-licensed Health Center (HLHC) – a hospital satellite clinic that also

- (1) meets all MassHealth requirements for reimbursement as an HLHC as provided in 130 CMR 410.413; and
- (2) is enrolled with the MassHealth agency as a hospital-licensed health center.

Hospital Outpatient Department –

- (1) For an acute hospital, a department or unit within the physical framework of the hospital's inpatient facility that operates under the hospital's license and provides services to members on an outpatient basis. Acute hospital outpatient departments include day-surgery units, primary-care clinics, specialty clinics, and emergency departments.
- (2) For a CDR hospital, a department or unit that operates under the hospital's license or is operated by the Department of Public Health's Bureau of Public Health Facilities, and provides services to members on an outpatient basis.

Hospital Satellite Clinic – a facility that

- (1) operates under a hospital's license issued to an acute hospital (in the case of an acute hospital satellite clinic) or to a CDR hospital (in the case of a CDR hospital satellite clinic);
- (2) is subject to the fiscal, administrative, and clinical management of the hospital;
- (3) provides services to members solely on an outpatient basis;
- (4) is not located at the same site as the hospital's inpatient facility; and
- (5) demonstrates to the MassHealth agency's satisfaction that it has Centers for Medicare & Medicaid (CMS) provider-based status in accordance with 42 CFR 413.65.

Institutionalized Individual – an individual who is either:

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

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

Mental Illness – mental and emotional disorders as defined in the current *International Classification of Diseases, Clinical Modification* or the American Psychiatric Association's *Diagnostic and Statistical Manual* and manifested by impaired functioning in one or more of the following: emotional stability, vocational/educational productivity, social relations, and self-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.

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 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.

<b>Commonwealth of Massachusetts</b> <b>MassHealth</b> <b>Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-4
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22

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, 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.

Outpatient Hospital Services – medical services provided to a member in a hospital outpatient department, hospital-licensed health center, or other hospital satellite clinic, by or under the direction of a physician or dentist. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, and day-surgery 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 or other hospital satellite clinics, physicians’ offices, nurse practitioners’ offices, freestanding ambulatory surgery centers, day treatment centers, or the member’s home.

Outpatient Visit – an in-person encounter between an eligible member and a licensed practitioner (such as a physician, optician, optometrist, dentist, or therapist) or other medical professional under the direction of a physician or dentist for the provision of outpatient services as defined in 130 CMR 410.402.

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.

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.

Sheltered Workshop – a program of vocational counseling and training in which the participants receive paid work experience or other supervised employment.

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 the presence of a communication disability), and those that impair comprehension, or 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.

Vocational Rehabilitative Services – services such as vocational assessments, job training, career counseling, and job placement.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-5
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

410.403: Eligible Members

- (A) (1) MassHealth Members. MassHealth covers outpatient hospital services only when provided to eligible 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) For information on verifying member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

410.404: Provider Eligibility

Payment for the services described in 130 CMR 410.000 is made only to hospital outpatient departments and hospital-licensed health centers participating in MassHealth on the date of service.

- (A) In-State.
- (1) To participate in MassHealth, acute hospital outpatient departments and hospital-licensed health centers located in Massachusetts must
- (a) operate under a hospital license issued to an acute hospital by the Massachusetts Department of Public Health;
  - (b) have a signed provider agreement that specifies a payment methodology with the MassHealth agency; and
  - (c) participate in the Medicare program.
- (2) To participate in MassHealth, chronic disease and rehabilitation hospital outpatient departments located in Massachusetts must
- (a) operate under a hospital license issued to a CDR hospital by the Massachusetts Department of Public Health or be operated as a CDR hospital by the Department of Public Health's Bureau of Public Health Facilities;
  - (b) have a signed provider agreement for participation in MassHealth; and
  - (c) participate in the Medicare program.
- (B) Out-of-State
- (1) Out-of-state outpatient hospital services provided to an eligible MassHealth member are covered in the following instances:
- (a) emergency services provided to a member;
  - (b) outpatient hospital services provided to a member whose health would be endangered if the member were required to travel to Massachusetts;
  - (c) outpatient hospital services provided to a member when MassHealth determines on the basis of medical advice that the medical service is more readily available in the other state;
  - (d) it is general practice for members in a particular locality to use medical resources in another state;
  - (e) outpatient hospital services provided to a member who is authorized to reside or

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-6
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

- (f) who is placed out of state by the Massachusetts Department of Children and Families or by a Chapter 766 core team evaluation;
- (g) outpatient hospital services provided to a member who has been authorized by the MassHealth agency to reside in an out-of-state nursing facility; or
- (h) when prior authorization has been obtained from the MassHealth agency for nonemergency services provided to a member by an out-of-state hospital outpatient department.

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

- (a) it operates under a hospital license from or is approved as a hospital by the governing or licensing agency in its state, and the hospital licensure is appropriate to the services it seeks to provide under MassHealth (i.e., acute hospital or chronic disease and rehabilitation hospital);
- (b) it participates in the Medicare program; and
- (c) it participates in that state's Medicaid program (or the equivalent).

(3) Payment for out-of-state outpatient hospital services is made in accordance with 130 CMR 450.233: *Rates of Payment to Out-of-state Providers*.

(C) Chronic Disease and Rehabilitation, or Similar Hospitals with Both Out-of-state Inpatient Facilities and In-state Outpatient Facilities

(1) To participate in MassHealth, chronic disease and rehabilitation, or similar hospitals with both out-of-state inpatient facilities and in-state outpatient facilities must meet the following criteria:

- (a) Out-of-state Outpatient Facilities. The hospital's out-of-state outpatient facilities must comply with 130 CMR 410.404(B).
- (b) In-state Outpatient Facilities. The hospital's in-state outpatient facilities must
  1. be appropriately licensed by the Massachusetts Department of Public Health;
  2. have a signed provider agreement for participation in MassHealth; and
  3. participate in Medicare as a provider-based satellite of the out-of-state hospital.

(2) Payment for outpatient services at chronic disease and rehabilitation, or similar hospitals with both out-of-state inpatient facilities and in-state outpatient facilities is made in accordance with 130 CMR 450.234(B): *Outpatient Services*.

410.405: Noncovered Services

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

- (1) nonmedical services, such as social, educational, and vocational services;
- (2) cosmetic surgery;
- (3) canceled or missed appointments;
- (4) telephone conversations and consultations;
- (5) court testimony;
- (6) research or the provision of experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments;
- (7) the provision of whole blood; however, administrative and processing costs associated with the provision of blood and its derivatives are covered; and
- (8) 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 infertility.



<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-7
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

(B) The MassHealth agency does not pay for mental health services such as, but not limited to, the following (*see* 130 CMR 410.472):

- (1) vocational rehabilitation services;
- (2) sheltered workshops;
- (3) 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 covered);
- (4) life-enrichment services; and
- (5) alcohol or drug drop-in centers.

(C) The MassHealth agency does not pay for pharmacy services such as, but not limited to, the following (*see* 130 CMR 406.000: *Pharmacy Services*):

- (1) any drug used for the treatment of obesity;
- (2) cough and cold preparations;
- (3) less-than-effective drugs; and
- (4) drugs related to the treatment of male or female infertility.

(D) The MassHealth agency does not pay for certain vision care services and materials as specified in MassHealth regulations at 130 CMR 402.000: *Vision Care Services*.

(E) The MassHealth agency does not pay an independent practitioner for services provided to members in an outpatient department except when that practitioner has an active provider number issued by the MassHealth agency and meets one of the following criteria.

- (1) The practitioner serves in an attending, visiting, or supervisory role at the hospital where the services are provided, is legally responsible for the management of the member's care, is physically present and actively involved in the treatment for which payment is claimed, and provides a service for which the MassHealth agency pays an independent practitioner when provided in an outpatient hospital setting. Supervisory surgeons must be scrubbed and physically present during the major portion of an operation.
- (2) The independent practitioner, if serving as a salaried intern, resident, fellow, or house officer, provides services during off-duty hours at an institution that does not pay his or her salary.
- (3) The independent practitioner receives a salary from an institution for administrative or teaching services, but not for delivery of care, and provides direct medical care to a member that meets the conditions set forth in 130 CMR 410.405(E)(1).

#### 410.406: Payment

(A) Acute hospital outpatient departments and hospital-licensed health centers in Massachusetts are paid for services provided to eligible members according to the rate for services established in the signed MassHealth provider agreement, subject to the limitations set forth in 130 CMR 410.406.

(B) For purposes of making payments to acute hospital outpatient departments and hospital-licensed health centers in Massachusetts, the following limitations apply.

- (1) The MassHealth agency does not pay for outpatient services provided to a member who is an inpatient at the same or a different hospital on the same day.
- (2) The MassHealth agency pays only for emergency outpatient services provided to a member on the day that the member is discharged from the hospital, whether from the same or a different facility.
- (3) If a member receives outpatient services at one facility and, later on the same day, is

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-8
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

admitted as an inpatient to another facility, the MassHealth agency pays both hospitals for services.

(4) When a member is admitted to inpatient status through the emergency department or outpatient department, the hospital must bill for only the inpatient stay. The MassHealth agency does not pay for services furnished in the emergency department or outpatient department on the admitting day.

(C) Chronic Disease and Rehabilitation hospital outpatient departments in Massachusetts are paid for services provided to eligible members according to the rate of payment established for each hospital in the signed MassHealth provider agreement, subject to the limitations set forth in 130 CMR 410.406(C)(1) and (2).

(1) Charges.

(a) The MassHealth agency pays only those charges contained in the charge book that the hospital has currently filed with the Center for Health Information and Analysis and no more than those charges.

(b) For changes in charges, the appropriate EOHHS regulations apply.

(c) In those cases where a specific rate has been established by EOHHS for a specific service or program (such as for adult day health services), the MassHealth agency pays no more than that rate.

(2) Payments. For purposes of making payments to chronic disease and rehabilitation outpatient hospitals, the following limitations apply.

(a) The MassHealth agency does not pay for outpatient services provided to a member who is an inpatient at the same or a different hospital on the same day.

(b) The MassHealth agency pays only for emergency outpatient services provided to a member on the day that he or she is discharged from the hospital, whether from the same or a different facility.

(c) If a member receives outpatient services at one facility and, later on the same day, is admitted as an inpatient to another facility, the MassHealth agency pays both hospitals for services.

(d) When a member is admitted to inpatient status through the emergency department or outpatient department, the hospital must bill for only the all-inclusive *per diem* rate for that day. The MassHealth agency does not pay for services furnished in the emergency department or outpatient department on the admitting day.

(D) The MassHealth agency pays for laboratory services in accordance with 130 CMR 410.456.

#### 410.407: Certification

Hospital-based home health agencies must be certified by the Medicare program and must provide to the MassHealth agency, upon its request, documentation of that certification.

#### 410.408: Prior Authorization

(A) For certain outpatient services described in 130 CMR 410.000, the MassHealth agency requires that the hospital outpatient department obtain prior authorization. No payment is made for outpatient services whenever a hospital is required, but fails, to obtain prior authorization from the MassHealth agency or its designee. It is the responsibility of the hospital to obtain the necessary prior authorization.

(B) Prior authorization determines only the medical necessity of the authorized service and does not

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-9
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

establish or waive any other prerequisites for payment, such as member eligibility or resort to health insurance payment.

(C) All requests for prior authorization must be submitted in accordance with the instructions in Subchapter 5 of the *Outpatient Hospital Manual*. For more information on requests for prior authorization, see 130 CMR 450.303: *Prior Authorization*.

(D) Members enrolled with a MassHealth managed care provider require service authorization before certain behavioral health services are provided. For more information, see 130 CMR 450.124: *Behavioral Health Services*.

(E) The hospital must obtain prior authorization for the following outpatient therapy services:

- (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.

#### 410.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any outpatient service covered by MassHealth is conditioned upon its full and complete documentation in the member's medical record. If the information in the member's record is not sufficient to document the service for which payment is claimed by the provider, the MassHealth agency will not pay for the service or, if payment has been made, will consider such payment to be an overpayment subject to recovery as defined in the MassHealth administrative and billing regulations in 130 CMR 450.000. Medical record requirements as set forth in 130 CMR 410.000 constitute the standard against which the adequacy of records is measured, as set forth in 130 CMR 450.000: *Administrative and Billing*.

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

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

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

- (1) the member's name and date of birth;
- (2) the date of each service;
- (3) the reason for the visit;
- (4) the name and title of the person who performed the service;
- (5) the member's medical history;

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-10
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

- (6) the diagnosis or chief complaint;
- (7) a clear indication of all findings, whether positive or negative, on examination;
- (8) any tests administered and their results;
- (9) a description of any treatment given;
- (10) any medications administered or prescribed, including strength, dosage, regimen, and duration of use;
- (11) any anesthetic agent administered;
- (12) any medical goods or supplies dispensed or supplied;
- (13) recommendations and referrals for additional treatments or consultations, when applicable;
- (14) the federally required consent form for sterilization or hysterectomy, when applicable; and
- (15) such other information as is applicable for the specific service provided, or as is otherwise required in 130 CMR 410.000.

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

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

(F) For therapist services, in addition to the applicable information required in 130 CMR 410.409(D), the member's medical record must include at least the required records and information set forth in 130 CMR 410.453: *Therapist Services: Recordkeeping Requirements*.

(G) For mental health services, in addition to the applicable information required in 130 CMR 410.409(D), the member's medical record must include at least the required records and information set forth in 130 CMR 410.478.

(H) Hospital pharmacies must maintain a record for each member of the drug and amount dispensed, the date, and the original prescription (*see also 130 CMR 406.000: Pharmacy Services and 130 CMR 450.205: Recordkeeping and Disclosure*).

(I) For vision care services, in addition to the applicable information required in 130 CMR 410.409(D), the record must fully disclose all pertinent information about the services provided, including the date of service, the dates on which materials were ordered and dispensed, and a description of materials (including the frame style and the manufacturer's name) ordered and dispensed. Additional recordkeeping requirements for vision care services that must be followed are set forth in 130 CMR 402.000: *Vision Care Services*.

(J) For laboratory services, in addition to the applicable information required in 130 CMR 410.409(D), the member's medical record must contain a suitable record of each specimen and laboratory test result for at least six years from the date on which the results were reported to the authorized prescriber. Such a record must contain at least the information as specified in 130 CMR 401.417: *Recordkeeping Requirements* (*see also 130 CMR 410.458*).

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-11
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22

410.410: Assurance of Member Rights

No provider shall use any form of coercion in the provision of any services (for example, abortion, sterilization, and family planning). Neither the MassHealth agency, nor any provider, nor any agent or employee of a provider, shall mislead any member into believing that a decision to receive any services reimbursable under 130 CMR 410.000 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 the confidentiality of patient records for all medical services reimbursable under MassHealth.

410.411: Emergency Services

(A) The MassHealth agency covers emergency services provided in a hospital emergency department without prior authorization.

(B) For services provided in the emergency department, handwritten or time-stamped documentation of the length of the member's stay in the emergency room must be kept in the member's record or on an easily accessible hospital log.

410.412: Utilization Management Program and Mental Health and Substance Use Disorder Admission Screening Requirements

(A) Utilization Management Program. The MassHealth agency pays for procedures and acute hospital stays that are subject to the acute hospital Utilization Management Program only if the applicable requirements of the program as described in 130 CMR 450.207: *Utilization Management Program for Acute Inpatient Hospitals* through 450.209: *Utilization Management: Prepayment Review for Acute Inpatient Hospitals* are satisfied. Appendices A and D of the *Acute Outpatient Hospital Manual* contains the name, address, and telephone number of the contact organization for the Utilization Management Program and describes the information that must be provided during the review process.

(B) Mental Health and Substance Use Disorder Admissions. The MassHealth agency will pay for mental health and substance use disorder services provided in an acute inpatient setting only if the admitting provider has satisfied the screening requirements established by MassHealth policy, bulletin or other issuance.

410.413: Medical Services Required on Site at a Hospital-Licensed Health Center

In order to be reimbursed at the rates established for hospital-licensed health centers (HLHCs), an HLHC must provide on site the medical services specified in 130 CMR 410.413(D), (E), and (F), and at least two of the medical services described in 130 CMR 410.413(A), (B), and (C). It is not necessary that all of these services be available during all hours of the HLHC's operation, but all services must be available to members on a regularly scheduled basis with sufficient frequency to ensure access to care and continuity of care.

(A) Pediatric Services. The HLHC must provide pediatric services.

(B) Internal Medicine. The HLHC must provide internal medicine services.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-12
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

(C) Obstetrics/Gynecology. The HLHC must provide obstetrical and gynecological services. When a family practitioner is employed in place of a medical specialist in obstetrics/gynecology, the family practitioner must have admitting privileges to a hospital for delivery and obstetrical and gynecological backup.

(D) Health Education. The HLHC must provide health education designed to prepare members for their participation in and reaction to specific medical procedures, and to instruct members in self-management of medical problems and in disease prevention. Health education may be provided by any health practitioner or by any other individual approved by the HLHC's professional services director as possessing the qualifications and training necessary to provide health education to members.

(E) Medical Social Services. The HLHC must provide medical social services designed to assist members in their adjustment to and management of social problems resulting from medical treatment, specific disease episodes, or chronic illness. Medical social services must be provided by a clinical social worker who is licensed by the Massachusetts Board of Registration. This individual must be on site sufficient hours and with sufficient frequency to provide medical social services to members.

(F) Nutrition Services. The HLHC must provide counseling in the purchase, preparation, and consumption of proper nutrients to members who have been determined to require such counseling because of their health problems or because they have a high potential for developing health problems that might be avoided or made less severe through proper nutrition. Each HLHC must employ either a nutrition professional with a bachelor's or master's degree in public health nutrition, community nutrition, or human nutrition, or a dietitian who is currently registered by the American Dietetic Association. This individual is responsible for planning, directing, and evaluating the nutrition services provided at the HLHC; for educating the HLHC's staff about nutrition; for supervising any nutrition aides; for consulting with practitioners and other staff members of the HLHC; and for counseling members referred for nutrition information. The nutrition professional or registered dietitian must be on site at least one day per calendar month.

#### 410.414: Observation Services

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

(B) Nonreimbursable Services.

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

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-13
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22

(b) observation services provided concurrently with therapeutic services such as chemotherapy.

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

The MassHealth agency pays for all medically necessary outpatient hospital services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction, et seq.*, without regard to service limitations described in 130 CMR 410.000, and with prior authorization.

(130 CMR 410.416 through 410.419 Reserved)

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-14
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

410.420: Tobacco Cessation Services

(A) Introduction. MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 410.420(B) and pharmacotherapy treatment, including nicotine replacement therapy (NRT), in accordance with 130 CMR 406.000.

(B) Tobacco Cessation Counseling Services.

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

(a) Individual counseling consists of face-to-face tobacco cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobacco cessation services as set forth in 130 CMR 410.420(B) and (C).

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

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

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

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

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; and
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, nurse practitioners, nurse midwives, and physician assistants may provide tobacco cessation counseling services without additional experience or training in tobacco cessation counseling services.

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



<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-15
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22

of instruction.

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

(D) Tobacco Cessation Services: Claims Submission. An acute outpatient hospital may submit claims for tobacco cessation counseling services that are provided by physicians, or by mid-level providers under the supervision of a physician (i.e. nurse practitioner, registered nurse, nurse midwife, physician assistant, and MassHealth-qualified tobacco cessation counselor), according to 130 CMR 410.420(B) and (C). Acute outpatient hospital departments cannot bill separately for services provided by mid-level providers. See Subchapter 6 of the *Acute Outpatient Hospital Manual* for service codes and descriptions.

(130 CMR 410.421 through 410.430 Reserved)

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-16
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

410.431: Sterilization Services: Introduction

(A) Covered Services. The MassHealth agency pays for sterilization services performed by a licensed physician in an acute hospital outpatient department 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 410.432, and such consent is documented in the manner described in 130 CMR 410.433.
- (2) The member is at least 18 years of age 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 410.431(A) are met.

410.432: 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 410.432(A) and (B), and such consent is documented as specified in 130 CMR 410.433.

(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 410.432(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

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-17
	<b>Transmittal Letter</b> AOH-52	<b>Date</b> 06/10/22
Acute Outpatient Hospital Manual		

CMR 410.432(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 410.432. 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 410.432(A)(1).

410.433: 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 *Outpatient Hospital Manual*.)

(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.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-18
	<b>Transmittal Letter</b> AOH-52	<b>Date</b> 06/10/22
Acute Outpatient Hospital Manual		

(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 410.433(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 410.433(D)(2) (for example, the physician and hospital), each provider must submit a copy of the signed attachment along with the claim.

410.434: Abortion Services: Reimbursable Services

The MassHealth agency pays for abortion services performed by a licensed physician, physician assistant, certified nurse practitioner, or certified nurse midwife in a hospital outpatient department only when all of the following conditions are met:

- (A) the abortion is performed in accordance with law;
- (B) the abortion is medically necessary—that is, according to the medical judgment of a licensed physician, or, consistent with c. 112, s. 12M and the time limitations established therein a physician assistant, certified nurse practitioner, or certified nurse midwife, necessary in light of all factors affecting the pregnant individual's health; and
- (C) the abortion service is claimed according to the requirements in 130 CMR 410.435.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-19
	<b>Transmittal Letter</b> AOH-52	<b>Date</b> 06/10/22
Acute Outpatient Hospital Manual		

410.435: Abortion Services: Certification for Payable Abortion Form

All providers (i.e., physicians, physician assistants, nurse practitioners, or nurse midwives and hospital outpatient departments) must complete a Certification for Payable Abortion (CPA-2) form and retain the form in the member's record. (Instructions for obtaining the Certification for Payable Abortion form are in Subchapter 5 of the *Outpatient Hospital Manual*.) 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 410.435(A) through (C), when applicable. For all medically necessary abortions not included in 130 CMR 410.435(A) through (C), the certification described in 130 CMR 410.435(D) 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.

(A) 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.

(B) Severe and Long-lasting Damage to the 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.

(C) Victim of Rape or Incest. The provider is responsible for retaining 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.

(D) Other Medically Necessary Abortions. The attending provider must certify that, in their medical judgment, for reasons other than those described in 130 CMR 410.435(A) through (C), the abortion performed was necessary in light of all factors affecting the pregnant individual's health.

410.436: Abortion Services: Out-of-state Abortions

The MassHealth agency will pay for an abortion performed in an out-of-state facility only if the abortion meets the conditions specified in 130 CMR 410.434 and if prior authorization is requested and received from the MassHealth agency.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-20
	<b>Transmittal Letter</b> AOH-52	<b>Date</b> 06/10/22

(A) The member, the referring provider, or a referral agency may request prior authorization from the MassHealth agency in writing. The request must be made in accordance with the instructions for requesting prior authorization for abortion services in Subchapter 5 of the *Outpatient Hospital Manual*.

(B) If the MassHealth agency authorizes the abortion, it will issue a prior authorization number directly to the out-of-state facility. The facility must enter the prior authorization number on the claim form when requesting payment from the MassHealth agency.

(C) Out-of-state abortion services will be authorized only when such services are not available in a Massachusetts facility.

(D) Prior authorization is not required for abortion services provided in the situations described in 130 CMR 410.404(B)(1).

#### 410.437: Family Planning Services

The MassHealth agency will pay for outpatient hospital services related to family planning. These services may include but are not limited to the following:

(A) nonpermanent contraceptive care;

(B) comprehensive medical examination;

(C) diagnosis and treatment of medical problems specific to reproduction as well as diagnosis of and appropriate referral for other medical problems;

(D) sexually transmitted infection (STI) testing and treatment;

(E) cervical cancer screening (Pap smear);

(F) breast examination;

(G) laboratory services related to family planning (for example, Pap smear, gonorrhea culture, vaginal culture and smear, blood test for sexually transmitted infection (STI), hematocrit, complete blood count, urinalysis, and pregnancy testing); and

(H) family planning counseling, including discussions about family planning, human reproduction, and methods of contraception.

#### 410.438: Acupuncture

(A) Introduction. MassHealth members are eligible to receive acupuncture for the treatment of pain as described in 130 CMR 410.438(C), for use as an anesthetic as described in 130 CMR 433.454(C): *Acupuncture as an Anesthetic*, and for use for detoxification as described in 130 CMR 418.406(C)(3): *Acupuncture Detoxification*.

(B) General. 130 CMR 410.438 applies specifically to acupuncture services rendered in a hospital by physicians and licensed practitioners of acupuncture.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-21
	<b>Transmittal Letter</b> AOH-52	<b>Date</b> 06/10/22

(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.

(1) Qualified Providers. MassHealth pays a hospital for acupuncture services only when the provider rendering the service is:

- (a) a physician; or
- (b) licensed in acupuncture by the Massachusetts Board of Registration in Medicine under 243 CMR 5.00: *The Practice of Acupuncture.*

(2) Acupuncture Providers in Hospitals. Hospitals must ensure that acupuncture providers for whom the hospital will submit claims possess the appropriate training, credentials, and licensure.

(E) Conditions of Payment. The MassHealth agency pays the hospital for services of an acupuncturist qualified to render such services in accordance with 130 CMR 410.438(D) 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) Hospitals may submit claims for on-site acupuncture services when a provider qualified to render such services in accordance with 130 CMR 410.438(D) provides those services directly to MassHealth members. *See* Subchapter 6 of the *Acute Outpatient 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 a visit, the hospital may bill for both the visit and the acupuncture services.

(130 CMR 410.439 through 410.440 Reserved)

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-22
	<b>Transmittal Letter</b> AOH-52	<b>Date</b> 06/10/22
Acute Outpatient Hospital Manual		

410.441: Early Intervention Program Services

(A) An early intervention program provides services such as therapy and social, medical, educational, and developmental services for children aged three years or younger who are at biological, environmental, or established risk, and for their families.

(B) The MassHealth agency pays for services provided as part of an organized early intervention program by hospital outpatient departments. These services must be furnished in compliance with the MassHealth regulations governing early intervention program services in 130 CMR 440.000. (See Subchapter 5 of the *Outpatient Hospital Manual* for instructions about obtaining the *Early Intervention Program Manual*, which contains the necessary regulations.)

(C) Acute and nonacute hospital-based early intervention programs are paid according to the regulations governing early intervention services in 130 CMR 440.000: *Early Intervention Program Services*.

410.442: Home Health Agency Services

(A) A home health agency is a public or private agency or organization, or a subdivision of such an agency or organization, that is primarily engaged in furnishing part-time skilled nursing and other therapeutic services to patients in their homes.

(B) The MassHealth agency pays for home health services provided by hospital-based home health agencies. These services must be furnished in compliance with the MassHealth regulations governing home health agency services in 130 CMR 403.000: *Home Health Agency*. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the *Home Health Agency Manual*, which contains the necessary regulations.)

(C) Acute hospital-based home health agencies will be paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based home health agencies are paid according to the regulations governing home health services in 130 CMR 403.000: *Home Health Agency*.

410.443: Adult Day Health Program Services

(A) An adult day health program is an organized program of health care and supervision, restorative services, and social activities whose general goal is to provide an alternative to long-term institutional care.

(B) The MassHealth agency pays for services provided as part of an organized adult day health program by a hospital outpatient department. These services must be furnished in accordance with the MassHealth regulations governing adult day health programs in 130 CMR 404.000: *Adult Day Health Services*. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the *Adult Day Health Manual*, which contains the necessary regulations.)

(C) Acute hospital-based adult day health programs will be paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.



<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-23
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

(D) Nonacute hospital-based adult day health programs will be paid according to the regulations governing adult day health services in 130 CMR 404.000: *Adult Day Health Services*.

410.444: Adult Foster Care Services

(A) An adult foster care program provides personal care services in a family-like setting to elderly or disabled individuals who are at imminent risk of institutional placement.

(B) The MassHealth agency pays for services provided by hospital-based adult foster care programs. These services must be furnished in compliance with 130 CMR 408.000: *Adult Foster Care Services*. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the *Adult Foster Care Manual*.)

(C) Acute hospital-based adult foster care programs will be paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based adult foster care programs will be paid according to the regulations governing adult foster care services in 130 CMR 408.000: *Adult Foster Care Services*.

410.445: Psychiatric Day Treatment Program Services

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

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

(C) Acute hospital-based psychiatric day treatment programs are paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based psychiatric day treatment programs are paid according to the regulations governing psychiatric day treatment services in 130 CMR 417.000: *Psychiatric Day Treatment Program Services*.

410.446: Dental Services

(A) The MassHealth agency pays for dental services provided by hospital outpatient departments. These services must be provided in compliance with the MassHealth regulations governing dental services in 130 CMR 420.000: *Dental Services*. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the *Dental Manual*, which contains the necessary regulations.)

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-24
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

(B) Acute hospital-based providers of dental services are paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(C) Nonacute hospital-based providers of dental services are paid according to the regulations governing dental services in 130 CMR 420.000: *Dental Services*.

(130 CMR 410.447 through 410.450 Reserved)

410.451: Therapist Services: Covered Services

(A) The MassHealth agency pays for occupational, physical, and speech/language therapy provided in hospital outpatient departments by or under the supervision of licensed therapists. Therapist services include the following:

- (1) individual treatment;
- (2) comprehensive evaluation;
- (3) group therapy; and
- (4) design and fitting of an adaptive device.

(B) All therapy must be provided subsequent to a written referral from a licensed physician or licensed nurse practitioner. The MassHealth agency pays for continuing physical, occupational, or speech/language therapy only when the referral is renewed in writing every 60 days, subject to the prior-authorization requirements described in 130 CMR 410.408(E).

(C) Before therapy is initiated, a comprehensive evaluation of the member's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop a treatment plan. A comprehensive evaluation must include preparation of a written report for the member's medical record that contains at least the following information:

- (1) the member's name and address;
- (2) the name of the referring physician or nurse practitioner;
- (3) objective evaluation findings;
- (4) a detailed treatment plan prescribing the type, amount, estimated frequency, and duration of therapy and indicating the diagnosis and anticipated goals, or the reason treatment is not indicated;
- (5) a description of any conferences with the member, the member's family or clinician, or other interested persons;
- (6) other health care evaluations, as indicated;
- (7) a description of the member's psychosocial and health status that includes:
  - (a) the present effects of the disability on both member and family;
  - (b) a brief history, the date of onset, and any past treatment of the disability;
  - (c) the member's level of functioning, both current and before onset of the disability, if applicable; and
  - (d) any other significant physical or mental disability that may affect therapy;
- (8) for speech/language therapy only:
  - (a) assessments of articulation, stimulability, voice, fluency, and receptive and expressive language;
  - (b) a description of the member's cognitive functioning; and
  - (c) a description of the member's communication needs and motivation for treatment;
- (9) for physical or occupational therapy only: a description of the member's physical

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-25
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

limitations; and  
(10) the therapist's signature and the date of the evaluation.

(D) The hospital must obtain prior authorization as a prerequisite to payment for certain outpatient therapy services pursuant to 130 CMR 410.408(E).

410.452: Therapist Services: Service Limitations

(A) 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 410.452(B).

(B) In certain instances, the specialized knowledge and judgment of a 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 therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

(C) For each type of therapy, the MassHealth agency pays for no more than one individual visit and one group therapy session for a member per day.

410.453: Therapist Services: Recordkeeping Requirements

In addition to the information required in 130 CMR 410.409, the member's record must include the following:

(A) a licensed physician's or licensed nurse practitioner's written referral for evaluation, referral for treatment, and renewal of referral (if applicable) every 60 days (see 130 CMR 410.451(B));

(B) the written comprehensive evaluation report (*see* 130 CMR 410.451(C));

(C) the name, address, and telephone number of the member's primary physician;

(D) a treatment notation for each date on which therapy was provided that includes at least the following:

- (1) the specific therapeutic procedures and methods used;
- (2) the amount of time spent in treatment; and
- (3) the signature and title of the person who provided the service;

(E) at least weekly documentation of the following:

- (1) the member's response to treatment;
  - (2) any changes in the member's condition;
  - (3) the problems encountered or changes in the treatment plan or goals, if any;
  - (4) the location where the service was provided if different from that in the evaluation report;
- and
- (5) the signature and title of the therapist; and

(F) a discharge summary, when applicable.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-26
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22

410.455: Laboratory Services: Introduction

(A) 130 CMR 410.455 through 410.459 establish the requirements and procedures for clinical laboratory services provided by hospital outpatient departments. A clinical laboratory service includes the following types of services: microbiological, serological, chemistry, hematological, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

(B) The MassHealth agency does not pay separately for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipuncture; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue.) Specimen collection and preparation is considered part of the laboratory service.

410.456: Laboratory Services: Payment

(A) Maximum Allowable Fees. The MassHealth agency pays an acute or a private chronic disease and rehabilitation hospital outpatient department for laboratory services in accordance with the rates set forth in regulations at 101 CMR 320.00: *Clinical Laboratory Services*, and 114.3 CMR 16.00: *Surgery and Anesthesia*, as applicable, subject to the conditions, exclusions, and limitations set forth in 130 CMR 410.000.

(B) Usual and Customary Fee. The term usual and customary in the hospital outpatient department laboratory context means the lowest fee charged by a hospital outpatient department laboratory for any laboratory service (including both individual and profile tests) specified in the hospital outpatient department's charge book or by such hospital, with the exception of a fee offered for a bulk purchase. (A bulk purchase is a single purchase of a laboratory service (one or more tests) to be uniformly and concurrently performed on a minimum of 40 specimens of the same type. A single purchase of various, non-uniform laboratory services, such as by a physician, is not considered a bulk purchase, regardless of the number of specimens presented by such a purchaser to the hospital outpatient department laboratory.)

(C) Profile or Panel Tests.

(1) A profile or panel test is 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 hospital outpatient department laboratory performing the tests.

(b) The group of tests is performed by the hospital outpatient department laboratory at a usual and customary fee that is lower than the sum of that hospital outpatient department laboratory's usual and customary fees for the individual tests in that group.

(2) In no event shall a hospital outpatient department laboratory 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 hospital outpatient department laboratory or requested by an authorized person.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-27
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

410.457: Laboratory Services: Request for Services

In order to receive payment for a laboratory service, a hospital outpatient department must have received a written request by an authorized prescriber, as defined in 130 CMR 401.402: *Definitions*, to perform the service. Such written request must comply with the requirements specified in 130 CMR 401.416: *Reimbursable Services*.

410.458: Laboratory Services: Recordkeeping Requirements

In addition to meeting the recordkeeping requirements specified in 130 CMR 410.409, the hospital outpatient department must keep a suitable record of each specimen and laboratory test result for at least six years from the date on which the results were reported to the authorized prescriber. Such a record must contain the information specified in the MassHealth Independent Clinical Laboratory regulations at 130 CMR 401.417: *Recordkeeping Requirements*.

410.459: Laboratory Services: Specimen Referral

A hospital outpatient department may refer a specimen to an independent laboratory that is eligible to participate in MassHealth, or to another hospital laboratory that is eligible to participate in MassHealth. To be eligible, a hospital laboratory must be in a hospital that is licensed by the Massachusetts Department of Public Health and that is an approved Medicare provider. The referring hospital outpatient department laboratory must inform the prescriber of the name and address of the testing laboratory. The testing laboratory must inform the referring hospital outpatient department laboratory of the results of the test. Only the referring laboratory is authorized to bill the MassHealth agency.

(130 CMR 410.460 Reserved)

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-28
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22

410.461: Pharmacy Services: Drugs Dispensed in Pharmacies Including but not Limited to Hospital-based Pharmacies

(A) Coverage of drugs and medical supplies dispensed to MassHealth members by MassHealth pharmacy providers, and related prescription requirements for prescribing clinicians, are governed by 130 CMR 406.000: *Pharmacy Services* and 130 CMR 410.468.

(B) Section 130 CMR 410.468 refers to prescription drugs dispensed in pharmacies, not to drugs administered in the office (Physician-Administered Drugs) and is only applicable to 340B-Covered Entities.

(130 CMR 410.462 through 410.467 Reserved)

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-29
	<b>Transmittal Letter</b> AOH-51	<b>Date</b> 01/24/22
Acute Outpatient Hospital Manual		

410.468: Participation in the 340B Drug Pricing Program for Pharmacy Services

(A) Notification of Participation. Except for drugs that cost \$100,000 (gross cost per utilizer per year) that are designated as excluded from coverage for MassHealth members through the 340B Drug Pricing Program, a hospital outpatient department or a hospital-licensed health center that is a 340B-covered entity may provide drugs to MassHealth members through the 340B Drug Pricing Program provided that it notifies the MassHealth agency that the 340B-covered entity is registered and approved by the federal Office of Pharmacy Affairs (OPA). Any high-cost drug designated for exclusion from coverage for MassHealth members through the 340B Drug-Pricing Program will be communicated by provider bulletin or other written issuance from the MassHealth agency, and be consistent with all requirements of M.G.L. c. 118E, §13L, and shall include an opportunity for eligible providers to provide input regarding the designation. The MassHealth agency may designate up to 25 drugs for exclusion from coverage for MassHealth members through the 340B Drug Pricing Program. Any exclusion from coverage for MassHealth members through the 340B Drug Pricing Program does not apply to claims paid using the adjudicated payment amount per discharge (APAD) or adjudicated payment per episode of care (APEC) methodology, other than for drugs listed on the Acute Hospital Carve-Out Drugs List section of the MassHealth Drug List.

(B) Subcontracting for 340B Outpatient Pharmacy Services.

(1) A hospital outpatient department or hospital-licensed health center that is a 340B-covered entity may contract with a MassHealth pharmacy provider to dispense 340B drugs for the 340B-covered entity's MassHealth patients. All such subcontracts between the 340B-covered entity and a pharmacy provider must be in writing, ensure continuity of care, specify that the hospital pays the pharmacy, specify that such payment constitutes payment in full for 340B drugs provided to MassHealth members, be consistent with all applicable provisions of 130 CMR 406.000: *Pharmacy Services*, and are subject to MassHealth agency approval.

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

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

(D) Payment for 340B Outpatient Pharmacy Services. The MassHealth agency pays the 340B-covered entity for outpatient hospital pharmacy services, whether provided and billed directly or through a subcontractor, at the rates established in 101 CMR 331.00: *Prescribed Drugs*.

(130 CMR 410.469 through 410.470 Reserved)

<b>Commonwealth of Massachusetts</b> <b>MassHealth</b> <b>Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b>  4. Program Regulations (130 CMR 410.000)	<b>Page</b>  4-30
	<b>Transmittal Letter</b>  AOH-51	<b>Date</b>  01/24/22

410.471: Mental Health Services: Introduction

A mental health program is a comprehensive group of diagnostic and treatment services, as outlined in 130 CMR 410.474, furnished to mentally or emotionally disabled persons and their families under the direction of a licensed psychiatrist. The MassHealth agency pays for mental health services provided in hospital outpatient departments subject to the restrictions and limitations in 130 CMR 410.472 through 410.479.

410.472: Mental Health Services: Noncovered Services

(A) Nonmedical Services. The MassHealth agency does not pay for nonmedical mental health services. These services include, but are not limited to, the following:

- (1) vocational rehabilitation services;
- (2) sheltered workshops;
- (3) educational services;
- (4) 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 covered);
- (5) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and
- (6) telephone conversations.

(B) 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 noncovered services. Such programs include alcohol or drug drop-in centers.

(130 CMR 410.473 Reserved)



<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-31
	<b>Transmittal Letter</b> AOH-40	<b>Date</b> 07/28/17
Acute Outpatient Hospital Manual		

#### 410.474: Mental Health Services: Definitions

The following terms used in 130 CMR 410.471 through 410.479 will have the meanings given in 130 CMR 410.474 unless the context clearly requires a different meaning. When provided in a hospital outpatient department, services that are defined below must conform to the definitions given.

Case Consultation – environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions which may include the preparation of reports of the patient's psychiatric status, history, treatment, or progress (other than for legal purposes) for other physicians, agencies, or insurance carriers.

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 tool for behavioral-health providers serving MassHealth members younger than 21.

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

Diagnostic Services – 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.

Family Consultation – interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

Family/Couple Therapy – the psychotherapeutic treatment of more than one member of a family simultaneously in the same session.

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

Home Visit – crisis intervention, individual, group, or family therapy, and medication provided in the member's residence (excluding a medical institution), when the member is unable to be served at the hospital outpatient department.

Individual Therapy – therapeutic services provided to an individual.

Medication Visit – a member visit specifically for prescription, review, and monitoring of medication by a psychiatrist or licensed clinician with prescriptive authority or for the administration of prescribed intramuscular medication by a qualified clinician.

Psychological Testing – the use of standardized test instruments by a licensed psychologist to evaluate aspects of an individual's functioning, including aptitudes, educational achievements, cognitive processes, emotional conflicts, and type and degree of psychopathology, subject to the limitations of 130 CMR 410.479(E).

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-32
	<b>Transmittal Letter</b> AOH-40	<b>Date</b> 07/28/17
Acute Outpatient Hospital Manual		

410.475: Mental Health Services: Staffing Requirements

(A) Provider Responsibilities.

- (1) The hospital outpatient department must employ a multidisciplinary staff to furnish mental health services under the direction of a licensed psychiatrist.
- (2) The hospital outpatient department must designate a professional staff member as director of clinical services and a licensed psychiatrist as medical director.
- (3) A licensed psychiatrist must be on call during all hours of operation.
- (4) Although the MassHealth agency does not require that the hospital outpatient department employ mental health professionals from all the disciplines listed in 130 CMR 410.475(B), staff members who provide services to members must be qualified as set forth in 130 CMR 410.475(B) for their respective disciplines.

(B) Staff Qualifications.

- (1) Psychiatrist. At least one staff psychiatrist must be either currently certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry or eligible for such certification. Any additional psychiatrists must be, at the minimum, licensed physicians in their second year of a psychiatric residency program accredited by the Council on Medical Education of the American Medical Association. Such physicians must be under the direct supervision of a licensed psychiatrist. Any psychiatrist or psychiatric resident who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by the Executive Office of Health and Human Services (EOHHS).
- (2) Psychologist. At least one staff psychologist must be licensed by the Massachusetts Board of Registration of Psychologists with a specialization listed in clinical or counseling psychology or a closely related specialty. Additional staff members trained in the field of clinical or counseling psychology or a closely related specialty must
  - (a) have a minimum of a master's degree or the equivalent graduate study in clinical or counseling psychology or a closely related specialty from an accredited educational institution;
  - (b) be currently enrolled in or have completed a doctoral program in clinical or counseling psychology or a closely related specialty;
  - (c) have had two years of full-time supervised clinical experience subsequent to obtaining a master's degree in a multidisciplinary mental health setting (one year of supervised clinical work in an organized graduate internship program may be substituted for each year of experience); and
  - (d) for any psychologist who provides individual, group, or family therapy to members under the age of 21, be certified every two years to administer the CANS, according to the process established by the Executive Office of Health and Human Services (EOHHS).
- (3) Social Worker.
  - (a) At least one staff social worker must be licensed or have applied for and have a license pending as an independent clinical social worker by the Massachusetts Board of Registration of Social Workers.
  - (b) Any additional social workers on the staff must provide services under the direct and continuous supervision of an independent clinical social worker. Such additional social workers must be licensed or applying for licensure as certified social workers by the Massachusetts Board of Registration of Social Workers and have received a master's degree in social work and completed two years of full-time supervised clinical work in an organized graduate internship program.
  - (c) Any social worker who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations	<b>Page</b> 4-33
	<b>Transmittal Letter</b> AOH-40	<b>Date</b> 07/28/17
Acute Outpatient Hospital Manual		

process established by the Executive Office of Health and Human Services (EOHHS).

(4) Psychiatric Nurse. At least one psychiatric nurse must be currently registered by the Massachusetts Board of Registration in Nursing and must have a master's degree in nursing from an accredited National League of Nursing graduate school with two years of full-time supervised clinical experience in a multidisciplinary mental health setting and be eligible for certification as an Adult Psychiatric-Mental Health Clinical Nurse Specialist, Child/Adolescent Psychiatric-Mental Health Clinical Nurse Specialist, or Psychiatric Mental Health Nurse Practitioner by the American Nursing Association. Any other nurses must have a bachelor's degree from an educational institution accredited by the National League of Nursing and two years of full-time supervised skilled experience in a multidisciplinary mental health setting subsequent to that degree, or a master's degree in psychiatric nursing. Any Adult Psychiatric-Mental Health Clinical Nurse Specialist-Board Certified (PMHCNS-BC), Child/Adolescent Psychiatric-Mental Health Clinical Nurse Specialist-Board Certified (PMHCNS-BC) or, Psychiatric Mental Health Nurse Practitioner-Board Certified (PMHNP-BC) who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by the Executive Office of Health and Human Services (EOHHS). Nurses who are not board certified as PMHCNS-BC or PMHNP-BC are not eligible to administer the CANS.

(5) Counselor. A counselor must have a master's degree in counseling education, counseling psychology, or rehabilitation counseling from an accredited educational institution and two years of full-time supervised clinical experience in a multidisciplinary mental health setting subsequent to obtaining the master's degree (one year of supervised clinical work in an organized graduate internship program may be substituted for each year of full-time experience). Any counselor who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by the Executive Office of Health and Human Services (EOHHS).

(6) Occupational Therapist. An occupational therapist must be currently licensed by the Massachusetts Division of Registration of Allied Health Professions and registered by the American Occupational Therapy Association and must have either

- (a) a master's degree in occupational therapy from an accredited program in occupational therapy; or
- (b) a bachelor's degree in occupational therapy from an accredited program in occupational therapy and a master's degree in a related field such as psychology, social work, or counseling.

410.476: Mental Health Services: Treatment Procedures

(A) A staff member from one of the disciplines described at 410.475(B) must conduct a comprehensive evaluation of each member prior to initiation of therapy. For members under the age of 21, a CANS must be completed during the initial behavioral-health assessment before initiation of therapy and be updated at least every 90 days thereafter by a CANS-certified provider, as described in 130 CMR 410.475(B). The CANS is not required during an assessment that is conducted as part of the emergency department screening.

(B) The hospital outpatient department must accept for treatment, refer for treatment elsewhere, or both, any member for whom the intake evaluation substantiates a mental or emotional disorder.

(C) The hospital outpatient department will ensure that one professional staff member (the primary therapist) assumes primary responsibility for each member. This responsibility will include

- (1) within four client visits, preparation of a comprehensive written treatment plan that is based on the initial evaluation, incorporates short- and long-term treatment goals, and establishes criteria for determining when termination of treatment is appropriate;

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-34
	<b>Transmittal Letter</b> AOH-40	<b>Date</b> 07/28/17
Acute Outpatient Hospital Manual		

- (2) ongoing utilization review;
- (3) review of each case at termination of treatment and preparation of a termination summary that describes the course of treatment and any aftercare program or resources in which the member is expected to participate; and
- (4) ensuring that a CANS-certified provider, as described in 130 CMR 410.475(B), completes the CANS in accordance with 130 CMR 410.476(A).

(D) The hospital outpatient department will make provisions for responding to persons needing services on a walk-in basis.

(E) The hospital outpatient department will take appropriate steps to facilitate uninterrupted and coordinated member care whenever it refers a member elsewhere for concurrent or subsequent treatment.

(F) Before referring a member elsewhere, the hospital outpatient department will, with the member's consent, send a summary of or the actual record of the member to that referral provider.

410.477: Mental Health Services: Utilization Review Plan

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

(A) A utilization review committee will be formed, composed of the clinical director (or a designee), a psychiatrist, and one other professional staff member from each core discipline represented who meets all the qualifications for the discipline, as outlined in 130 CMR 410.475.

(B) The utilization review committee will review a representative sample of cases at least in the following circumstances:

- (1) within 90 days after initial contact;
- (2) when a member has required more than 50 visits every 12 months and has not required hospitalization or extensive crisis intervention during that period; and
- (3) following termination.

(C) The utilization review committee will verify for a representative sample of cases that

- (1) the diagnosis has been adequately documented;
- (2) the treatment plan is appropriate and specifies the methods and duration of the projected treatment program;
- (3) the treatment plan is being or has been carried out;
- (4) the treatment plan is being or has been modified as indicated by the member's changing status;
- (5) there is adequate follow-up when a member misses appointments or drops out of treatment;
- (6) there is progress toward achievement of short- and long-term goals; and
- (7) for members under the age of 21, the CANS has been completed at the initial behavioral-health assessment and updated at least every 90 days thereafter as part of the treatment plan review.

(D) No staff member will participate in the utilization review committee's deliberations about any member that staff member is treating directly.

(E) The program will maintain minutes that are sufficiently detailed to show the decisions of each review and the basis on which any decisions are made so that the MassHealth agency may conduct such audits as it deems necessary.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-35
	<b>Transmittal Letter</b> AOH-40	<b>Date</b> 07/28/17
Acute Outpatient Hospital Manual		

(F) Based on the utilization review, the director of clinical services or a designee will determine whether continuation, modification, or termination of treatment is necessary and promptly communicate this decision to the primary therapist.

410.478: Mental Health Services: Recordkeeping Requirements

(A) The hospital outpatient department must obtain, upon the initiation of treatment, written authorization from each member or the member's legal guardian to release information obtained by the provider to hospital staff, federal and state regulatory agencies, and, when applicable, referral providers, to the extent necessary to carry out the purposes of the program and to meet regulatory requirements, including provider audits.

(B) In addition to the information required in 130 CMR 410.409, each member's record must include the following information:

- (1) the member's case number, address, telephone number, sex, age, marital status, next of kin, and school or employment status (or both);
- (2) the date of initial contact and, if applicable, the referral source;
- (3) a report of a physical examination performed within six months (if such an examination has not been performed in that period, one must be given within 30 days after the member's request for services or, if the member refuses to be examined, the record must document the reasons for the exam postponement);
- (4) the name and address of the member's primary physician or medical clinic (a physician or medical clinic must be recommended if there is not one currently attending the member);
- (5) a description of the nature of the member's condition;
- (6) the relevant medical, social, educational, and vocational history;
- (7) a comprehensive functional assessment of the member;
- (8) the clinical impression of the member and a diagnostic formulation, including a specific diagnosis using the current International Classification of Diseases, Clinical Modification (ICD) or the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) diagnosis codes;
- (9) the member's treatment plan, updated as necessary, including long-range goals, short-term objectives, and the proposed schedule of therapeutic activities;
- (10) a schedule of dates for utilization review to determine the member's progress in accomplishing goals and objectives;
- (11) the name, qualifications, and discipline of the primary therapist;
- (12) a written record of utilization reviews by the primary therapist;
- (13) documentation of each visit, including the member's response to treatment, written and signed by the person providing the service, and including the therapist's discipline and degree;
- (14) all information and correspondence regarding the member, including appropriately signed and dated consent forms;
- (15) a medication-use profile;
- (16) when the member is discharged, a discharge summary; and
- (17) for members under the age of 21, a CANS completed during the initial behavioral-health assessment and updated at least every 90 days thereafter.

(C) A brief history is acceptable for emergency or walk-in visits when the treatment plan does not call for extended care.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b>	<b>Page</b>
	4. Program Regulations (130 CMR 410.000)	4-36
Acute Outpatient Hospital Manual	<b>Transmittal Letter</b>	<b>Date</b>
	AOH-40	07/28/17

410.479: Mental Health Services: Service Limitations

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

(B) Multiple Sessions on the Same Date of Service. The MassHealth agency does not pay for more than one session of a single type of service provided to an individual member on the same day, except for the provision of psychotherapy for crisis. The MassHealth agency will pay for multiple different treatment modalities (i.e., individual therapy, family/couples therapy, group therapy, or psychotherapy for crisis) for the same member on the same day, but will not pay for a diagnostic service and a treatment modality for the same member on the same day. The MassHealth agency also will pay for case consultation and family consultation services regardless of whether a diagnostic service or one of the treatment modalities listed above is provided on the same day.

(C) Case Consultation.

- (1) The MassHealth agency pays only for a case consultation that involves a personal meeting with a professional of another agency.
- (2) The MassHealth agency will pay 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 hospital outpatient department and the other party are actively involved in treatment or management programs with the member (or family members) and where a lack of face-to-face communication would impede a coordinated treatment program.
- (3) The MassHealth agency will not pay for court testimony.

(D) Group Therapy.

- (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 will not pay for group therapy when it is performed as an integral part of a psychiatric day treatment program.

(E) Psychological Testing. The MassHealth agency will pay for psychological testing only when all of the following conditions are met.

- (1) The MassHealth agency pays for psychological testing when a qualified individual responsible for providing services to the member orders the testing. This ensures that the service is provided within the context of an overall service plan. A qualified individual includes a physician, psychologist, physician assistant, nurse practitioner, clinical nurse specialist, psychiatric clinical nurse specialist, or licensed independent clinical social worker who is either practicing independently, or as staff of a community health center, mental health center or hospital. Any other individual or entity wishing to request psychological testing services must coordinate with a qualified individual to obtain the necessary order. The MassHealth agency may deny or recover payment if the provider fails to provide to the MassHealth agency when requested, documented evidence that psychological testing was initiated and provided in accordance with 130 CMR 410.479(E).
- (2) Testing is performed by a psychologist who is licensed by the Massachusetts Board of Registration of Psychologists with a specialization listed in clinical or counseling psychology or a closely related specialty either personally administers the testing or personally supervises such testing during its administration by an unlicensed psychologist.
- (3) The psychologist must determine the specific tests to administer, and these tests must be

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b>  4. Program Regulations (130 CMR 410.000)	<b>Page</b>  4-37
	<b>Transmittal Letter</b>  AOH-40	<b>Date</b>  07/28/17

published, valid, and in general use, as defined by listing in the current edition of the *Mental Measurement Yearbook* or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological Association;

(4) Limitations on Psychological Testing.

(a) The MassHealth agency does not pay for psychological testing provided as an outpatient hospital service if a psychologist has provided that test to the member within the preceding six months unless the following conditions exist and are documented in the billing provider's medical record:

1. psychological testing is provided in order to ascertain changes relating to suicidal, homicidal, toxic, traumatic, or neurological conditions of the member; or
2. psychological testing is provided in order to ascertain changes following such special forms of treatment or interventions as electroconvulsive therapy (ECT) or psychiatric hospitalization.

(b) The MassHealth agency does not pay for:

1. periodic testing to measure the member's response to psychotherapy;
2. self-rating forms and other paper-and-pencil instruments, unless administered as part of a comprehensive battery of tests and interpreted by the psychologist;
3. group forms of intelligence tests; or
4. an intelligence test performed at the same time as a brain assessment.

(F) Family/Couple Therapy: Payment for family/couple therapy is limited to one fee per session, regardless of the number of staff members or family members present.

(G) Home Visits.

(1) The MassHealth agency will pay for intermittent home visits. Payment will also be made for home visits made for diagnostic purposes.

(2) Home visits are reimbursable on the same basis as comparable services provided at the hospital outpatient department. Travel time to and from the member's home is not reimbursable.

(3) A report of the home visit must be entered into the member's record.

(H) Multiple Therapies. The MassHealth agency will pay for more than one mode of therapy used for 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 should be documented in the member's record.

(I) Outreach Services Provided in Nursing Facilities. The MassHealth agency will pay for diagnostic and treatment services provided in a nursing facility to a member who resides in that nursing facility only in the following circumstances:

- (1) the nursing facility specifically requests treatment and the member's record at the nursing facility documents this request;
- (2) the treatment provided does not duplicate services usually provided in the nursing facility;
- (3) such services are generally available through the hospital outpatient department to members not residing in that nursing facility; and
- (4) the member either cannot leave the nursing facility or is sufficiently mentally or physically incapacitated to be unable to come to the hospital outpatient department alone.

410.480: Mental Health Services: 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.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-38
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

410.481: Vision Care Services

(A) Introduction. Vision care services are the professional care of the eyes for purposes of diagnosing and correcting refractive errors, analyzing muscular anomalies, and determining pathological conditions. They include eye examinations, vision training, and the prescription and dispensing of ophthalmic materials. Professional and technical services must be provided in accordance with the established standards of quality and health care necessity recognized by the vision care industry and licensing agencies in Massachusetts.

(B) Provision of Vision Care Services. The MassHealth agency pays for vision care services, including the dispensing of ophthalmic materials, provided to MassHealth members by an acute hospital outpatient department, HLHC or other hospital satellite clinic. These services must be furnished in accordance with, and coverage of such services and related prescription requirements for authorized prescribers are governed by, MassHealth regulations at 130 CMR 402.000: *Vision Care*. Payment is subject to the conditions, exclusions, and limitations set forth in 130 CMR 402.000: *Vision Care*.

(C) Payment. Acute hospital outpatient departments and HLHCs are paid pursuant to 101 CMR 315.000 for services described as ophthalmic materials dispensing in Subchapter 6 of the *Vision Care Manual*. All other vision care services provided by an acute hospital outpatient department, HLHC or other hospital satellite clinic are paid according to the outpatient hospital payment methodology established by the signed MassHealth provider agreement.

(D) Prior Authorization.

(1) For certain vision care services specified in 130 CMR 402.000: *Vision Care*, the MassHealth agency requires the provider to obtain prior authorization as a prerequisite to payment.

(2) All prior authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Outpatient Hospital Manual*.

410.482: 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 410.482(D) to members younger than 21 years of age who satisfy the eligibility criteria set forth in 130 CMR 410.482(C). The MassHealth agency pays for CARES program services provided by CARES program providers subject to restrictions and limitations in 130 CMR 410.482(A) through 410.482(H) and Appendix M of the *Physician Manual*.

(B) Definitions. The following terms used in 130 CMR 410.482(A) through 410.482(H) have the meanings given in 130 CMR 410.482(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.



<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-39
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

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.

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

- (1) be younger than 21 years of age;
- (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 410.482(C)(3)(b)(1); and
  - (b) all of the eligibility criteria in either 130 CMR 410.482(C)(3)(b)(2) or 130 CMR 410.482(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: 1.) be episodically or continuously debilitating, and 2.) require ongoing treatment for control of the condition that will use health care resources above the level of a healthy child; or

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-40
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

- 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 absenteeism from school 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 410.482(A) through 410.482(H) will be made only to acute hospital outpatient departments, hospital licensed health centers (HLHCs), or other hospital satellite clinics participating in MassHealth on the date of service that are also certified by the MassHealth agency for the provision of CARES program services at or associated with that service location on the date of service.
- (2) An acute hospital outpatient department, HLHC, or other hospital satellite clinic seeking to provide CARES program services must meet the requirements listed in 130 CMR 410.482(A) through 410.482(H). A separate application for certification as a CARES program provider must be submitted for each acute hospital outpatient department, HLHC, or other hospital satellite clinic 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 acute hospital program. The MassHealth agency may request additional information from the applicant to evaluate the applicant’s compliance with 130 CMR 410.482(A) through 410.482(H). Through this certification, the applicant must, among other requirements:
  - (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 410.482(A) through 410.482(H);
  - (b) agree to establish, maintain, and comply with written policies and procedures to satisfy all the requirements in 130 CMR 410.482(A) through 410.482(H);
  - (c) agree to assess and annually reassess each member in its care in accordance with 130 CMR 410.482(E)(3)(a) and 130 CMR 410.482(F)(1)(a) to ensure that each such member satisfies, and continues to satisfy, the clinical eligibility criteria for receipt of

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-41
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

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 410.482(A) through 410.482(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 410.482(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 of age with medical complexities; and
2. has the capacity to provide on-call care coordination to members assigned to the applicant 24 hours a 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 410.482(A) through 410.482(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 before 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

<b>Commonwealth of Massachusetts</b> <b>MassHealth</b> <b>Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-42
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

has been taken.

(5) The certification is valid only for the acute hospital outpatient department, HLHC, or other hospital satellite clinic 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.

(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 of the *Physician Manual*. The CARES team must satisfy any other staff composition requirements specified in Appendix M of the *Physician Manual*. 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 of the *Physician Manual*. 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 410.482(F) and Appendix M of the *Physician Manual*.
- (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,

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-43
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

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 of the *Physician Manual*.

(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 (e.g., by virtue of licensure, certification, or experience).

Detailed service components are outlined in Appendix M of the *Physician Manual*.

(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 a day, 365 days per year to respond to and triage any medical and care coordination-related questions;

<b>Commonwealth of Massachusetts</b> <b>MassHealth</b> <b>Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-44
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

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 of the *Physician Manual*.

- (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 of age; 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 TCM 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 set forth in Appendix M of the *Physician Manual*.

(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 of the *Physician Manual*, 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

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-45
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23
Acute Outpatient Hospital Manual		

CARES program services provided by the CARES program provider, the CARES program must follow the removal of assignment procedures as specified in Appendix M of the *Physician Manual*, 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 410.482(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 410.482(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 CARES services described in this regulation to the member.
- (4) Payment for the CARES program is subject to the conditions, exclusions, and limitations in 130 CMR 410.000 and 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 410.482(A) through 410.482(H) and Appendix M of the *Physician Manual*. 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 410.000: M.G.L. c. 118E, §§ 7 and 12.

<b>Commonwealth of Massachusetts MassHealth Provider Manual Series</b>  Acute Outpatient Hospital Manual	<b>Subchapter Number and Title</b> 4. Program Regulations (130 CMR 410.000)	<b>Page</b> 4-46
	<b>Transmittal Letter</b> AOH-55	<b>Date</b> 07/07/23

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