Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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Boston, MA 02111
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MassHealth
Transmittal Letter AIH-43
January 2009

TO: Acute Inpatient Hospitals Participating in MassHealth

FROM: Tom Dehner, Medicaid Director

RE: *Acute Inpatient Hospital Manual* (Implementation of the Child and Adolescent Needs and Strengths Tool)

This letter transmits revisions to the acute inpatient hospital regulations to implement the Child and Adolescent Needs and Strengths (CANS) tool. The CANS is a standardized behavioral-health assessment tool that MassHealth is implementing as part of the Children's Behavioral Health Initiative (CBHI) for members under the age of 21.

These regulations are effective December 26, 2008.

Overview of the MassHealth CANS Requirement
MassHealth providers who furnish behavioral-health services to MassHealth members under the age of 21 are required to ensure that certain clinicians are certified every two years, according to the process established by MassHealth, to use the CANS, and that those clinicians complete the CANS when the member is discharged from a behavioral-health inpatient setting. For each CANS conducted, these providers are required to document the data collected during the discharge planning process in the member's medical record and report it to MassHealth in a specified manner and format.

Description of the CANS Tool
MassHealth has developed two versions of the CANS tool: "CANS Birth through Four" and "CANS Five through Twenty." In addition to the CANS assessment questions, both forms allow the clinician to record the determination of whether the member has a serious emotional disturbance (SED).

Providers can access the two CANS forms, as well as frequently asked questions relating to them, on the MassHealth CBHI Web site at www.mass.gov/masshealth/childbehavioralhealth. Click on Information for Providers. The link for the CANS tool is under the first heading. The CBHI Web site also includes a bibliography of published papers and other resources on the CANS approach.

CANS Requirements for Acute Inpatient Hospitals
Acute inpatient hospitals must complete the CANS during the discharge planning process for members under the age of 21 who are receiving services in a bed licensed by the Department of Mental Health. The CANS must be completed by one of the following clinician types certified in the CANS:

- psychiatrists and psychiatric residents;
- psychologists who have a specialization in clinical or counseling psychology;
- social workers who have a master's degree in social work from an accredited educational institution;
- psychiatric nurse mental-health clinical specialists; or
- counselors who have a master's degree in counseling education, counseling psychology, or rehabilitation psychology from an accredited educational institution.

The medical record of each member under the age of 21 must include a CANS completed during the discharge planning process. In addition, for each CANS conducted, acute inpatient hospitals must ensure that the data collected is reported to MassHealth in the format that is specified in the section entitled "CANS Reporting Requirements: "Paper CANS" and the Web-based Massachusetts CANS Application."

CANS Certification and Training Requirements
Clinicians who are required to use the CANS must be certified every two years by passing an online CANS certification examination. Bachelors-level direct service providers or paraprofessionals will not be trained or certified in the CANS.

Certified clinicians can use both versions of the Massachusetts CANS: "CANS Birth through Four" and "CANS Five through Twenty."

MassHealth is offering online and in-person training opportunities to assist clinicians with the certification process. The in-person training is being conducted by the University of Massachusetts Medical School on various dates across the state. Participation in both the in-person and online training will be free of charge and will include free Continuing Education Units (CEUs). Participation is voluntary, but encouraged. It is not necessary to participate in training in order to take the certification exam.

Information about the CANS training and certification exam can be found on the Web at https://masscans.ehs.state.ma.us. This Web site provides access to the online training, the online certification exam, and the schedule of the in-person training sessions.

For more information about CANS training or certification, please contact the Massachusetts CANS Training Center by calling **508-856-1016** or e-mailing Mass.CANS@umassmed.edu.

CANS Reporting Requirements: "Paper CANS" and the Web-based Massachusetts CANS Application
MassHealth has developed a new Web-based application that permits providers to enter and view CANS data in a secure environment, subject to consent by the member, his or her custodial parent, or other authorized individual. The CANS application is accessible through the Executive Office of Health and Human Services (EOHHS) Virtual Gateway (VG) Web portal.

MassHealth is rolling out the online CANS application in two stages. The first release was in December 2008. It allows users to develop familiarity with the application and asks users to document certain member demographic information and answer the questions that determine if the member has a serious emotional disturbance (SED). The second release, which is expected in the spring of 2009, will add the rest of the assessment questions from the two versions of the CANS tool.

With the CANS application available online, acute inpatient hospitals are required to use this application each time the CANS is completed or updated to satisfy their CANS data reporting requirements. Until the second release of the online CANS application, which is expected in the spring of 2009, the CANS must be completed on paper and be included in the member's medical record. Once the second release occurs, providers can choose to include a copy of the CANS in either an electronic or paper form in the member's medical record. However, providers must be sure to exercise one of these options. At no point should a CANS form be mailed to EOHHS or MassHealth. The CANS forms are available at the MassHealth CBHI Web site at www.mass.gov/masshealth/childbehavioralhealth. Click on Information for Providers. The link for the CANS tool is under the first heading. This link will take you to PDF and RTF (for screen readers for the visually disabled) versions of the two CANS forms.

Acute inpatient hospitals can obtain updated information about the release schedule for the CANS applications on the CBHI Web site at www.mass.gov/masshealth/childbehavioralhealth. Providers should check this site regularly for updated information.

In order to use the online CANS application, acute inpatient hospitals must ensure that the facility is enrolled with the VG and that each clinician who will be entering and viewing data in the CANS application has his or her own VG user ID. In addition, the CANS application will allow data entry operators to perform certain functions on behalf of clinicians. Each data entry operator also needs his or her own VG user ID. Enrollment with the VG for other business applications, such as STARS or EIM/EIS, does not satisfy this requirement.

For assistance in the process in obtaining access to the CANS application, acute inpatient hospitals should send the following information to VirtualGatewayCBHI@state.ma.us:

- the name of the facility or organization;
- the name, address, phone, and e-mail address for a CANS point-of-contact at the organization who is being identified to work with the Virtual Gateway Deployment Unit;
- a statement indicating whether or not the organization has access to the VG Web portal (yes or no);
- the number of clinicians who need access to the CANS application; and
- a statement indicating whether or not anyone in the organization has completed the CANS training. (If yes, provide the number of individuals who have completed the training.)

If you have any comments or concerns about the VG enrollment process or technical questions about the CANS application, please send them to VirtualGatewayCBHI@state.ma.us.

MassHealth is developing job aids and interactive flash files for the CANS application. There will be a job aid explaining how to log onto the application. Also, there will be separate job aids for clinicians, data entry operators, and provider organization staff to help them use and navigate the various functions that they have access to in the system. The job aids will be available on the CBHI Web site at www.mass.gov/masshealth/childbehavioralhealth. In addition, for clinicians registered on the VG, the job aids and flash files will be transmitted electronically from the VG Team to provide instruction on the application.

Other Changes to the Regulations
Other revisions to the acute inpatient hospital regulations add language about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Specifically, pursuant to 130 CMR 450.144(A), a provider may request prior authorization for any medically necessary service for a MassHealth Standard or CommonHealth member under the age of 21, even if it is not otherwise covered under the acute inpatient hospital regulations.

Contact Numbers
If you need technical assistance with the VG, you may contact VG Customer Assistance at 1-800-421-0938, ext. 5.

If you have questions about CANS training or certification, contact the Massachusetts CANS Training Center at 508-856-1016 or e-mail your questions to Mass.CANS@umassmed.edu.

If you have any questions about the information in this transmittal letter please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

Acute Inpatient Hospital Manual

Pages iv, 4-1 through 4-4, 4-4a, 4-4b, 4-5, 4-6, and 4-9 through 4-12

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Acute Inpatient Hospital Manual

Pages iv, 4-3, and 4-4 — transmitted by Transmittal Letter AIH-41

Pages 4-1 and 4-2 — transmitted by Transmittal Letter AIH-39

Pages 4-4a and 4-4b — transmitted by Transmittal Letter AIH-33

Pages 4-5 and 4-6 — transmitted by Transmittal Letter AIH-34

Pages 4-9 through 4-12 — transmitted by Transmittal Letter IH/AC-27

4. Program Regulations

415.401: Introduction

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

415.402: Definitions

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

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

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

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

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

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

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

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

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

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

DMH-Licensed Bed – a bed in an acute inpatient hospital that is located in a unit licensed by the Department of Mental Health (DMH), pursuant to 104 CMR 27.00 et seq.

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

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

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

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

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

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

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

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

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

Nursing Facility – a long-term-care institution that meets the provider eligibility and certification requirements of 130 CMR 456.005 or 456.006.

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

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

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

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

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

Sterilization – any medical procedure, treatment, or operation that renders an individual permanently incapable of reproducing. A sterilization is "nontherapeutic" when the individual has chosen sterilization as a permanent method of contraception. A sterilization is "therapeutic" when it occurs as a necessary part of the treatment of an existing illness or injury or is medically indicated and performed in conjunction with surgery upon the genito-urinary tract.

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

Working Days – Monday through Friday except for legal holidays.

415.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency pays for acute inpatient hospital services provided to MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 415.000 specifically states, for each 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.

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

415.404: Provider Eligibility

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

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

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

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

(3) participate in the Medicare program.

(B) Out of State.

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

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

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

(b) participate in the Medicare program; and

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

415.405: Utilization Management Program

The MassHealth agency pays for procedures and hospital stays that are subject to the Utilization Management Program only if the requirements of the program, as described in 130 CMR 450.207 through 450.211, are satisfied. Appendix E of the *Acute Inpatient 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 as part of the review process.

415.406: Payment Methodology

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

415.407: Covered Administrative Days: Payment Methodology

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

415.408: Nonpayable Services

The following are not payable:

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

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

(C) leaves of absence;

(D) research or the provision of experimental, unproven, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, the MassHealth agency will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993;

(E) cosmetic surgery;

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

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

(H) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).

415.409: Sterilization Services: Introduction

(A) Eligible Members. MassHealth members in categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8 are eligible for sterilization services as described in 130 CMR 415.409 through 415.411. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), see 130 CMR 450.111.

(B) Reimbursable Services. The MassHealth agency will pay for an inpatient stay that includes sterilization services performed by a licensed physician in an acute inpatient hospital for a member only if all of the following conditions are met.

(1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 415.410, and such consent is documented in the manner described in 130 CMR 415.411.

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

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

(C) Assurance of Member Rights. No provider will use any form of coercion in the provision of sterilization services. Neither the MassHealth agency nor any provider, nor any agent or employee of a provider, will mislead any member into believing that a decision to have or not to 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 reimbursable under MassHealth.

(D) Retroactive Eligibility. The MassHealth agency will not pay for a sterilization performed during the period of a member's retroactive eligibility unless all conditions for payment listed in 130 CMR 415.409(B) are met.

415.410: Sterilization Services: Informed Consent

A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained in accordance with the requirements specified in 130 CMR 415.410(A) and (B).

(A) Informed Consent Requirements.

(1) The person who obtains consent (a physician, nurse, or counselor, for example) must orally provide all of the following information and advice to the member requesting sterilization:

(a) advice that the member is free to withhold or withdraw consent for the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss of any federal- or state-funded program benefits to which the member otherwise might be entitled;

(b) a description of available alternative methods of family planning and birth control;

(c) advice that the sterilization procedure is considered irreversible;

(d) a thorough explanation of the specific sterilization procedure to be performed;

(e) a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

(f) a full description of the benefits or advantages that may be expected as a result of the sterilization; and

(g) advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in 130 CMR 415.410(B)(1).

(2) The person who obtains consent must also

(a) offer to answer any questions the member may have concerning the sterilization procedure;

(b) give the member a copy of the consent form;

(c) make suitable arrangements to ensure that the information and advice required by 130 CMR 415.410(A)(1) are effectively communicated to any member who is blind, deaf, or otherwise handicapped;

(d) provide an interpreter if the member does not understand the language used on the consent form or the language used by the person obtaining consent; and

(e) allow the member to have a witness of the member's choice present when consent is obtained.

(B) When Informed Consent Must Be Obtained.

(1) A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A member may not be sterilized at the time of a premature delivery or emergency abdominal surgery unless at least 72 hours have passed since the member gave informed consent for the sterilization in the manner specified in 130 CMR 415.410(A). In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

(2) A member's consent for sterilization will not be considered informed or voluntary if such consent is obtained or given while the member requesting sterilization is

(a) in labor or childbirth;

(b) seeking to obtain or obtaining an abortion; or

(c) under the influence of alcohol or other substances that affect the individual's state of awareness.

(3) Shortly before the performance of the sterilization procedure, the physician performing the procedure must orally inform the member of all of the information and advice specified in 130 CMR 415.410(A)(1).

415.411: Sterilization Services: Consent Form Requirements

Informed consent for sterilization must be documented by the completion of the MassHealth Consent for Sterilization form in accordance with the following requirements. (Instructions for obtaining the Consent for Sterilization forms are located in Subchapter 5 of the *Acute Inpatient Hospital Manual*.)

(A) Required Consent Form.

(1) One of the following Consent for Sterilization forms must be used:

(a) CS-18 — for members aged 18 through 20; or

(b) CS-21 — for members aged 21 and older.

(2) Under no circumstances will the MassHealth agency accept any other consent for sterilization form.

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

(C) Required Submission and 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;

(2) a copy must be included in the member's permanent medical record at the site where the sterilization is performed; and

(3) all providers 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. 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 consent form.

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

The MassHealth agency pays for all medically necessary acute inpatient hospital services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 415.000, and with prior authorization.

(130 CMR 415.413 Reserved)

(C) Appeals to the MassHealth Agency.

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

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

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

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

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

415.418: Accident Victims

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

415.419: Discharge-Planning Standards

(A) Staff.

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

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

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

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

(B) Operations and Procedures.

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Nursing Facility Medical Eligibility Criteria.

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

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

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

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

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

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

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

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

(A) psychiatrists and psychiatric residents;

(B) psychiatric nurse mental-health clinical specialists;

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

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

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

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

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

(130 CMR 415.422 through 415.424 Reserved)