Commonwealth of Massachusetts
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Division of Medical Assistance
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MASSHEALTH
TRANSMITTAL LETTER ALL-113
March 2003

TO: All Providers Participating in MassHealth

FROM: Douglas S. Brown, Acting Commissioner

RE: *All Provider Manuals* (Revised Administrative and Billing Regulations)

The Division has revised the entire chapter of its administrative and billing regulations to make it easier for providers to understand. Language has been simplified and Division policies have been clarified.

The administrative and billing regulations contain provisions that are applicable to all MassHealth providers, including provisions about provider eligibility, notifications to the Division, recordkeeping, medical necessity, prior authorization, and claim-submission requirements. Providers and their staff are encouraged to read, and make sure that they are familiar with, all provisions of the Division's administrative and billing regulations.

Some of the Division's policy clarifications and changes in the revised regulations are highlighted below.

- **Provider Participation.** The regulations have been clarified to indicate that a "group practice" is a MassHealth provider subject to the requirements of the Division's regulations.

- **Primary Care Clinician (PCC) Plan Provider Participation**. The eligibility requirements for physicians, nurse practitioners, and group practices who want to be PCCs have been revised. General practice is no longer an allowable PCC specialty; however any provider in general practice who is enrolled as a PCC before April 1, 2003, may remain a PCC, subject to all other eligibility requirements in the Division's regulations. The Division's right to terminate a PCC has also been clarified.

- **PCC Plan Referral Requirements**. For MassHealth members enrolled in the PCC Plan, the members' PCC no longer needs to provide a referral for obstetric services for pregnant and postpartum members, clinical laboratory services, emergency-department services, and admissions to acute inpatient hospitals. To avoid denials of claims for obstetric services provided without a referral to a MassHealth member enrolled with a PCC, the provider must include a pregnancy diagnosis on the claim. Despite the changes in the referral policy, PCCs should continue to communicate with all specialists about the care delivered to their PCC Plan members.

- **Claims**. The regulations about the Division's 90-day billing deadline have been clarified. The Division has also changed the name of the Division unit to which providers submit claim appeals. The name has changed from the "Claims Review Board" to the "Final Deadline Appeals Board" to make it clear that the unit will only review those claims that have been denied for exceeding the Division's final billing deadline.

- **Electronic Submission of Claims**. Language has been updated to acknowledge the industry shift from paper to electronic claims. Claims for payment may be submitted either electronically or on paper, as designated by the Division. To simplify claims processing and to reduce administrative costs, the Division prefers that providers submit electronic claims whenever possible.

- **Electronic Funds Transfer**. Language has been updated to acknowledge the industry shift to electronic funds transfer for payment of claims. To expedite payments to providers and to reduce administrative costs, the Division prefers to make payments by electronic funds transfer.

- **Billing Agencies**. The language about when and how the Division will recognize a billing agent acting on a provider's behalf and a provider's responsibility about the acts of their billing agent has been simplified.

The Division hopes that the revised regulations will help all MassHealth providers and their staff to work well with MassHealth.

This letter also transmits a revised Appendix W for all provider manuals. Appendix W is the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Protocol and Periodicity Schedule. The revised Schedule reflects the recommendations of the Massachusetts Health Quality Partners (MHQP) and the American Academy of Pediatrics.

These regulations are effective April 1, 2003.

NEW MATERIAL

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

All Provider Manuals

Pages i, ii, ii-a, iii, 1-1 through 1-32, 2-1 through 2-36, 3-1 through 3-12, and W-1 through W-4

OBSOLETE MATERIAL

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

All Provider Manuals

Pages i, 1-27, and 1-28 — transmitted by Transmittal Letter ALL-110

Page ii — transmitted by Transmittal Letter ALL-105

Pages iii and 2-37 through 2-40 — transmitted by Transmittal Letter ALL-94

Pages iii-a, 2-25, and 2-26 — transmitted by Transmittal Letter ALL-76

Pages 1-1 through 1-4 — transmitted by Transmittal Letter ALL-95

Pages 1-5 and 1-6 — transmitted by Transmittal Letter ALL-109

Pages 1-7, 1-8, 2-21, and 2-22 — transmitted by Transmittal Letter ALL-111

Pages 1-9 and 1-10 — transmitted by Transmittal Letter ALL-89

Pages 1-11 through 1-24, 3-5, and 3-6 — transmitted by Transmittal Letter ALL-98

Pages 1-25 and 1-26 — transmitted by Transmittal Letter ALL-97

Pages 1-29 through 1-34 and W-1 through W-6 — transmitted by Transmittal Letter ALL-99

Pages 2-1, 2-2, and 2-31 through 2-34 — transmitted by Transmittal Letter ALL-106

Pages 2-3 through 2-10, 2-27, and 2-28 — transmitted by Transmittal Letter ALL-85

Pages 2-11 and 2-12 — transmitted by Transmittal Letter ALL-86

Pages 2-13, 2-14, 2-17, 2-18, 3-7, and 3-8 — transmitted by Transmittal Letter ALL-80

Pages 2-15, 2-16, 2-35, 2-36, and 3-11 through 3-16 — transmitted by Transmittal Letter ALL-51

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Pages 3-1 and 3-2 — transmitted by Transmittal Letter ALL-96

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450.101: Definitions

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

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

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

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

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

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

Commissioner — the commissioner of the Division of Medical Assistance appointed pursuant to M.G.L. c. 118E, § 2.

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

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

DHCFP – the Massachusetts Division of Health Care Finance and Policy.

Division — the Massachusetts Division of Medical Assistance organized under M.G.L. c. 118E, or its agent.

Emergency Aid to the Elderly, Disabled and Children Program (EAEDC) — a cash assistance program administered by the Department of Transitional Assistance for certain residents of Massachusetts that also covers certain medical services. The medical services component of the program is administered by the Division.

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

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

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

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

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

Individual Practitioners — physicians, dentists, psychologists, nurse practitioners, nurse midwives, and certain other licensed, registered, or certified medical practitioners.

Managed Care — a system of primary care and other medical services that are provided and coordinated by a MassHealth managed care provider in accordance with the provisions of 130 CMR 450.117 et seq. and 130 CMR 508.000.

Managed Care Organization (MCO) — any entity with which the Division contracts to provide and coordinate primary care and certain other medical services to members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), or that otherwise meets the State Plan definition of an HMO.

MassHealth — the medical assistance and benefit programs administered by the Division pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

MassHealth Enrollment Center (MEC) — a regional office of the Division that determines MassHealth eligibility of individuals and families who do not receive cash assistance (TAFDC, EAEDC, SSI).

MassHealth Managed Care Provider — a Primary Care Clinician participating in the Primary Care Clinician Plan or a managed care organization that has contracted with the Division to provide and coordinate primary care and certain other medical services to certain MassHealth members.

Medicaid — see "MassHealth."

Medical Services — medical or related care, including goods and services provided to members, the cost of which is paid or payable by the Division under MassHealth.

Medicare — a federally administered health insurance program for persons eligible under the "Health Insurance for the Aged Act," Title XVIII of the Social Security Act (42 U.S.C. 1395-1395pp).

Member — a person determined by the Division to be eligible for MassHealth.

Overpayment — a payment made by the Division to or for the use of a provider to which the provider was not entitled under applicable federal and state laws and regulations.

Party in Interest — a person with an ownership or control interest.

Peer Review — an evaluation of the quality, necessity, and appropriateness of medical services provided by a provider, to determine compliance with professionally recognized standards of health care or compliance with laws, rules, and regulations under which MassHealth is administered.

Primary Care — the provision of coordinated, comprehensive medical services, on both a first-contact and a continuous basis, to members enrolled in managed care. Services include: an initial medical history intake, medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services.

Primary Care Clinician (PCC) Plan — a managed care option administered by the Division through which enrolled members receive primary care and certain other medical services.

Provider — an individual, group, facility, agency, institution, organization, or business that furnishes medical services and participates in MassHealth under a provider contract with the Division. For purposes of applying 130 CMR 450.235 through 450.240, the term "provider" includes formerly participating providers.

Provider Contract (also referred to as "Provider Agreement") – a contract between the Division and a contractor for medical services.

Provider Type — a provider classification specifying and limiting the kinds of medical services for which the provider may be paid under MassHealth.

Provider under Common Ownership — two or more providers in which a person or corporation has or had, at any time, an ownership or control interest, whether concurrently, sequentially, or otherwise. See 130 CMR 450.221(A)(9)(a), (b), (c), or (f).

Recipient Eligibility Verification System (REVS) — the member eligibility verification system accessible to providers.

Sanction — an administrative penalty imposed by the Division pursuant to M.G.L. c. 118E, § 37 against a provider found to have violated MassHealth laws, regulations, or contract requirements. Sanctions include, but are not limited to, administrative fines, suspension, and termination from participation in MassHealth.

Statutory Prerequisite — any license, certificate, permit, or other requirement imposed by state or federal law or regulation as a precondition to the practice of any profession or to the operation of any business or institution in or by which medical services are provided. Statutory prerequisites include, but are not limited to, licenses required by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health, licenses and certificates issued by the Massachusetts boards of registration, and certificates required by the Massachusetts Department of Public Safety.

Third Party – any individual, entity, or program other than MassHealth that is or may be liable to pay all or part of the costs for medical services.

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

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

450.102: Purpose of 130 CMR 400.000 through 499.000

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

450.103: Promulgation of Regulations

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

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

(130 CMR 450.104 Reserved)

450.105: Coverage Types

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

(A) MassHealth Standard.

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

(a) abortion services;
(b) acute inpatient hospital services;
(c) adult day health services;
(d) adult foster care services;
(e) ambulance services;
(f) ambulatory surgery services;
(g) audiologist services;
(h) behavioral health (mental health and substance abuse) services;
(i) Chapter 766: home assessments and participation in team meetings;
(j) chiropractor services;
(k) chronic disease and rehabilitation inpatient hospital services;
(l) community health center services;
(m) day habilitation services;
(n) dental services;
(o) durable medical equipment and supplies;
(p) early intervention services;
(q) family planning services;
(r) hearing aid services;
(s) home health services;
(t) hospice services;
(u) laboratory services;
(v) nurse midwife services;
(w) nurse practitioner services;
(x) nursing facility services;
(y) orthotic services;
(z) outpatient hospital services;
(aa) oxygen and respiratory therapy equipment;
(bb) personal care services;
(cc) pharmacy services;
(dd) physician services;
(ee) podiatrist services;
(ff) private duty nursing services;

(gg) prosthetic services;
(hh) rehabilitation services;
(ii) renal dialysis services;
(jj) speech and hearing services;
(kk) therapy services: physical, occupational, and speech/language;
(ll) transportation services;
(mm) vision care; and
(nn) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Standard members must enroll with a MassHealth managed care provider unless excluded from participation in managed care (see 130 CMR 450.117 et seq. and 130 CMR 508.000) or during a period of presumptive eligibility. (See 130 CMR 505.002(C)(4).)

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

(a) The Division will not pay a provider other than the MCO for any services that are covered by the Division's contract with the MCO, except for family planning services that were not provided or arranged for by the MCO. It is the responsibility of the provider to verify the scope of services covered by the Division's contract with the MCO.

(b) The Division will pay providers other than the MCO for those services listed in 130 CMR 450.105(A)(1) that are not covered by the Division's contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Behavioral Health Services.

(a) MassHealth Standard members enrolled in the PCC Plan receive behavioral health services only through the Division's behavioral health contractor. (See 130 CMR 450.124 et seq.)

(b) MassHealth Standard members enrolled in an MCO receive behavioral health services only through the MCO. (See 130 CMR 450.117 et seq.)

(c) MassHealth Standard members who are excluded from participating in managed care under 130 CMR 508.004 or who have not enrolled in an MCO or with the Division's behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services.

(5) Purchase of Health Insurance. The Division may purchase third-party health insurance for any MassHealth Standard member if the Division determines such premium payment is cost-effective. Under such circumstances, the Division will pay a provider only for those services listed in 130 CMR 450.105(A)(1) that are not available through the member's third-party health insurer.

(B) MassHealth Basic.

(1) Covered Services. The following services are covered for MassHealth Basic members (see 130 CMR 505.006 and 519.008).

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

(2) Managed Care Member Participation. MassHealth Basic members for whom eligibility is determined under 130 CMR 505.006 must participate in managed care as described in 130 CMR 450.117. These members are eligible to receive services listed in 130 CMR 450.105(B)(1) only after enrolling with a MassHealth managed care provider in accordance with 130 CMR 508.002(I).

(3) Managed Care Organizations. For MassHealth Basic members who are enrolled in MassHealth MCOs, the following rules apply.

(a) The Division will not pay a provider other than the MCO for any services that are covered by the Division's contract with the MCO, except for family planning services that were not provided or arranged for by the MCO. It is the responsibility of the provider to verify the scope of services covered by the Division's contract with the MCO.

(b) The Division will pay providers other than the MCO for those services listed in 130 CMR 450.105(B)(1) that are not covered by the Division's contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Behavioral Health Services.

(a) MassHealth Basic members enrolled in the PCC Plan receive behavioral health services only through the Division's behavioral health contractor. (See 130 CMR 450.124 et seq.)

(b) MassHealth Basic members enrolled in an MCO receive behavioral health services only through the MCO. (See 130 CMR 450.117 et seq.)

(C) MassHealth Buy-In.

(1) For a MassHealth Buy-In member who is under age 65 and is not institutionalized (see 130 CMR 505.007), the Division will pay for all or part of the member's health insurance premium. The amount of the Division's payment will be based on the Division's determination of cost-effectiveness. The Division does not pay for any other benefit for these members.

(2) For a MassHealth Buy-In member who is aged 65 or older or is institutionalized (see 130 CMR 519.010), the Division will pay all of the member's Medicare Part B premium. The Division does not pay for any other benefit for these members.

(3) MassHealth Buy-In members are responsible for payment of copayments, coinsurance, and deductibles. MassHealth Buy-In members are also responsible for payment for any services that are not covered by the member's insurance.

(4) The Division does not pay providers directly for any services provided to any MassHealth Buy-In member, and therefore does not issue a MassHealth card to MassHealth Buy-In members.

(5) MassHealth Buy-In members are excluded from participation in any of the Division's managed care options pursuant to 130 CMR 508.004.

(D) MassHealth Senior Buy-In.

(1) Covered Services. For MassHealth Senior Buy-In members (see 130 CMR 519.009), the Division will pay the member's Medicare Part B premiums, and where applicable, Medicare Part A premiums. The Division will also pay for coinsurance and deductibles under Medicare Parts A and B.

(2) Managed Care Member Participation. MassHealth Senior Buy-In members are excluded from participation in managed care pursuant to 130 CMR 508.004.

(E) MassHealth CommonHealth.

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

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

(2) Managed Care Member Participation. MassHealth CommonHealth members have the option of participating in managed care through the Division unless excluded pursuant to 130 CMR 508.004. For CommonHealth members who choose to participate in managed care, the provisions of 130 CMR 450.105(A)(3) and (4) apply.

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

(F) MassHealth Prenatal.

(1) Covered Services. For MassHealth Prenatal members (see 130 CMR 505.003), the Division will pay only for ambulatory prenatal care provided by a MassHealth provider.

(2) Managed Care Member Participation. MassHealth Prenatal members are excluded from participation in managed care pursuant to 130 CMR 508.004.

(G) MassHealth Limited.

(1) Covered Services. For MassHealth Limited members (see 130 CMR 505.008 and 519.009), the Division will pay only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in:

(a) placing the member's health in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(2) Organ Transplants. Pursuant to 42 U.S.C. 1396b(v)(2), the Division will not pay for an organ-transplant procedure, or for care and services related to that procedure, for MassHealth Limited members, regardless of whether such procedure would otherwise meet the requirements of 130 CMR 450.105(G)(1).

(3) Managed Care Member Participation. MassHealth Limited members are excluded from participation in managed care pursuant to 130 CMR 508.004.

(H) MassHealth Family Assistance.

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

(a) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B)(4) and (C), the only benefit the Division provides is partial payment of the member's employer-sponsored health insurance, except as provided in 130 CMR 450.105(H)(2). No MassHealth card is issued to these members.

(b) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(D), the Division issues a MassHealth card and provides:

(i) full payment of the member's private health-insurance premium; and

(ii) coverage of any services listed in 130 CMR 450.105(H)(3) not covered by the member's private health insurance. Coverage includes payment of copayments, coinsurance, and deductibles required by the member's private health insurance.

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

(a) For children who meet the requirements of 130 CMR 505.005(B)(6), the Division pays providers directly, or reimburses the member, for

(i) copayments, coinsurance, and deductibles relating to well-baby and well-child care; and

(ii) copayments, coinsurance, and deductibles for services covered under the member's employer-sponsored health insurance once the member's family has incurred and paid copayments, coinsurance, and deductibles for eligible members that equal or exceed five percent of the family group's annual gross income.

(b) Providers should check the Recipient Eligibility Verification System (REVS) to determine whether the Division will pay a provider directly for a copayment, coinsurance, or deductible for a specific MassHealth Family Assistance member.

(3) Covered Services for Members Who Are Not Receiving Premium Assistance. For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B)(3), (E), (F), or (G), the following services are covered.

(a) abortion services;
(b) acute inpatient hospital services;
(c) ambulance services (emergency only);
(d) ambulatory surgery services;
(e) audiologist services;
(f) behavioral health (mental health and substance abuse) services;
(g) Chapter 766: home assessments and participation in team meetings;
(h) chiropractor services;
(i) chronic disease and rehabilitation inpatient hospital services;
(j) community health center services;
(k) dental services;
(l) durable medical equipment and supplies;
(m) early intervention services;
(n) family planning services;
(o) hearing aid services;
(p) home health services;
(q) hospice services;
(r) laboratory services;
(s) nurse midwife services;
(t) nurse practitioner services;
(u) orthotic services;
(v) outpatient hospital services;
(w) oxygen and respiratory therapy equipment;
(x) pharmacy services;
(y) physician services;
(z) podiatrist services;

(aa) prosthetic services;
(bb) rehabilitation services;
(cc) renal dialysis services;
(dd) speech and hearing services;
(ee) therapy services: physical, occupational, and speech/language;
(ff) vision care; and
(gg) X-ray/radiology services.

(4) Managed Care Participation.

(a) MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(E) must enroll with a Primary Care Clinician or a Division-contracted managed care organization (MCO) (see 130 CMR 450.117).

(b) MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(F) must enroll with a Primary Care Clinician (see 130 CMR 450.118.)

(5) Managed Care Organizations. For MassHealth Family Assistance members who are enrolled in a MassHealth MCO, the following rules apply.

(a) The Division will not pay a provider other than the MCO for any services that are covered by the Division's contract with the MCO, except for family planning services that were not provided or arranged for by the MCO. It is the responsibility of the provider to verify the scope of services covered by the Division's contract with the MCO.

(b) The Division will pay providers other than the MCO for those services listed in 130 CMR 450.105(H)(3) that are not covered by the Division's contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(6) Behavioral Health Services.

(a) MassHealth Family Assistance members enrolled in the PCC Plan receive behavioral health services only through the Division's behavioral health contractor. (See 130 CMR 450.124 et seq.)

(b) MassHealth Family Assistance members enrolled in an MCO receive behavioral health services only through the MCO. (See 130 CMR 450.117 et seq.)

(c) MassHealth Family Assistance members who are not receiving premium assistance, and have not enrolled in an MCO or been enrolled with the Division's behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services.

450.106: Emergency Aid to the Elderly, Disabled and Children Program

(A) Covered Services. The following services are covered for EAEDC recipients:
(1) physician services specified in 130 CMR 433.000;
(2) community health center services specified in 130 CMR 405.000;
(3) legend drugs (those drugs that require a prescription under federal or state law) specified in 130 CMR 406.000;
(4) insulins (the only nonlegend drugs that are covered) and diabetic supplies;
(5) infusion (intravenous) therapy, including chemotherapy, pain management, antibiotics, chelation, and cardiac management;
(6) oxygen and respiratory therapy services specified in 130 CMR 427.000;
(7) substance abuse treatment services as specified in 130 CMR 418.000 if provided in public detoxification and outpatient substance abuse treatment centers; and
(8) diagnostics and testing (such as laboratory, radiology, magnetic resonance imaging, or psychological testing) necessary for the determination or redetermination of eligibility for the EAEDC Program, upon referral from a physician or a community health center.

(B) Responsibilities of Acute Hospitals. Acute outpatient and inpatient hospitals are obligated under M.G.L. c. 118G, § 13 to provide medically necessary services to recipients of the EAEDC Program. EAEDC recipients are entitled to receive the services described in 130 CMR 410.000 and 415.000 to the same extent that such services are provided to MassHealth members under M.G.L. c. 118E.

(C) Prior Authorization. Any covered services that require prior authorization in the MassHealth regulations (130 CMR 400.000 through 499.000) require prior authorization for the EAEDC Program.

450.107: Eligible Members and the MassHealth Card

(A) Eligibility Determination. MassHealth eligibility is determined in accordance with 130 CMR 501.000 et seq. Eligibility for the EAEDC Program is determined pursuant to 106 CMR 319.000 through 321.000, 701.000 through 701.600, 705.000 through 705.950, and 706.000 through 706.800.

(B) Recipient Eligibility Verification System. The Division uses the Recipient Eligibility Verification System (REVS) for day-specific eligibility verification, and to communicate a member's MassHealth eligibility, coverage type, managed care status, restrictions, and other insurance information to health-care providers.

(C) MassHealth Card. The Division issues a plastic identification card for most MassHealth members. The MassHealth card contains information necessary to access REVS. Members for whom the Division pays health-insurance premiums only may not have a MassHealth card.

(D) Temporary MassHealth Eligibility Card. When necessary, the Division or the Department of Transitional Assistance will issue a temporary MassHealth card to the cardholder for use until a plastic MassHealth card is issued. The temporary MassHealth card shows dates of eligibility, service restrictions, and other insurance information. If a discrepancy occurs between information given on a temporary MassHealth card and by REVS, the information on the temporary card prevails. To be paid for a covered service that was provided based on information given on a temporary card, a provider must produce a copy of the temporary card, and have otherwise met all other prerequisites for payment.

(E) The Division may determine certain individuals to be eligible for MassHealth Standard or MassHealth Family Assistance coverage for a limited period of time if, on the basis of preliminary information, the individual appears to meet the applicable requirements. Coverage for members with time-limited eligibility begins 10 days before the date on which the Division receives the Medical Benefit Request (MBR). The Division may determine time-limited eligibility for:

(1) MassHealth Standard or MassHealth Family Assistance for children under age 19; and

(2) MassHealth Family Assistance for persons who claim to have a positive human immunodeficiency virus (HIV) status.

450.108: Selective Contracting

(A) Use of Selective Contracts. The Division may provide some services through selective contracts where such contracts are permitted by federal and state law.

(B) Termination of Provider Contracts. The Division may terminate, in whole or in part, existing provider contracts where selective contracts are in effect. In the event of any such termination, the Division will notify the affected providers in writing, at least 30 days prior to termination. Such termination will not affect payments to providers for services provided prior to the date of termination.

450.109: Out-of-State Services

(A) The Division will cover services provided in another state to a MassHealth member, subject to all applicable limitations, including service coverage, prior authorization, and provider enrollment, only in the following circumstances:

(1) medical services are needed because of a medical emergency;

(2) medical services are needed and the member's health would be endangered if the member were required to travel to Massachusetts; or

(3) it is the general practice for members in a particular locality to use medical resources in another state.

(B) The Division does not cover services provided outside the United States and its territories.

(130 CMR 450.110 and 450.111 Reserved)

450.112: Advance Directives

(A) Provider Participation. All hospitals, nursing facilities, MCOs, home health agencies, personal care agencies, and hospices participating in MassHealth must:

(1) provide to all adults aged 18 or over, who are receiving medical care from the provider, written information concerning their rights to:

(a) make decisions concerning their medical care;

(b) accept or refuse medical or surgical treatment; and

(c) formulate advance directives (for example, living wills or durable powers of attorney for health care, or health-care proxy designations);

(2) provide written information to all adults about the provider's policies concerning implementation of these rights;

(3) document in the patient's medical record whether the patient has executed an advance directive;

(4) not condition the provision of care or otherwise discriminate against a patient based on whether that patient has executed an advance directive;

(5) ensure compliance with requirements of state law concerning advance directives; and

(6) educate staff and the community on advance directives.

(B) When Providers Must Give Written Information to Adults.

(1) A hospital must give written information at the time of the person's admission as an inpatient.

(2) A nursing facility must give information at the time of the person's admission as a resident.

(3) A provider of home health care or personal care services must give information to the person before services are provided.

(4) A hospice program must give information to the person before services are provided.

(5) An MCO must give information at the time the person enrolls or reenrolls with the MCO.

(C) Incapacitated Persons. If a person is admitted to a facility in an incapacitated state and is unable to receive information or articulate whether he or she has executed an advance directive, the facility must include materials about advance directives in the information to the families or to the legal representatives, surrogates, or other concerned persons of the incapacitated patient to the extent it does so in accordance with state law. This does not relieve the facility of its obligation to provide this information to the patient once the patient is no longer incapacitated.

(D) Previously Executed Advance Directives. When the patient or a relative, surrogate, or other concerned or related person presents the provider with a copy of the person's advance directive, the provider must comply with the advance directive, including recognition of the power of attorney, to the extent allowed under state law. Unless contrary to state law, if no one comes forward with a previously executed advance directive and the patient is incapacitated or otherwise unable to receive information or articulate whether he or she has executed an advance directive, the provider must note in the medical record that the person was not able to receive information and was unable to communicate whether an advance directive existed.

(E) Religious Objections. No private provider will be required to implement an advance directive if such action is contrary to the formally adopted policy of such provider that is expressly based on religious beliefs, provided:

(1) the provider has informed the person or, if the person is incapacitated at the time of admission and unable to receive information due to the incapacitated condition or mental disorder, the person's family or surrogate, of such policy prior to or upon admission, if reasonably possible; and

(2) the person is transferred to another equivalent facility that is reasonably accessible to the person's family and willing to honor the advance directive. If the provider or the health care agent is unable to arrange such a transfer, the provider must seek judicial guidance or honor the advance directive.

(130 CMR 450.113 through 450.116 Reserved)

450.117: Managed Care Participation

(A) MassHealth members are required to participate in managed care unless they are excluded from such participation under 130 CMR 508.004.

(1) Members who participate in managed care must enroll with either a Primary Care Clinician (PCC) or a Division-contracted managed care organization (MCO).

(2) MassHealth Family Assistance members described in 130 CMR 450.105(H)(4)(b) can only enroll with a PCC.

(3) Members excluded from managed care under 130 CMR 508.004 receive those MassHealth services for which they are eligible through any participating MassHealth provider.

(B) The Division's managed care options provide for the management of medical care, including primary care, behavioral health services, and other medical services.

(1) Members who enroll with a PCC obtain primary care through the PCC, and behavioral health services through the Division's behavioral health contractor.

(2) Members who enroll with an MCO obtain all medical services, including behavioral health services, through the MCO, except those services not covered under the MassHealth contract with the MCO.

(C) Members who participate in managed care are identified on REVS (see 130 CMR 450.107). For members enrolled with a MassHealth managed care provider, this system will give the name and telephone number of the managed care provider (the PCC, the MCO, and the behavioral health contractor, as applicable). The conditions under which the Division will pay other providers for services provided to MassHealth members enrolled with a MassHealth managed care provider are limited to those described in 130 CMR 450.105 and 450.118.

450.118: Primary Care Clinician (PCC) Plan

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

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

(1) individual physicians who have current admitting privileges to at least one MassHealth-participating Massachusetts acute hospital in the physician's service area that participates in MassHealth or who meet 130 CMR 450.118(F)(1), and who are board-eligible or board-certified in family practice, pediatics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology, or who meet 130 CMR 450.118(F)(2);

(2) independent nurse practitioners who have a collaborative arrangement with a MassHealth-participating physician who meets the criteria of 130 CMR 450.118(B)(1) and who is in the nurse practitioner's service area;

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

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

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

(E) Group Practice Participation. When a group practice participates as a PCC, the group practice
(1) may claim an enhanced fee only for services provided by those individual practitioners within the group who meet the requirements of 130 CMR 450.118(B)(1) or (2) and have signed the PCC contract; and
(2) must assign each enrollee to an individual practitioner who meets the criteria under 130 CMR 450.118(B)(1) or (2).

(F) Waiver of Eligibility Requirements. The Division may, if necessary to ensure adequate member access to services, and under the following circumstances, allow an individual physician to enroll as a PCC or as a physician in a group practice PCC notwithstanding the physician's inability to meet certain eligibility requirements set forth in 130 CMR 450.118(B)(1).
(1) Upon written request from a physician, the Division may waive the requirement that an individual physician or a physician in a group practice have admitting privileges to at least one MassHealth-participating Massachusetts acute hospital, if the physician demonstrates to the Division's satisfaction that the physician:
(a) practices in an area that is too distant to adequately respond to emergencies at the nearest acute hospital or where lack of admitting privileges is common for physicians practicing in that area;
(b) admits exclusively to acute hospitals that employ one or more physicians to care for their inpatient census, provided that the hospital's medical director agrees to admit and care for the physician's patients through the use of such physicians employed by the hospital; or
(c) establishes a collaborative relationship with a physician participating in MassHealth who has admitting privileges at the acute hospital closest to the requesting physician's office and who will assume responsibility for admitting the requesting physician's managed care members to that hospital when necessary.

(2) Upon written request from a physician, the Division may waive the requirement that the individual physician or physician in a group practice is board-eligible or board-certified in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology, if the physician is board-eligible or board-certified in another medical specialty, and otherwise meets the requirements of 130 CMR 450.118.

(G) PCC Provider Qualifications Grandfathering Provision. Notwithstanding the generality of the provisions of 130 CMR 450.118, any provider who is continuously enrolled as a PCC before April 1, 2003, is subject to the PCC provider eligibility requirements in effect on and before March 31, 2003.

(H) Rate of Payment. The Division pays PCCs an enhanced fee for primary care services, in accordance with the terms of the PCC provider contract.

(I) Termination.

(1) If the Division determines that a PCC fails to fulfill any of the obligations stated in the Division's regulations or PCC contract, the Division may terminate the PCC contract in accordance with its terms. To the extent required by law, a pretermination hearing will be held in substantial conformity with the procedures set forth in 130 CMR 450.238 through 450.248.

(2) If the Division determines that an individual practitioner within a PCC group practice fails to fulfill any of the obligations stated in the Division's regulations or the PCC contract, the Division may terminate the PCC contract pursuant to 130 CMR 450.118(I)(1), or require the group practice to stop assigning enrollees to such practitioner and to reassign existing enrollees to other practitioners in the group who meet the requirements of 130 CMR 450.118(B)(1) or (2).

(J) Referral for Services.

(1) Referral Requirement. For members enrolled in the PCC Plan, all services, with the exception of those listed below, require referral from the member's PCC in order to be payable when provided by any provider other than the PCC. (This includes referral to individual practitioners in a group practice who are not part of the group PCC under 130 CMR 450.118(B)(5)). The PCC must make the referral by telephone or in writing prior to the delivery of the service and must give his or her PCC referral number to the other provider for the purpose of documenting the referral. The Division will pay a provider other than the member's PCC for services that require PCC referral only when the provider's claim contains the referral number of the referring PCC. A PCC's referral number may not be used by a provider at any time or under any circumstance without the express authorization of the referring PCC.

(2) Referral Exceptions. The following services may be provided without a referral and will be paid without the referral number if the service is otherwise covered for the member (see 130 CMR 450.105 and individual program regulations for information on covered services and specific service limitations).

(a) Abortion services.

(b) Anesthesia services.

(c) Any services provided under a home and community-based services waiver.

(d) Behavioral health (mental health and substance abuse) services (including inpatient and outpatient psychiatric services).
(e) Clinical laboratory services.
(f) Dental care.
(g) Drugs (legend and nonlegend) and diabetic supplies.
(h) Family planning services and supplies for members of childbearing age.
(i) HIV pre- and post-test counseling services provided by community health centers.
(j) HIV testing.
(k) Hospice services.
(l) Hospitalization.

(i) Elective Admissions. All elective admissions are exempt from the PCC referral requirement and are subject to the Division's admission-screening requirements at 130 CMR 450.208(A). The hospital must notify the member's PCC within 48 hours following an elective admission.

(ii) Non-elective Admissions. Non-elective admissions are exempt from the PCC referral requirement. The hospital must notify the member's PCC within 48 hours following a non-elective admission.

(m) Obstetric services for pregnant and postpartum members up to the end of the month in which the 60-day period following the termination of pregnancy ends.
(n) Nursing-facility services.
(o) Services delivered to a homeless member outside of the PCC office. Any covered service that is provided to a member with no residence or fixed address (that is, a homeless member) is exempt from the PCC referral requirement when such service is provided by a participating MassHealth provider who is also a PCC, according 130 CMR 450.118(B). The service must be provided at a location where medical services are not usually or customarily delivered (for example, a homeless shelter or a soup kitchen). The provider must attempt to contact the member's PCC within 72 hours after the delivery of care, in writing or by telephone, in order to notify the PCC of the date of service, the service provided, and the diagnosis. The provider must also maintain a written medical record for each member.
(p) Services to treat an emergency condition or emergency department screening services.
(q) Sexually transmitted disease diagnosis and treatment when provided by entities that have contracts with the Massachusetts Department of Public Health (DPH) pursuant to DPH's Request for Proposals for State-Cooperating Sexually Transmitted Disease Clinics and DPH's Request for Proposals for Community Health Networks.
(r) State school intermediate care facilities for the mentally retarded.
(s) Sterilization when performed for family planning.
(t) Surgical pathology services.
(u) Transportation to covered medical care.
(v) Vision care in the following categories (see Subchapter 6 of the *Vision Care Manual*): visual analysis, frames, single-vision prescriptions, bifocal prescriptions, and repairs.

(K) Services to Homeless Members. To provide services to homeless members according to 130 CMR 450.118(J)(2)(o), the provider must provide written evidence of demonstrated experience in delivering medical care in a nonmedical setting, and request, in writing, designation from the Division that the PCC is approved to provide services to homeless members. The Division retains the right to approve or disapprove such a request or revoke an approval of such a request at any time.

(L) Recordkeeping and Reporting.

(1) PCC Recordkeeping Requirement. The PCC must document all referrals in the member's medical record by recording the following:

(a) the date of the referral;
(b) the name of the provider to whom the member was referred;
(c) the reason for the referral;
(d) number of visits authorized; and
(e) copies of the reports required by 130 CMR 450.118(J)(9).

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

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

(130 CMR 450.119 through 450.123 Reserved)

450.124: Behavioral Health Services

(A) Behavioral Health Contractor. Except as provided in 130 CMR 450.124(B) and (C), all behavioral health (mental health and substance abuse) services will be authorized, provided, and solely paid by the Division's behavioral health contractor (the Contractor). Payment for such services will be subject to the terms of the Contractor's provider contracts including, but not limited to, provisions governing service authorization and billing requirements. Any provider seeking a contract with the Contractor should contact the Contractor directly.

(B) Emergency Services. Emergency services may be provided by any provider regardless of whether that provider has entered into an agreement with the Contractor. However, all providers of emergency services (except those provided to exempt members pursuant to 130 CMR 450.124(C)) may claim payment for such services solely from the Contractor and such payment will be subject to the Contractor's billing requirements.

(C) Services to Exempt Members. Services provided to the following MassHealth members are not subject to 130 CMR 450.124:

(1) members who are enrolled in a MassHealth-contracted MCO; and
(2) members who are excluded from participating in managed care under 130 CMR 508.004.

(130 CMR 450.125 through 450.129 Reserved)

450.130: Copayments Required by the Division

(A) The Division requires MassHealth members who are not enrolled in MCOs to make the copayments described in 130 CMR 450.130(B) for drugs obtained from the dispensing pharmacy and for nonemergency services provided in a hospital emergency department, except as excluded in 130 CMR 450.130(C). Providers may collect copayments only in the amounts and for the services listed in 130 CMR 450.130(B). MassHealth members who are enrolled in MassHealth MCOs must make copayments in accordance with the MCO's MassHealth copayment policy. Those MCO copayment policies must be approved by the Division, must exclude the services and persons listed in 130 CMR 450.130(C), and may not exceed the MassHealth copayment amounts set forth in 130 CMR 450.130(B). (See also 130 CMR 508.016 through 508.019.) If the usual and customary fee is less than the copayment amount, the member must pay the amount of the service.

(B) Copayments consist of the following:

(1) $2 for each prescription for drugs covered by MassHealth (whether legend or nonlegend), including the original prescription and all refills; and

(2) $3 for nonemergency services covered by MassHealth provided in a hospital emergency department. (See 130 CMR 450.118 for a discussion of payment for hospital emergency department services for members who are enrolled with a MassHealth managed-care provider.)

(C) The following are excluded from the copayment requirement described in 130 CMR 450.130(B):

(1) MassHealth members who have not reached their 19th birthday;

(2) MassHealth members who are pregnant;

(3) MassHealth members who are in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15, she is exempt from the copayment requirement until August 1);

(4) MassHealth Limited members;

(5) MassHealth Senior Buy-In members or MassHealth Standard members for Medicare-covered drugs only, when provided by a Medicare-certified provider;

(6) MassHealth members who are inpatients in hospitals, nursing facilities, chronic-disease or rehabilitation hospitals, and intermediate-care facilities for the mentally retarded;

(7) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;

(8) emergency services;

(9) hospice-care services; and

(10) persons receiving medical services through the EAEDC Program pursuant to 130 CMR 450.106, if they do not receive MassHealth Basic or MassHealth Standard.

(D) Pharmacies and hospital emergency departments must post a notice in a conspicuous area that specifies the exclusions from the copayment requirement listed in 130 CMR 450.130(C), and that instructs members to inform providers if members believe they are excluded from the copayment requirement.

(E) A member must pay the copayment described in 130 CMR 450.130(B) at the time service is provided unless exempted by 130 CMR 450.130(C) or unless the member claims inability to make the copayment at the time service is provided. The member's inability to make the copayment at the time service is provided does not alleviate the member's liability for the copayment, and providers may bill the member for the copayment amount. The Division will deduct the amount of the copayment from the amount paid to the provider (whether or not the provider collects the copayment from the member), unless the member or service is exempt according to 130 CMR 450.130(C). Providers should not deduct the copayment amount from the amount claimed. Providers may not refuse services to any members who are unable to pay the copayment at the time service is provided.

(130 CMR 450.131 through 450.139 Reserved)

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

(A) Legal Basis.

(1) In accordance with federal law at 42 U.S.C. § 1396d(a)(4)(b) and (r) and 42 CFR 441.50, the Division has established a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for MassHealth Standard members under age 21 years, including those who are parents.

(2) Any MassHealth provider may deliver EPSDT services. However, in delivering well-child care, providers must follow the EPSDT Medical Protocol and Periodicity Schedule.

(3) EPSDT screening services include health, vision, dental, hearing, and immunization status screening services.

(4) The regulations governing the EPSDT program are set forth in 130 CMR 450.140 through 450.149.

(B) Program Objectives. The objectives of the EPSDT program are:

(1) to provide comprehensive and continuous health care designed to prevent illness and disability;

(2) to foster early detection and prompt treatment of health problems before they become chronic or cause irreversible damage;

(3) to create an awareness of the availability and value of preventive well-child care services; and

(4) to create an awareness of the services available under the EPSDT program, and where and how to obtain those services.

450.141: EPSDT Services: Definitions

EPSDT Medical Protocol and Periodicity Schedule (the Schedule) — a schedule (see Appendix W of all MassHealth provider manuals) developed and periodically updated by the Division in consultation with the Massachusetts Chapter of the American Academy of Pediatrics, Massachusetts Department of Public Health, dental professionals, the Massachusetts Health Quality Partners, and other organizations concerned with children's health. The Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Interperiodic Visit — the provision of screening procedures or treatment services at an age other than those indicated on the Schedule. Interperiodic visits may be:

(1) screenings that are medically necessary to determine the existence of a suspected illness or condition, or a change in or complication of a preexisting condition;

(2) the provision of the full-range of EPSDT screening services delivered at an age other than one listed on the Schedule to update the member's care according to the Schedule; or

(3) additional screening services provided to a member whose care is already up-to-date according to the Schedule.

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

450.142: EPSDT Services: Medical Protocol and Periodicity Schedule

(A) Screening Providers.

(1) Providers of screening services must follow the procedures listed in the Schedule in providing routine well-child care visits to members under age 21 years.

(2) The health assessments described in the Schedule are payable when provided by a physician or independent nurse practitioner, or by a nurse practitioner or physician's assistant under a physician's supervision.

(B) Explanation of Procedures.

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

(2) Explanation of procedures that must be maintained in the medical record to substantiate the performance of such procedures are provided in the Schedule.

450.143: EPSDT Services: Description of EPSDT Visits

(A) Initial EPSDT Visit.

(1) An initial EPSDT visit must be provided for every:

(a) new member;

(b) member previously seen only for sick care; and

(c) newborn previously seen only in the hospital.

(2) An initial EPSDT visit includes the recording of:

(a) family, medical, developmental, and immunization history;

(b) a review of all systems;

(c) a comprehensive physical examination; and

(d) all exams, assessments, screening, and laboratory work indicated on the Schedule as appropriate for the member's age.

(B) EPSDT Periodic Visit.

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

(2) A provider may claim payment for an EPSDT periodic visit only when all the screening procedures on the Schedule that correspond to the member's age have been delivered to the member.

(a) While the screening procedures are based upon a presumption of regular contact with health-care providers, many members will need additional screening procedures to bring them up-to-date.

(b) It is the provider's responsibility to provide those additional screening procedures necessary to bring the member up-to-date with his or her preventive health care according to the Schedule.

(3) If the provider is unequipped to perform a test (for example, if he or she does not have an audiometer and an audiometric test is required), the provider must make a screening referral to another provider. However, in every case, for the referring provider to claim payment for an EPSDT periodic visit:

(a) all required screening procedures must be performed; and

(b) the referring provider must receive and document all results in the member's medical record.

(C) EPSDT Interperiodic Visit. An EPSDT interperiodic visit is any visit not indicated on the Schedule. Such visits may be either:

(1) preventive health-care visits provided at an age or age interval not indicated on the Schedule; or

(2) a screening that is medically necessary to determine the existence of a suspected illness or condition, or a change in or complication of a preexisting condition.

450.144: EPSDT Services: Diagnosis and Treatment

(A) (1) EPSDT diagnosis and treatment services consist of all medically necessary services listed in §1905(a) of the Social Security Act (42 U.S.C. § 1396d(a) and (r)) that are:

(a) required to correct or improve conditions discovered as a result of a medical screening; and

(b) payable for MassHealth Standard members under age 21 years, if the service is determined by the Division to be medically necessary.

(2) To receive payment for any service described in 130 CMR 450.144(A)(1) that is not specifically included as a covered service under any MassHealth regulation, service code list, or contract, the requester must submit a request for prior authorization in accordance with 130 CMR 450.303. This request must include, without limitation, a letter and supporting documentation from a MassHealth enrolled physician or nurse practitioner documenting the medical need for the requested service. If the Division approves such a request for service for which there is no established payment rate, the Division will establish the appropriate payment rate for such service on an individual-consideration basis in accordance with 130 CMR 450.271.

(B) For any condition that requires further diagnosis or treatment after the periodic or interperiodic visit, the provider must inform the member how and where to obtain further diagnosis or treatment, and must either:

(1) request that the member return for another appointment as soon as possible; or

(2) make a referral as soon as the provider determines that a referral is needed.

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

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

450.145: EPSDT Services: Claims for Visits

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

(B) Periodic Visits.

(1) For each member from birth through two years of age, a provider may bill for only one periodic visit per age level listed in the Schedule.

(2) For each member aged two years through 20 years, a provider may bill for only one periodic visit every year.

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

(D) Newborn Visits. (Physician, Independent Nurse Practitioner, and Community Health Center Only)

(1) To be paid for an EPSDT periodic visit of a newborn, the provider must have visited the newborn at least twice before the newborn leaves the hospital.

(a) The first visit, for an initial history and physical examination, is payable as newborn care and not as an EPSDT periodic visit.

(b) The second visit, for a discharge history, physical examination, and all other screens required for the newborn, is payable as an EPSDT periodic visit.

(2) Additional hospital visits for ill newborns are payable according to the service codes and descriptions for hospital visits.

(3) The newborn EPSDT periodic visit may occur at the provider's office if the infant's length of stay in the hospital is not long enough for the provider to visit the infant twice before the infant is discharged from the hospital.

(E) Reporting Requirement. To claim payment for an EPSDT periodic visit, a provider must submit a completed claim according to the billing instructions in Subchapter 5 of his or her MassHealth provider manual.

450.146: EPSDT Services: Claims for Laboratory Services (Physician, Independent Nurse Practitioner, and Community Health Center Only)

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

450.147: EPSDT Services: Claims for Audiometric Hearing and Titmus Vision Tests (Physician, Independent Nurse Practitioner, and Community Health Center Only)

Payments for the audiometric hearing test and the Titmus vision test, which are both included in the Schedule, are not included in the fee for an initial or periodic visit. Payment for these tests may be claimed separately.

450.148: EPSDT Services: Payment for Transportation

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

450.149: EPSDT Services: Recordkeeping Requirements

(A) Medical Records.

(1) A provider must create and maintain a record for every member receiving EPSDT services, in accordance with Division regulations governing medical records at 130 CMR 450.205.

(2) In addition, the medical record for each member receiving EPSDT services must contain documentation of the screening procedures listed in the Schedule as well as the following:

(a) the results of all laboratory tests;

(b) the name of each referral provider; and

(c) the results of any component of the Schedule that wasdelivered by another provider.

(B) Determination of Compliance with Medical Standards. The Division may review the medical records of members receiving EPSDT services to determine the necessity and quality of the medical services provided. Any such determinations will be made in accordance with 130 CMR 450.206.

450.150: Preventive Pediatric Health-Care Screening and Diagnosis Services for Certain MassHealth Members

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

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

(1) In delivering preventive pediatric health-care screening and diagnosis services, providers must:

(a) follow the procedures listed in the Schedule; and

(b) comply with the regulations at 130 CMR 140.141, 140.142, 140.143, 140.145, 140.146, 140.147, and 140.149.

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

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

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

(130 CMR 450.151 through 450.199 Reserved)

This page is reserved.

450.200: Conflict Between Regulations and Contracts

If the Division's regulations about payment methods and conditions of provider participation conflict with a provider contract, such contract will supersede the regulation, unless the contract expressly states otherwise.

450.201: Choice of Provider

Pursuant to federal regulations set forth in 42 CFR 431.51, members have the right to choose providers from whom they may obtain medical services with certain exceptions that are specified in the Division's regulations, including, but not limited to, 130 CMR 450.117(B) and 450.316. However, a member's right to choose a provider does not permit or require payment by the Division to any person or institution not eligible for such payment under the Division's regulations in effect at the time a medical service is provided.

450.202: Nondiscrimination

(A) M.G.L. c. 151B, § 4, clause 10 prohibits discrimination against any individual who is a recipient of federal, state, or local public assistance, including MassHealth, because the individual is such a recipient or because of any requirement of such an assistance program. Accordingly, except as specifically permitted or required by regulations relative to institutional providers, no provider may deny any medical service to a member eligible for such service unless the provider would, at the same time and under similar circumstances, deny the same service to a patient who is not a MassHealth member (for example, no new patients are being accepted, or the provider does not provide the desired service to any patient). A provider may not specify a particular setting for the provision of services to a member that is not also specified for nonmembers in similar circumstances.

(B) No provider may engage in any practice, with respect to any member, that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80 (relative to discrimination on account of race, color, or national origin), 45 CFR Part 84 (relative to discrimination against handicapped persons), and 45 CFR Part 90 (relative to age discrimination).

(C) Violations of 130 CMR 450.202(A) and (B) may result in administrative action, referral to the Massachusetts Commission Against Discrimination, or referral to the U.S. Department of Health and Human Services, or any combination of these.

450.203: Payment in Full

(A) Federal and state laws require that participation in MassHealth be limited to providers who agree to accept, as payment in full, the amounts paid in accordance with the applicable fees and rates or amounts established under a provider contract or regulations applicable to MassHealth payment (see 42 CFR 447.15, M.G.L. c. 118E, § 36, and M.G.L. c. 118G, § 7). No provider may solicit, charge, receive, or accept any money, gift, or other consideration from a member, or from any other person, for any item or medical service for which payment is available under MassHealth, in addition to, instead of, or as an advance or deposit against the amounts paid or payable by the Division for such item or service, except to the extent that the Division's regulations specifically require or permit contribution or supplementation by the member or by a health insurer.

(B) If the provider receives payment from a member for any service payable under MassHealth without knowing that the member was a MassHealth member at the time the service was provided, the provider must, upon learning that the individual is a MassHealth member, immediately return all sums solicited, charged, received, or accepted with respect to such service.

450.204: Medical Necessity

The Division will not pay a provider for services that are not medically necessary; and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

(A) A service is "medically necessary" if:
(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the Division. Services that are less costly to the Division include, but are not limited to, health care reasonably known by the provider, or identified by the Division pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.

(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the Division upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the Division.

(D) Additional requirements about the medical necessity of acute inpatient hospital admissions are contained in 130 CMR 415.414.

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

450.205: Recordkeeping and Disclosure

(A) The Division will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. All providers must keep such records, including medical records, as are necessary to disclose fully the extent and medical necessity of services provided to, or prescribed for, members and must provide to the Division and the Attorney General's Medicaid Fraud Control Unit on request such information and any other information about payments claimed by the provider for providing services (see 42 U.S.C. 1396a(a)(27) and the regulations thereunder).

(B) All providers must maintain complete patient account records. Patient account records must include complete documentation of charges, indicate the date and amount of all debit and credit transactions, and support the appropriateness of the amounts billed and paid. Institutional providers must, in addition, provide on request all records maintained by or within the institution about services provided to members by other providers. Pharmacy providers must, in addition, keep photocopies of the temporary MassHealth cards referenced when filling prescriptions, if applicable, and must produce a copy of the card on request.

(C) A provider must maintain and disclose any and all financial, statistical, and other information as may be required by the Division, the Attorney General's Medicaid Fraud Control Unit, or DHCFP. The required information must include, but is not limited to, ownership and licensure information, cost reports, charge books, audited financial statements, financial records, federal and state tax returns, invoices, general ledgers, trial balances, remittance advices, and explanations of benefits from health insurers and managed care organizations. Such records and documents must be provided within the time period specified by the Division, the Attorney General's Medicaid Fraud Control Unit, or DHCFP.

(D) All records, including but not limited to those containing signatures of medical professionals authorizing services, such as prescriptions, must, at a minimum, be legible and comply with generally accepted standards for recordkeeping within the applicable provider type as they may be found in laws, rules, and regulations of the relevant board of registration, professional treatises, and guidelines and other information published, adopted, or promulgated by state or national professional organizations and societies. All accounting records must be maintained in accordance with generally accepted accounting principles. In those instances where MassHealth regulations identify specific recordkeeping requirements for particular types of providers, such regulations constitute an additional standard against which the adequacy of records will be measured for the purposes of 130 CMR 450.205. In no instance will the completion of the appropriate MassHealth claim, the maintenance of a copy of such claim, or the simple notation of service codes constitute sufficient documentation for the purpose of 130 CMR 450.205.

(E) The records and information required to be maintained or disclosed under 130 CMR 450.000 include only those that relate in any manner to services provided to or prescribed for members, provided, however, that disclosure may not be refused on the ground that such records are commingled with records related to persons who are not members. Such records and information must be made available to the Division and the Attorney General's Medicaid Fraud Control Unit for examination or copying during reasonable office hours at the provider's place of business or record depository. Alternatively, the Division and the Attorney General's Medicaid Fraud Control Unit may each require that the provider submit copies of such records and information.

(F) Notwithstanding any regulatory or contractual provisions that may provide for a shorter retention period, all records described in 130 CMR 450.204 and 450.205 must be kept for at least six years after the date of medical services for which claims are made or the date services were prescribed, or for such length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever period is longer. Providers must retain records to substantiate costs listed on a cost report for at least six years following the date of filing of the cost report or for such length of time as may be required by DCHFP regulations, whichever period is longer. In no event may any provider destroy any records while any review, audit, or administrative or judicial action involving such records is pending.

(G) In cases where audits or other reviews reveal provider noncompliance with 130 CMR 450.204 and 450.205, the Division may seek to pursue recovery of overpayments and to impose sanctions in accordance with the provisions of 130 CMR 450.000.

(H) (1) The provider, as holder of personal data under M.G.L. c 66A, must comply with all regulatory and statutory requirements applicable to such a holder, including those set forth in M.G.L. c. 66A, and must inform each of its employees having access to such personal data of such requirements and ensure compliance by each employee with such requirements.
(2) The provider must take reasonable steps to ensure the physical security of personal data under its control including, but not limited to:
(a) fire protection;
(b) protection against smoke and water damage;
(c) alarm systems;
(d) locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data;
(e) passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; and
(f) limited access to input and output documents.

450.206: Determination of Compliance with Medical Standards

Violations of 130 CMR 450.204 may be determined by peer review. Except as otherwise required by law, the Division will decide the level and manner of peer review in each instance. Such peer review may be conducted by a qualified Division employee or consultant or by one or more qualified persons provided by health-care foundations, professional societies, or such other professional organizations as the Division may select. In appropriate cases, the Division may rely in part or in whole upon reviews conducted by a utilization and quality-control review organization or a board of registration. In the event that the Division decides to pursue any sanction or recovery of overpayment as a result of a peer-review recommendation, the provisions of 130 CMR 450.235 through 450.260 apply.

450.207: Utilization Management Program for Acute Inpatient Hospitals

(A) Introduction. 130 CMR 450.207 through 450.209 describes the Utilization Management Program for acute inpatient hospitals. The purpose of this program is to ensure that certain medical services for which the Division pays are medically necessary and provided in the appropriate setting. To this end, the Division conducts reviews before elective admissions (admission screening) and after discharge but before payment (prepayment review). The Division also conducts utilization reviews of inpatient admissions and outpatient services on a postpayment basis pursuant to 130 CMR 450.237. The term "admitting provider" as used in 130 CMR 450.207 through 130 CMR 450.209 refers to the provider (for example, physician or dentist) who admits the member to the facility and who assumes primary responsibility for the member's care and the admitting provider's designee, where appropriate. The requirements of the Utilization Management Program detailed in 130 CMR 450.207 through 450.209 apply to both in-state and out-of-state hospitals.

(B) General Provisions.

(1) Appendix. The Division has issued an appendix to the provider manual for each facility and admitting provider affected by the Utilization Management Program. This appendix contains a list of information the admitting provider must provide for each review, and the name, address, and telephone number of the Division's agent for the Utilization Management Program.

(2) Stipulations. The Utilization Management Program does not waive or replace any other Division requirements, such as prior-authorization or consent-form requirements.

(3) Payment Restrictions.

(a) The Division will pay the acute inpatient hospital for services subject to the Utilization Management Program only if the admitting provider has complied with the requirements in 130 CMR 450.207 through 450.209 and the service is medically or administratively necessary.

(b) Payments are subject to all general conditions and restrictions of MassHealth.

(c) A provider may not bill the member for any medical care for which the Division has denied payment due to the provider's failure to comply with the requirements of the Utilization Management Program.

(4) Exceptions. Proposed admissions of the following members, are exempt from the requirements of the Utilization Management Program, regardless of admitting diagnosis:

(a) members whose hospitalization is court-ordered;

(b) recipients of the EAEDC Program; and

(c) members for whom MassHealth is not the primary payer of the acute inpatient admission, including but not limited to members covered by an MCO, commercial insurance, or Medicare. However, if the primary payer denies coverage before the member is admitted or if the member has Medicare Part B only, the admission of the member is not exempt from the requirements of the Utilization Management Program.

450.208: Utilization Management: Admission Screening for Acute Inpatient Hospitals

(A) Requirements.

(1) The Division conducts admission screening on elective admissions only. The admitting provider must telephone or fax the Division at least seven calendar days before a proposed elective admission and provide the information specified in the appendix described in 130 CMR 450.207(B). When the admitting provider cannot notify the Division within seven calendar days, the admitting provider must notify the Division prior to the elective admission, and no later than 5:00 P.M. on the first day after the decision to admit. The provider must explain to the Division why the seven-calendar-day notice requirement was not met. If the Division cannot complete the admission-screening process before the scheduled elective admission, when neither the admitting provider nor the acute inpatient hospital has informed the Division at least seven calendar days before the admission was scheduled, the provider may be required to reschedule the admission.

(2) Providers must notify the Division of any changes in an approved elective admission as soon as those changes are known, but in any event, before the admission occurs. The Division will deny payment if a service or procedure that is provided is not what was proposed and approved, and such procedure, service, or admission is not medically necessary.

(3) For postponed admissions, the admitting provider must contact the Division and provide updated information no later than 5:00 P.M. on the second business day following the originally planned admission date.

(B) Notice of Admission Screening Decisions. The Division will send written notice of its decisions to the admitting provider, PCC (if applicable), acute inpatient hospital, and member.

(C) Appeal of Admission Screening Decisions.

(1) If the Division determines that an acute inpatient hospital admission is not medically necessary, the admitting provider or the PCC may request a review of the determination. Such a request must be made in writing and received by the Division within seven calendar days after the date of the determination notice. This written request must include all documentation that the provider believes is pertinent for a second review.

(2) Providers or members may appeal the Division's decision to deny an elective admission by requesting a hearing before the Division's Board of Hearings. Provider hearings are governed by the Division's regulations at 130 CMR 450.241 through 450.248. Member hearings are governed by the Division's regulations at 130 CMR 610.000. Neither providers nor members are required to exhaust any other appeal rights before requesting a hearing on an admission screening decision.

(D) Requesting Reconsideration. If the Division denies payment for a claim because the admitting provider did not comply with the requirements of 130 CMR 450.208(A), the admitting provider or hospital may request reconsideration of the Division's decision by contacting the Division in writing within 30 calendar days after the date of the remittance advice on which the claim is denied. The Division will process the claim only if the admitting provider or acute inpatient hospital demonstrates that:

(1) the admission was exempt for one of the reasons described in 130 CMR 450.207(B)(4);

(2) the admitting provider, despite reasonable, good-faith efforts to identify all third-party payment sources, was unaware that the patient was a MassHealth member; or

(3) the admitting provider complied with all requirements of 130 CMR 450.208(A).

450.209: Utilization Management: Prepayment Review for Acute Inpatient Hospitals

(A) Introduction.

(1) The Division conducts prepayment reviews to evaluate acute inpatient hospital admissions for:

(a) medical necessity, including, but not limited to, the appropriateness of the inpatient admission and any services;

(b) the stability of the member at the time of discharge;

(c) the quality of care provided; and

(d) compliance with the Division's billing procedures and requirements.

(2) The Division will identify each admission to be reviewed by mailing to the acute inpatient hospital a request for selected medical records.

(B) Submission Requirements and Time Frames.

(1) The acute inpatient hospital must submit the requested medical records to the Division. Such medical records must be received by the Division within 17 calendar days of the date appearing on the request. If the hospital fails to timely submit the records, the Division will deny payment for the admission.

(2) If the Division concludes that the records submitted are incomplete, it will inform the acute inpatient hospital in writing. The hospital must submit the documents that were missing from the medical record or records to the Division. Such documents must be received by the Division within 17 calendar days of the date appearing on the Division's notice requesting such information. If the hospital fails to timely submit the documents to complete the medical record, the Division will deny payment for the admission.

(3) The acute inpatient hospital may request reconsideration of any denials issued in accordance with 130 CMR 450.209(B)(1) or (2). Such a request must be made in writing and received by the Division within 33 calendar days of the date appearing on the denial notice, and must include the complete medical record or records. If the hospital requests reconsideration pursuant to 130 CMR 450.209(B)(3), the Division will review the medical record or records and notify the hospital of the determination. If the hospital does not timely request reconsideration, the denial issued pursuant to 130 CMR 450.209(B)(1) or (2) constitutes the Division's final action, and the hospital will have no right to an adjudicatory hearing pursuant to 130 CMR 450.209(C)(3), because of its failure to exhaust its administrative remedies.

(C) Determination of Noncompliance.

(1) Division's Determination. If, based on its review of the information submitted in accordance with 130 CMR 450.209(B), the Division determines that an acute hospital inpatient admission was not medically necessary, the Division will deny payment for the admission. The hospital may rebill for medically necessary services as an outpatient claim pursuant to 130 CMR 415.414. If, based on its review, the Division determines that the admission was medically necessary but the hospital has failed to comply with the Division's billing procedures and requirements, the Division will deny the claim. In such a case, the hospital may rebill the claim pursuant to the proper billing requirements.

(2) Requesting Reconsideration.

(a) The acute inpatient hospital must request reconsideration of any denial issued in accordance with 130 CMR 450.209(C)(1) in order to be entitled to file a claim for an adjudicatory hearing pursuant to 130 CMR 450.241. Such reconsideration request must be made in writing and received by the Division within 33 calendar days of the date appearing on the denial notice, and must include the following:

(i) a written statement from a physician explaining why the Division's denial was in error. Such explanation must specifically address all clinical issues cited in the Division's denial and must not consist solely of the resubmission of previously submitted documents;

(ii) a certification from the acute inpatient hospital's Utilization Review Department (URD) that it has reviewed the medical record or records and believes that both the treatment delivered and the inpatient admission were in compliance with all Division regulations about the medical or administrative necessity of the admission, treatment, and continued stay of that patient; and

(iii) if the Division's denial indicates that any service should have been delivered as an outpatient service, the physician statement and URD certification must explain why this would have been contrary to accepted standards of medical practice.

(b) If the hospital does not submit a request for reconsideration, the denial issued pursuant to 130 CMR 450.209(C)(1) constitutes the Division's final action. If the hospital requests reconsideration but fails to timely comply with the requirements of 130 CMR 450.209(C)(2)(a), the reconsideration request will be summarily denied. In either case, the Division's denial constitutes the Division's final action, and the hospital has no right to an adjudicatory hearing pursuant to 130 CMR 450.209(C)(3) because of its failure to exhaust its administrative remedies.

(3) Division's Final Determination. The Division will review a request for reconsideration and accompanying material submitted in compliance with the requirements of 130 CMR 450.209(C)(2) and will issue a final determination based on such review. The determination will be in writing, state the reasons for the determination, and inform the acute inpatient hospital of its right to file a claim for an adjudicatory hearing in accordance with 130 CMR 450.241. The claim will be decided by the Division's Board of Hearings in accordance with 130 CMR 450.241 through 450.248.

(D) Resubmission of Claim after Denial or Pending Review. If the acute inpatient hospital resubmits an inpatient claim for payment that, pursuant to 130 CMR 450.209, has either been denied or is pending review, and if that resubmitted claim is paid by the Division, the Division will void the payment of the claim when it becomes aware of the resubmission. The hospital may file a claim for an adjudicatory hearing pursuant to 130 CMR 450.241 and 450.243 through 450.248 to contest the voiding of the payment.

(130 CMR 450.210 and 450.211 Reserved)

450.212: Provider Eligibility: Eligibility Criteria

(A) To be eligible to participate in MassHealth as any provider type, a provider must:
(1) meet all statutory requirements applicable to such provider type;
(2) meet all conditions of participation applicable to such provider type under Titles XVIII and XIX of the Social Security Act and regulations promulgated thereunder;
(3) meet all conditions of participation applicable to such provider type. Program regulations applicable to specific provider types appear in 130 CMR 400.000 through 499.000;
(4) be fully licensed, certified, or registered as an active practitioner by the agency or board overseeing the specific provider type;
(5) be registered with appropriate state and federal agencies to prescribe controlled substances, for any provider type that is legally authorized to write prescriptions for medications and biologicals;
(6) never have been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency or board, including but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, or remedial training or other educational or public service activities; and
(7) if the provider is a group practice, ensure that all individual practitioners comprising the group obtain an individual MassHealth provider number, and meet all the requirements of 130 CMR 450.212(A)(1) through (A)(6). In addition, for a group practice to participate in MassHealth, it must file with the Division a group practice provider application, and meet all of the following requirements.
(a) It must be a recognized legal entity (for example, partnership, corporation, or trust). A sole proprietorship may not be a group practice.
(b) It must satisfy at least one of the following:
(i) all of the beneficial interest in the group practice must be held by individual practitioners who are members of the group practice serviced by the group practice; or
(ii) all members of the group practice must be employees or contractors of the group practice.
(c) It must not be currently or have previously been suspended from MassHealth participation due to violations of applicable laws, rules, or regulations or have common parties in interest with any provider that is currently under suspension or has been suspended, if such common parties in interest own 50 percent or more of the beneficial interest in both the applicant and the suspended group practice.

(B) A provider who does not meet the requirements of 130 CMR 450.212(A)(6) may, at the Division's discretion, participate in MassHealth only if, in the judgment of the Division, such participation would neither:
(1) threaten the health, welfare, or safety of members; nor
(2) compromise the integrity of MassHealth.

(C) A provider who does not meet the requirements of 130 CMR 450.212(A) is not entitled to a hearing on the issue of eligibility.

(D) A Qualified Medicare Beneficiaries (QMB)-only provider is a provider who provides medical services only to those MassHealth members who are MassHealth Senior Buy-In members described in 130 CMR 450.105(D) and certain MassHealth Standard members described in 130 CMR 450.105(A), and submits claims only for the benefits described in 130 CMR 450.105(D). QMB-only providers are subject to all regulations pertaining to providers participating in MassHealth except as provided in 130 CMR 450.212(D)(1) through (3) or as otherwise specified in 130 CMR 450.000.

(1) QMB-only providers may not bill for medical services other than those specified in 130 CMR 507.500(B)

(2) QMB-only providers may bill for providing benefits specified in 130 CMR 507.500(B) whether or not the associated medical services are specified in 130 CMR 400.000 through 499.000.

(3) QMB-only providers may bill only for benefits pertaining to medical services that are payable under Title XVIII of the Social Security Act ("Medicare").

(E) All individual practitioners comprising the group and the group practice entity shall be jointly and severally liable for any overpayments owed and subject to sanctions imposed as a result of any violation of any statute or regulation committed by the individual practitioner that provided the service.

450.213: Provider Eligibility: Termination of Participation for Ineligibility

When a provider fails or ceases to meet any one or more of the eligibility criteria applicable to such provider, the provider's participation in MassHealth may be terminated, subject to 130 CMR 450.212(B) and 450.216. If such termination is based upon a finding, ruling, decision, or order, notification, or statement of any nature (including an agreement with the provider) by any federal, state, or quasi-public board, department (other than the Division), or other agency that revokes, voids, suspends, or denies the issuance, renewal, or extension of a license, certificate, or other statement of qualification that constitutes a statutory prerequisite or other eligibility criterion, or that takes any action of the nature set forth in 130 CMR 450.212(A)(6), the correctness or validity of the action taken by the issuing agency will be presumed, the termination will be effective as of the earliest date on which the provider failed or ceased to meet any of such criteria, and the Division will not afford a hearing as to the correctness or validity of such action. If such termination is based solely upon a determination of ineligibility by the Division, the provider will be afforded notice and an opportunity for hearing in substantially the manner set forth in 130 CMR 450.241 through 450.248, and any termination will be effective as of the date of receipt of notice thereof.

450.214: Provider Eligibility: Suspension of Participation Pursuant to U.S. Department of Health and Human Services Order

When a provider is the subject of a notice by the U.S. Department of Health and Human Services (DHHS) requiring the provider's suspension or the denial, termination, or refusal to renew a provider contract pursuant to §1902(a)(39) (42 U.S.C. 1396a(a)(39)) or any other section of the Social Security Act, the provider's participation in MassHealth will be suspended or its provider contract will be denied, terminated, or not renewed in accordance with the DHHS notice; subject, however, to the provisions of 130 CMR 450.216. The Division will not afford a hearing to the provider as to the correctness or validity of the action taken by DHHS.

450.215: Provider Eligibility: Notification of Potential Changes in Eligibility

(A) The provider must notify the Division in writing, within 14 days of receipt, of any written communication from an issuing agency that expresses an intention, conditionally or otherwise, to alter, revoke, void, suspend, or deny the issuance, renewal, or extension of any license, certificate, or other statement of qualification that constitutes a provider eligibility criterion, or take any action of the nature set forth in 130 CMR 450.212(A)(6).

(B) The provider must notify the Division in writing, within 14 days of sending to an issuing agency, of any communication that expresses an intention or desire to register as an inactive practitioner, resign, surrender, terminate, or substantially modify the conditions of any such license, certificate, or other statement of qualification that constitutes a provider eligibility criterion.

(C) Without limiting the generality of 130 CMR 450.215(A), the provider must notify the Division in accordance with 130 CMR 450.215(A) and (B) whenever the provider:

(1) has received notice of denial of Medicare or Medicaid certification from the Massachusetts Department of Public Health;
(2) has received notice of a denial of an application for renewal of a license;
(3) has filed application with the Department of Public Health to convert from nursing facility to rest home status;
(4) has received an order to show cause from a board of registration; or
(5) becomes subject to any action of the nature set forth in 130 CMR 450.212(A)(6).

450.216: Provider Eligibility: Limitations on Participation

If termination or suspension of a provider's participation in MassHealth has occurred or is imminent, the Division will take such action as may be reasonably necessary or appropriate to prevent or to mitigate injury to members or MassHealth or both, resulting from such termination or suspension. Such action may be taken immediately upon notice to the provider notwithstanding the exercise of such rights as the provider may have to secure administrative or judicial review of the action of the issuing agency, or of the U.S. Department of Health and Human Services, or of the Division, or any combination of them. With respect to chronic disease and rehabilitation hospitals and other long-term-care facilities, such action may include an order barring further admissions of members pending final resolution of the issues that prompted such action, or an order that the institution will continue to be paid by the Division, for a period specified in the order, for services to members admitted to the facility prior to an order barring new admissions, or prior to such termination. Such action will be reasonably calculated to achieve, so far as possible, the following goals:

(A) protecting the health and safety of members, including present and prospective patients of the provider; and

(B) maximizing federal financial participation in the cost of medical assistance.

450.217: Provider Eligibility: Ineligibility of Suspended Providers

A provider suspended from participation in MassHealth is not eligible to participate during the period of such suspension and until such time as a new application is filed and the provider contract is effective. If the violations resulted in overpayments, the Division may deny the participation of such provider until such time as arrangements satisfactory to the Division have been made for the restitution of all overpayments.

(130 CMR 450.218 through 450.220 Reserved)

450.221: Provider Contract: Definitions

(A) Defined Terms. For the purposes of 130 CMR 450.222 through 450.228, the following words and expressions have the indicated definitions. These definitions as they are applied in 130 CMR 450.222 through 450.228 are adopted pursuant to the provisions of 42 U.S.C. §§ 1320a-3, 1320a-5, 1396a(a)(38), 1396b(i)(2), and regulations at 42 CFR 455.100 et seq.

(1) Agent – any person who has been delegated the authority to obligate or act on behalf of a provider.

(2) Convicted – a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

(3) Disclosing Entity – a provider or fiscal agent.

(4) Other Disclosing Entity – any other disclosing entity and any entity that does not participate in MassHealth, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act. This includes:

(a) any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or managed care organization that participates in Medicare;

(b) any Medicare intermediary or carrier; and

(c) any entity (other than an individual practitioner or group practice that provides, or arranges for the provision of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Social Security Act).

(5) Fiscal Agent – a contractor that processes or pays for provider claims on behalf of the Division.

(6) Indirect Ownership Interest – an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

(7) Managing Employee – a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

(8) Ownership Interest – the possession of equity in the capital, the stock, or the profits of the disclosing entity.

(9) Person with an Ownership or Control Interest –

(a) a person or corporation that:

(i) has an ownership interest totaling 5 percent or more in a disclosing entity;

(ii) has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(iii) has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(iv) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(v) is an officer or director of a disclosing entity that is organized as a corporation;

(vi) is a partner in a disclosing entity that is organized as a partnership; or

(vii) owns directly or indirectly an interest of five percent or more in any real property leased to a disclosing entity for use as a nursing facility, rest home, or hospital.

(b) For the purpose of this definition, an individual is deemed to own any beneficial interest owned directly or indirectly by or for his or her minor children or spouse.

(10) Significant Business Transaction – any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or five percent of a provider's total operating expenses.

(11) Secretary – the Secretary of the U.S. Department of Health and Human Services or any successor agency.

(12) Subcontractor –

(a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the MassHealth agreement.

(13) Supplier – an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under MassHealth (for example, a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

(14) Wholly Owned Supplier – a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

(B) Determination of Ownership or Control Percentages. For the purposes of the definitions in 130 CMR 450.221(A), ownership or control percentages will be determined as follows.

(1) Indirect Ownership Interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an eight-percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns five percent of the stock of the disclosing entity, B's interest equates to a four-percent indirect ownership interest in the disclosing entity and need not be reported.

(2) Person with an Ownership or Control Interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to six percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to four percent and need not be reported.

450.222: Provider Contract: Application for Contract

A person or entity may become a participating provider only by submitting an Application for Provider Contract. If approved by the Division, the application will be part of any subsequent provider contract between the applicant and the Division. Any omission or misstatement in the application will (without limiting any other penalties or sanctions resulting therefrom) render such contract voidable by the Division.

450.223: Provider Contract: Execution of Contract

(A) If the provider applicant has filed a complete and properly executed application and meets all applicable provider eligibility criteria and nothing in the application or any other information in the possession of the Division reveals any bar or hindrance to the participation of the provider applicant, the Division will prepare and furnish a provider contract. When fully executed by the provider and the Division, the contract will take effect as of the effective date determined by the Division.

(B) Each MassHealth provider must notify the Division in writing within 14 days of any change in any of the information submitted in the application. Failure to do so constitutes a breach of the provider contract. In no event may a group practice file a claim for services provided by an individual practitioner until the individual practitioner is enrolled and approved by the Division as a member of the group. At its discretion, the Division may require a provider to recertify, at reasonable intervals, the continued accuracy and completeness of the information contained in the provider's application.

(C) The following provisions are a part of every provider contract whether or not they are included verbatim or specifically incorporated by reference. By executing any such contract, the provider agrees

(1) to comply with all laws, rules, and regulations governing MassHealth (see M.G.L. c. 118E, § 36).

(2) that the submission of any claim by or on behalf of the provider constitutes a certification (whether or not such certification is reproduced on the claim form) that:

(a) the medical services for which payment is claimed were provided in accordance with 130 CMR 450.301;

(b) the medical services for which payment is claimed were actually provided to the person identified as the member at the time and in the manner stated;

(c) the payment claimed does not exceed the maximum amount payable in accordance with the applicable fees and rates or amounts established under a provider contract or regulations applicable to MassHealth payment;

(d) the payment claimed will be accepted as full payment for the medical services for which payment is claimed, except to the extent that the regulations specifically require or permit contribution or supplementation by the member;

(e) the information submitted in, with, or in support of the claim is true, accurate, and complete; and

(f) the medical services were provided in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

(3) to keep for such period as may be required by 130 CMR 450.205 such records as are necessary to disclose fully the extent and medical necessity of services provided to or prescribed for members and on request to provide the Division or the Attorney General's Medicaid Fraud Control Unit with such information and any other information regarding payments claimed by the provider for providing services (see 42 U.S.C. 1396a(a)(27) and the regulations thereunder).

(4) that the contract may be terminated by the Division if the provider fails or ceases to satisfy all applicable criteria for eligibility as a participating provider.

(5) to submit, within 35 days after the date of a request by the Secretary or the Division, full and complete information about:

(a) the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request;

(b) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request; and

(c) any information necessary to update fully and accurately any information that the provider has previously delivered to the Division or to the Massachusetts Department of Public Health.

(6) the Division may recoup any sums payable by reason of a retroactive rate increase for any period during which the provider owned or operated part or all of a facility against any sums due the Division by reason of a retroactive rate decrease for any periods.

(D) The provider may terminate a provider contract only by written notice to the Division and such termination shall be effective no earlier than 30 days after the date on which the Division actually receives such notice, unless the Division explicitly specifies or agrees to an earlier effective date. Any provision allowing for termination upon written notice shall not constitute the Division's specification of or agreement to an earlier effective date.

(E) The provisions of 130 CMR 450.222 and 450.223 apply to any provider contract made on or after the effective date of 130 CMR 450.000, including any extension or renewal of a provider contract made prior to such effective date.

450.224: Provider Contract: Exclusion and Ineligibility of Convicted Parties

The Division may terminate, or refuse to enter into or to renew a provider contract if:

(A) the provider, any party in interest in such provider, an agent or managing employee of such provider, or in the case of a group practice, any individual practitioner enrolled as a member of the group, has been convicted of a criminal offense relating to that person's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act, or of a crime of such a nature that, in the judgment of the Division, the participation of such provider will compromise the integrity of MassHealth; or

(B) the provider or an individual practitioner enrolled as a member of a group practice has been a party in interest, a managing employee, or an agent of a provider that has been convicted of a criminal offense relating to that person's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act, or of a crime of such a nature that, in the judgment of the Division, the participation of such provider will compromise the integrity of MassHealth.

(130 CMR 450.225 Reserved)

450.226: Provider Contract: Issuance of Provider Numbers

(A) Upon execution of the provider contract, the Division will issue a provider number or numbers to be used to identify the provider that is the subject of the contract.

(B) For every case in which a provider is assigned two or more provider numbers, the provider must use each provider number only in conjunction with the facility or location to which the number is assigned. The Division, however, maintains its right to commence proceedings in accordance with the provisions of 130 CMR 450.234 through 450.248 against any or all of its provider numbers, regardless of the location or facility where the violation has been alleged to have occurred or the overpayment received.

450.227: Provider Contract: Termination or Disapproval

The Division may at its discretion disapprove a provider contract, and may terminate an existing contract, if the provider fails to disclose any information in accordance with the provisions of 130 CMR 450.222, 130 CMR 450.223, or 42 CFR 420.205.

(130 CMR 450.228 through 450.230 Reserved)

450.231: General Conditions of Payments

(A) Except to the extent otherwise permitted by state or federal regulations, no provider is entitled to any payment from MassHealth unless on the date of service the provider was a participating provider and the person receiving the services was a member.

(B) The "date of service" is the date on which a medical service is provided to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers to a member medical goods that had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date before the final delivery of the goods, the Division will pay the provider for the goods only under the following circumstances:

(1) the member must have been eligible for MassHealth on the date of the member's last visit with the provider before the provider orders or fabricates the goods;
(2) the date on which the provider orders or fabricates the goods occurs no later than seven days after the last visit;
(3) the provider has submitted documentation with the claim to the Division that verifies both the date of the member's last visit that occurred before the provider ordered or fabricated the goods and the date on which the goods were actually ordered or fabricated;
(4) the provider must not have accepted any payment from the member for the goods except copayments as provided in 130 CMR 450.130; and
(5) the provider must have attempted to deliver the goods to the member.

(C) For the purposes of 130 CMR 450.231, a provider who directly services the member and who also produces the goods for delivery to the member has "fabricated" an item if the provider has taken the first substantial step necessary to initiate the production process after the conclusion of all necessary member visits.

(D) A provider is responsible for verifying a member's eligibility status on a daily basis, including but not limited to members who are hospitalized or institutionalized. In order to receive MassHealth payment for a covered medical service, the person receiving such service must be eligible for MassHealth coverage on the date of service and the provider must comply with any service authorization requirements and all other conditions of payment. A provider's failure to verify a member's MassHealth status before providing services to the member may result in nonpayment of such services. For payment for services provided before a member's MassHealth eligibility determination, see 130 CMR 450.311. For payment to out-of-state providers providing services on an emergency basis, see 130 CMR 450.312.

(E) Payments to QMB-only providers as defined in 130 CMR 450.212(D) for covered services described in 130 CMR 450.105(D) for MassHealth Senior Buy-in members and 130 CMR 450.105(A) for MassHealth Standard members may be made upon the Division's receipt of a claim for payment within the time limitations set forth in provisions, regulations, or rules under Title XVIII of the Social Security Act. QMB-only providers are not required to be registered as such with the Division as of the date the medical services were delivered, but are required to sign a QMB-only provider contract with the Division or become a participating provider in MassHealth before receiving payment for such claim.

450.232: Rates of Payment to In-State Providers

Payment to all providers is made in accordance with the payment methodology applicable to the provider, subject to federal payment limitations. Without limiting the generality of the foregoing, payment to a Massachusetts in-state noninstitutional provider for any medical services payable under MassHealth is made in accordance with the applicable payment methodology established by DHCFP, or the Division, subject to any applicable federal payment limit (see 42 CFR 447.304).

450.233: Rates of Payment to Out-of-State Providers

(A) Payment to an out-of-state institutional provider for any medical service payable under MassHealth is made by the Division at the lesser of:

(1) the rate of payment established for the medical service under the other state's Medicaid program;

(2) the MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or

(3) the MassHealth rate of payment established for a comparable provider in Massachusetts.

(B) An out-of-state institutional provider must submit to the Division a copy of the applicable rate schedule under its state's Medicaid program.

(C) Payment to an out-of-state noninstitutional provider for any medical service payable under MassHealth is made in accordance with the applicable fee schedule established by DHCFP or the Division, subject to any applicable federal payment limit (see 42 CFR 447.304).

(130 CMR 450.234 Reserved)

450.235: Overpayments

Overpayments include, but are not limited to, payments to a provider:

(A) for services that were not actually provided or that were provided to a person who was not a member on the date of service;

(B) for services that were not payable under MassHealth on the date of service, including services that were payable only when provided by a different provider type and services that were not medically necessary (as defined in 130 CMR 450.204);

(C) in excess of the maximum amount properly payable for the service provided, to the extent of such excess;

(D) for services for which payment has been or should be received from health insurers, worker's compensation insurers, other third-party payers, or members;

(E) for services for which a provider has failed to make, maintain, or produce such records, prescriptions, and other documentary evidence as required by applicable federal and state laws and regulations and contracts;

(F) for services provided when, as of the date of service, the provider was not a participating provider, or was in any breach or default of the provider contract; or

(G) for services billed that result in a duplicate payment.

450.236: Overpayments: Calculation by Sampling

In any action or administrative proceeding to determine or recover overpayments, the Division may ascertain the amount of overpayments by reviewing a representative sample drawn from the total number of claims paid to a provider during a given period and extrapolating the results of the review over the entire period. The Division employs statistically valid techniques in establishing the size and distribution of the sample to ensure that it is a valid and representative sample.

450.237: Overpayments: Determination

The existence and amount of overpayment may be determined in an action to recover the overpayment in any court having jurisdiction. The Division may also determine the existence and amount of overpayments. The procedures described in 130 CMR 450.236 and 450.237 do not apply to overpayments resulting from rate adjustments, which are governed by methods described in 130 CMR 450.259.

(A) Overpayment Notice. When the Division believes that an overpayment has been made, the Division notifies the provider in writing of the facts upon which the Division bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. The Division may notify the provider by letter, draft audit report, computer printout, or other format.

(B) Timely Reply. To preserve its right to an adjudicatory hearing and judicial review, the provider must reply in writing to the Division and such reply must be received by the Division within 30 calendar days of the date on the overpayment notice. The reply must specifically identify and address all allegations in the overpayment notice with which the provider disagrees. With the reply, the provider may submit additional data and argument to support its claim for payment and must include any documentary evidence it wants the Division to consider.

(C) Overpayment Determination. The Division considers and reviews only information submitted with a timely reply. If, after reviewing the provider's reply, the Division determines that the provider has been overpaid, the Division will so notify the provider in writing of its final determination, which will state the amount of overpayment that the Division will recover from the provider.

(D) Adjudicatory Hearing. If the provider submits a timely reply, the provider may claim an adjudicatory hearing to appeal the Division's final determination, in accordance with 130 CMR 450.241 and 450.243.

(E) Consequences of Failure to Submit a Timely Reply. The provider has no right to an adjudicatory hearing if it fails to submit a timely reply. The Division will take appropriate action to recover the overpayment.

450.238: Sanctions: General

(A) Introduction. All providers are subject to the rules, regulations, standards, and laws governing MassHealth. The regulations at 130 CMR 450.238 through 450.240 set forth the Division's procedures for imposing sanctions for violations of those rules, regulations, standards, and laws. Such sanctions may include, but are not limited to, administrative fines and suspension or termination from participation in MassHealth. The Division determines the amount of any fine and may take into account the particular circumstances of the violation. The Division may assess an administrative fine whether or not overpayments have been identified based on the same set of facts.

(B) Instances of Violation. Instances of violation include, but are not limited to:
(1) billing a member for services that are payable under MassHealth, except copayments as provided in 130 CMR 450.130;
(2) submitting claims under an individual provider's MassHealth provider number for services for which the provider is entitled to payment from an employer or under a contract or other agreement;
(3) billing the Division for services provided by someone other than the provider, unless expressly permitted by the applicable regulations;

(4) billing the Division before delivery of service, unless permitted by the applicable regulations;
(5) failing to comply with recordkeeping and disclosure requirements;
(6) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more comprehensive service for which a single rate of payment is established;
(7) failing to return credit balance funds to the Division within 60 days of their receipt;
(8) failing to obtain or provide a physician's order, prescription, or referral when required by the applicable regulations;
(9) failing to comply with MassHealth enrollment, licensure, or certification requirements; and
(10) misapplication or misappropriation of personal needs allowance funds.

450.239: Sanctions: Calculation of Administrative Fine

(A) The Division may assess an administrative fine not to exceed the greater of:
(1) $100 for each instance of violation of the rules, regulations, standards, or laws governing MassHealth;
(2) $100 for each day of violation of the rules, regulations, standards, or laws governing MassHealth; or
(3) three times the payable amount of each claim, in accordance with 130 CMR 450.239.

(B) In determining the amount of any administrative fine, the Division considers the following factors:
(1) Nature and Circumstances of the Claim. The Division considers the circumstances to be mitigating if the violations were of the same type and occurred within a short period of time; there were only a few such instances; there was no history of similar types of violations; and the total monetary value of these instances was less than $1,000. Conversely, the Division considers the circumstances to be aggravating if the violations were of a single type or several types and occurred over a lengthy period of time; there were many such instances; there was a history of similar types of violations; and the total monetary value of these instances was $1,000 or more.
(2) Prior Offenses. The Division may consider the circumstances to be aggravating if the provider previously had been held liable for criminal, civil, or administrative sanctions relating to MassHealth.
(3) Financial Condition and Member-Access Considerations. The Division considers the circumstances to be mitigating if the imposition of a full penalty will jeopardize the ability of the provider to continue as a health-care provider and if the provider's inability to continue as a health-care provider would result in a demonstrable access problem for members in the provider's geographic region. The provider has the burden of demonstrating such access problem.
(4) Other Factors. The Division will consider other mitigating or aggravating circumstances. If there are substantial mitigating circumstances, the Division will decrease the administrative fine to be assessed. Conversely, if there are substantial aggravating circumstances, the Division will increase the administrative fine to be assessed.

450.240: Sanctions: Determination

(A) Sanction Notice. When the Division believes that sanctions should be imposed, the Division will notify the provider in writing of the alleged violations and the proposed sanctions. The notice will be sufficiently detailed to reasonably inform the provider of the acts that the Division alleges constitute such violations.

(B) Suspension or Termination upon Sanction Notice. If the Division seeks to suspend or terminate a provider's participation in MassHealth and finds, on the basis of information it has before it that a provider's continued participation during the pendency of the administrative process could reasonably be expected to endanger the health, safety, or welfare of its members or compromise the integrity of MassHealth, it may suspend or terminate participation at the same time the sanction notice described in 130 CMR 450.240(A) is sent to the provider. Said suspension or termination will remain in effect until either the Division, pursuant to 130 CMR 450.240(D), issues a final determination removing or revising said suspension or termination, or the commissioner, pursuant to 130 CMR 450.248 issues a final agency decision removing or revising said suspension or termination.

(C) Timely Reply. To preserve its right to an adjudicatory hearing and judicial review, the provider must reply in writing to the Division and such reply must be received by the Division within 30 calendar days of the date on the sanction notice. The reply must specifically identify and address all allegations in the sanction notice with which the provider disagrees and explain any objections to the proposed sanctions. The provider must also include any additional documentary evidence it wants the Division to consider.

(D) Sanction Determination. The Division will consider and review only information submitted with a timely reply. If, after reviewing the provider's reply, the Division determines that sanctions should be imposed because the provider has committed one or more violations of any rule, regulation, standard, or law governing MassHealth, the Division will notify the provider in writing of its final determination, which will state any sanctions that the Division will impose against the provider.

(E) Adjudicatory Hearing. If the provider submits a timely reply, the provider may claim an adjudicatory hearing to appeal the Division's final determination, in accordance with 130 CMR 450.241 and 450.243. The Division may amend or supplement the sanction notice at any time before the commencement of an adjudicatory hearing as long as any additional findings have been identified in a notice or amended notice. Once an adjudicatory hearing has commenced, the hearing officer may permit amendment of the sanction determination upon proper motion by the Division and will permit amendment, where necessary, to conform the sanction determination to the evidence.

(F) Consequences of Failure to Submit a Timely Reply. The provider has no right to an adjudicatory hearing if it fails to submit a timely reply. The Division will take appropriate action to implement the proposed sanctions.

450.241: Hearings: Claim for an Adjudicatory Hearing

A provider may challenge the findings set forth in the Division's final determination, issued pursuant to 130 CMR 450.209(C)(3), 450.237(C), or 450.240(D), by filing a claim for an adjudicatory hearing (claim) with the Board of Hearings and the Division within 30 calendar days of the date on the final determination, pursuant to 130 CMR 450.243. A claim is filed on the date actually received by both the Board of Hearings and the Division. Failure to file a timely claim will result in implementation of the action identified in the final determination.

450.242: Hearings: Stay of Suspension or Termination

A timely claim will stay any suspension or termination described in the final determination until there has been a final agency action pursuant to 130 CMR 450.243(D) or 450.248; provided, however, that if the Division finds on the basis of information it has before it that a provider's continued participation in MassHealth during the pendency of the administrative appeal could reasonably be expected to endanger the health, safety, or welfare of members or compromise the integrity of MassHealth, suspension or termination will not be stayed. A timely claim will not stay any withholding of payments under 130 CMR 450.249.

450.243: Hearings: Consideration of a Claim for an Adjudicatory Hearing

(A) A timely claim must specifically identify each issue and fact in dispute and state the provider's position, the pertinent facts to be adduced at the hearing, and the reasons supporting that position.

(B) If a matter has been referred to or is under investigation by the Attorney General's Medicaid Fraud Control Unit or other criminal investigation agency, or if a question of quality of care has been referred to a professional licensing board for investigation, the Division may postpone the hearing until the conclusion of such investigation and the final disposition of any criminal complaint, indictment, or order to show cause that ensues.

(C) The Board of Hearings will grant a hearing only if the claimant demonstrates all of the following.

(1) The claim was filed within the time limits set forth in 130 CMR 450.241.
(2) There is a genuine and material issue of adjudicative fact for resolution.
(3) The factual issues can be resolved by available and specifically identified reliable evidence as set forth in M.G.L. c. 30A, § 11(2). A hearing will not be granted on the basis of general allegations or denials or general descriptions of positions and contentions.
(4) The allegations of the provider, if established, would be sufficient to resolve a factual dispute in the manner urged by the provider. A hearing will not be granted if the provider's submissions are insufficient to justify the factual determination urged, even if accurate.
(5) Resolution of the factual dispute in the way sought by the provider is relevant to and would support the relief sought.

(D) Failure to comply with the conditions set forth in 130 CMR 450.243(C) will result in dismissal of the claim. Dismissal of a claim is a final agency action reviewable pursuant to M.G.L. c. 30A.

(E) Notwithstanding 130 CMR 450.243(C) and (D), if there is no issue of adjudicative fact, but the provider has challenged the Division's interpretation or application of regulations or laws, argument concerning such challenges will be presented in memoranda and briefs.

450.244: Hearings: Authority of the Hearing Officer

The hearing officer will not render a decision about the legality of federal or state laws, including, but not limited to the Division's regulations. If the legality of such law or regulation is raised by the provider, the hearing officer will render a decision based on the applicable law as interpreted by the Division. Such decision will include a statement that the hearing officer cannot rule on the legality of such law or regulation and will be subject to judicial review in accordance with M.G.L. c. 30A.

450.245: Hearings: Burden of Proof

The provider has the burden of establishing by a preponderance of the evidence that the provider has complied with the MassHealth requirements cited in the Division's final determination or otherwise has correctly received, or is entitled to receive, any amounts in dispute.

450.246: Hearings: Procedure

The hearing will be conducted in accordance with M.G.L. c. 30A, §§ 9, 10, and 11, and the formal rules of the Standard Rules of Practice and Procedure found at 801 CMR 1.00, 1.01, and 1.03, as modified or supplemented by 130 CMR 450.000.

450.247: Hearings: Hearing Officer's Decision

The hearing officer's decision will be in the form of a proposed decision to the commissioner. The proposed decision may affirm, modify, or overturn the actions proposed in the Division's final determination. The proposed decision will include a determination of the amount of overpayments, if overpayments have been alleged, and a statement of reasons for the decision, including determination of each issue of fact or law necessary to the decision. If the provider makes a written request for the proposed decision prior to its issuance, the Board of Hearings will notify the provider by mail of the proposed decision. The decision of the hearing officer will be effective when and to the extent it is adopted by the commissioner.

450.248: Commissioner's Decision

If the provider has made a written request for a copy of the proposed decision prior to its issuance, the provider has seven calendar days from its receipt of the proposed decision to file written objections with the commissioner. The commissioner may adopt or modify the proposed decision, or return the matter to the hearing officer for further consideration, based on evidence already in the record or, if necessary, additional evidence to be included in the reopened record. The hearing officer will resubmit the proposed decision to the commissioner, as modified pursuant to 130 CMR 450.247 and 450.248. The provider will be notified of the commissioner's action. When the commissioner has adopted or modified the proposed decision, the commissioner's decision is a final agency action reviewable pursuant to M.G.L. c. 30A.

450.249: Withholding of Payments

(A) Introduction. The term "withholding of payments" or "withholding payments" as used in 130 CMR 450.249 means the withholding of all or a portion of payments payable to a provider. While withholding payments, the Division will continue to process the provider's claims. To avoid rejection of otherwise proper claims because of late submission, a provider whose payments are being withheld must continue to submit timely claims.

(B) Withholding Payments from Providers. Upon written notice to the provider, the Division may withhold payments to a provider, or any provider under common ownership (defined the same as "provider under common ownership" in 130 CMR 450.101), if the Division believes that the provider has received any overpayments or committed any violations. The notice will state the effective date of the withholding, the amount being withheld, and the reason for the withholding. The withholding of payments will expire 90 calendar days after the date withholding begins (or 120 calendar days in the case of a withholding initiated at the request of the Attorney General's Medicaid Fraud Control Unit) unless the Division has sent the provider an overpayment or sanction notice pursuant to 130 CMR 450.237 or 450.240. The withholding of payments will continue until the entitlement to the withheld funds and the amount of overpayment or administrative fines has been finally adjudicated and all due amounts have been recovered.

(C) Withholding Payments from Providers Withdrawing from MassHealth.

(1) The Division may withhold payments from a provider, or from any providers under common ownership, at any time following receipt by the Division of notification of the provider's intention to close or to withdraw from MassHealth. The Division may withhold such payments whenever the Division reasonably believes that there may be an outstanding issue, claim, or adjustment in connection with or incident to any payment to the provider. Such payment may be withheld regardless of whether the outstanding issue, claim, or adjustment is related to that payment. Circumstances in which there may be an outstanding issue, claim, or adjustment include, without limitation:

(a) an outstanding provider cost report;
(b) an anticipated or pending audit or utilization review;
(c) a rate decrease or other payment adjustment; or
(d) an outstanding or incomplete payment reconciliation.

(2) The Division will notify the provider in writing of the date of the withholding, the amount withheld, and the reason for the withholding. The withholding of payments under 130 CMR 450.249(C) will continue until the provider's entitlement to the withheld funds, and all outstanding issues, claims, or adjustments in connection with or incident to the payments to the provider, have been finally adjudicated or otherwise finally resolved. During the period the Division withholds payments under 130 CMR 450.249(C), the Division may recoup or offset all or part of the withheld funds for repayment by the provider of any liability incurred due to a rate decrease, any recoupment account balance owed, or any other debt, liability, or account balance owed by the provider.

(D) Federal Orders to Withhold Payments. If the Division receives notice from the U.S. Department of Health and Human Services of an order for suspension of payments to a provider under 42 U.S.C. § 1396m or any other section of the Social Security Act, the Division will withhold payments otherwise due the provider in accordance with the terms of the notice. The Division will promptly notify the provider of such action and the reason for it. The Division will take such other action as may be necessary or appropriate to ameliorate the effect of actions taken under 130 CMR 450.249(D) on members and on MassHealth, including action similar to that described in 130 CMR 450.216. The withholding of payments will continue until the underlying Department of Health and Human Services order is rescinded, or becomes final and unappealable, at which time apportionment of the withheld amounts between the Division and the provider will be made.

(130 CMR 450.250 through 450.258 Reserved)

450.259: Overpayments Attributable to Rate Adjustments

(A) Whenever an overpayment occurs due to a rate adjustment that is certified by DHCFP or otherwise established by the Division in accordance with applicable law, the Division will notify the provider in writing by issuing a remittance advice identifying the impact of the rate adjustment on all previously paid claims and stating the amount of the overpayment.

(B) A provider must pay to the Division the full amount of any overpayment attributable to a rate adjustment within 30 calendar days after the date of issuance of a remittance advice under 130 CMR 450.259(A), unless the provider enters into a payment arrangement with the Division under 130 CMR 450.260(H).

(C) If a provider disputes the Division's computation of an overpayment attributable to a rate adjustment, the provider must submit proposed corrections, including a detailed explanation, in writing to the Division within 30 calendar days after the date of issuance of the remittance advice under 130 CMR 450.259(A). The fact that any rate adjustment certified by DHCFP is under appeal will not be considered a factor in determining the amount of liability. The fact that a provider has submitted proposed corrections to the Division will not delay or suspend the provider's payment obligations set forth under 130 CMR 450.259(B).

(D) If proposed corrections are timely submitted in accordance with 130 CMR 450.259(C), the Division will review the proposed corrections and notify the provider of its decision within 30 calendar days of receipt of the provider's corrections. If the Division determines that corrections are required, the Division will make any appropriate payment adjustments reflecting the corrections.

(E) A provider must pay the Division the full amount of the overpayment stated in a remittance advice under 130 CMR 450.259(A), regardless of any pending appeal, action, or other proceeding contesting the overpayment, including but not limited to, any appeal, action, or other proceeding contesting any rate on which the overpayment is computed. If required by a final disposition of any such appeal, action, or proceeding, the Division will issue a revised remittance advice and will make any appropriate payment adjustments to effect the final disposition.

450.260: Monies Owed by Providers

(A) Provider Liability. A provider is liable for the prompt payment to the Division of the full amount of any overpayments, or other monies owed under 130 CMR 450.000 et seq, or under any other applicable law or regulation. A provider that is a group practice is liable for any overpayments owed and subject to sanctions imposed as a result of any violation of any statute or regulation committed by the individual practitioner that provided the service.

(B) Ownership Liability. Any owner of an institutional provider is liable for the monetary liability of the institutional provider under 130 CMR 450.260(A) to the extent of the owner's ownership interest. For purposes of 130 CMR 450.260, an "owner" is a person or entity having an ownership interest in an institutional provider, as such interest is defined in 130 CMR 450.221(A)(9)(a), (b), (c), or (f). An "institutional provider" is any provider that provides nursing facility services, or acute, chronic, or rehabilitation hospital services.

(C) Common Ownership Liability. Any two or more providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or otherwise, are jointly and severally liable for each of their obligations to pay the full amount of any monies owed under 130 CMR 450.260(A).

(D) Successor Liability. Any successor owner of a provider is liable for the obligation of any prior owner to pay the full amount of any monies owed by the prior owner under 130 CMR 450.260(A). For purposes of 130 CMR 450.260, a “successor owner” is any successor owner, operator, or holder of any right to operate all or a part of the prior owner’s health-care business, which includes, but is not limited to, the business management, personnel, physical location, assets, or general business operations. A successor owner of a nursing facility, or acute, chronic, psychiatric, or rehabilitation hospital includes any successor owner or holder of a license to operate all or some of the beds of a nursing facility, or acute, chronic, psychiatric, or rehabilitation hospital.

(E) Group Practice Liability. The individual practitioner who provided the service and the group practice will be jointly and severally liable for each of their obligations to pay the full amount of any monies owed under 130 CMR 450.260.

(F) Recoupment. If a provider fails to pay the full amount of any monies owed under 130 CMR 450.260(A), the Division may recoup up to 100 percent of any and all payments to the provider, without further notice or demand, until such time as the full amount of any monies owed under 130 CMR 450.260(A) is paid in full.

(G) Set-Off. The Division may apply a set-off against payments to a provider in the following circumstances.

(1) Providers Under Common Ownership. Whenever any monies are owed by a provider under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to any providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or otherwise, without further notice or demand, until such time as the full amount of the monies owed under 130 CMR 450.260(A) is repaid in full.

(2) Successors. Upon the sale or transfer of all or part of a provider, the Division may set off up to 100 percent of any and all payments to any successor owner, without further notice or demand, until such time as the full amount of any monies owed by any prior owner under 130 CMR 450.260(A) is repaid in full.

(3) Group Practices. Whenever monies are owed by a group practice under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to the individual practitioner who provided the service, without further notice or demand, until such time as the full amount of any monies owed by the group practice under 130 CMR 450.260(A) is repaid in full. Whenever monies are owed by an individual practitioner who is a member of a group practice under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to the group practice, without further notice or demand, until such time as the full amount of any monies owed by the individual practitioner under 130 CMR 450.260(A) is repaid in full.

(H) Payment Arrangements. At its discretion, the Division may enter into a written arrangement with a provider, its owner, any provider under common ownership, or any successor owner to establish a schedule to pay to the Division the full amount of any monies owed, on such terms as are acceptable to the Division. The arrangement may provide for such guarantees or collateral as may be acceptable to the Division to secure the payment schedule.

(I) Court Action. The Division may recover the full amount of any monies owed to the Division under 130 CMR 450.260(A) by commencing an action in any court of competent jurisdiction. Such action may be commenced against any parties described under 130 CMR 450.260.

(J) Joint and Several Obligations. All obligations of any parties described under 130 CMR 450.260, are joint and several.

450.261: Member and Provider Fraud

All members and providers must comply with all federal and state laws and regulations prohibiting fraudulent acts and false reporting, specifically including but not limited to 42 U.S.C. 1320a-7b.

(130 CMR 450.262 through 450.270 Reserved)

450.271: Individual Consideration

(A) The Division may identify certain services as requiring individual consideration (I.C.) in program regulations, associated lists of service codes and service descriptions, billing instructions, provider bulletins, and other written issuances from the Division. For services requiring individual consideration, the Division will establish the appropriate amount of payment based on the standards and criteria set forth in 130 CMR 450.271(B). Providers claiming payment for any I.C.-designated service must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that shall minimally include where applicable, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The Division does not pay claims for "I.C." services unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim.

(B) The Division determines the appropriate payment for an I.C. service in accordance with the following standards and criteria:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the member's disease, disorder, or disability;
(4) any applicable relative-value studies; and
(5) any complications or other circumstances that the Division deems relevant.

(130 CMR 450.272 through 450.274 Reserved)

450.275: Teaching Physicians: Documentation Requirements

In order to be paid for physician services provided in a teaching setting, physicians must comply with the following documentation requirements.

(A) Definitions. Whenever one of the following terms is used in 130 CMR 450.275, it will have the meaning given in the definition, unless the context clearly requires a different meaning.

(1) Resident — an individual who participates in an approved Graduate Medical Education (GME) program, including interns and fellows. A medical student is never considered a resident.

(2) Teaching Physician — a physician (not a resident) who involves residents in the care of his or her patients. Where applicable and appropriate, the use of the phrase "teaching physician" will be construed to include teaching podiatrists and teaching dentists.

(3) Teaching Setting — a setting in which there is an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

(B) General Requirements.

(1) Under MassHealth, the Division will pay for physician services (which are otherwise payable) furnished in teaching settings only if documentation in the patient's medical record clearly substantiates that the key portions of the services are personally provided by a teaching physician, or the key portions of the services, which include decision-making processes, are provided jointly by a teaching physician and resident, or by a resident in the presence of a teaching physician. (The teaching physician must determine which portions of the service or procedure are to be considered key and require his or her presence.) Any contribution of a medical student to the performance of a service or procedure must be performed in the physical presence of a teaching physician, or jointly with a resident.

(2) The teaching physician may not bill for the supervision of residents. The Division reimburses for this through its GME reimbursement.

(3) The teaching physician may not bill for services provided solely by residents.

(C) Documentation.

(1) The teaching physician and resident are each responsible for documenting in the medical record his or her own level of involvement in the services. Documentation by the resident alone is not acceptable. In all cases, the teaching physician must personally document his or her presence and participation in the services in the medical record. This documentation by the teaching physician may either be in writing or via a dictated note, and may include references to notes entered by the resident.

(2) If the teaching physician would be repeating key elements of the service components previously documented by the resident (for example, the patient's complete history and physical examination), the teaching physician need not repeat the documentation of these components in detail. In these circumstances, the teaching physician's documentation may be brief, summary comments that reflect the resident's entry and that confirm or revise the key elements identified.

(D) Covered Services. The Division will pay for medical services (including, but not limited to, evaluation and management services, surgery services, anesthesia services, and radiology services) performed in a teaching setting if the following requirements are met, in addition to the general requirements in 130 CMR 450.275(A) through (C):

(1) Exceptions to Physical-Presence Requirement. For certain services (general/internal medicine, pediatric, obstetric/gynecologic, and psychiatric), the teaching physician does not have to be physically present for the key portions of the service. (Refer to Appendix K of the *Physician Manual* for a listing of the service codes for which this exception to the physical presence requirement applies.) (This exception does not apply when an acute hospital outpatient department (OPD) is designated as a primary care clinician (PCC) plan practice with unrestricted member enrollment.)

(2) Services Paid on the Basis of Time. For services paid on the basis of time (excluding anesthesia and those psychiatric services listed in Appendix K of the *Physician Manual*), the teaching physician must be present for the period of time for which the claim is made. Time spent by the resident in the absence of the teaching physician may not be added to time spent by the resident and teaching physician with the member, or time spent by the teaching physician alone with the member. For example, the Division will pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is present for 20 to 30 minutes.

(3) Medical Services. For medical services (including, but not limited to, evaluation and management services), the teaching physician may supervise up to four residents at any given time, and he or she must direct the care from such proximity as to constitute immediate physical availability.

(4) Surgery Services. For surgery services, the teaching physician is responsible for the preoperative, intra-operative, and postoperative care of the member. The teaching physician must be scrubbed and physically present during the key portion of the surgical procedure. During the intra-operative period in which the teaching physician is not physically present, he or she must remain immediately available to return to the procedure, if necessary. He or she must not be involved in another procedure from which he or she cannot return. If the teaching physician leaves the operating room after the key portion(s) of the surgical procedure or during the closing of the surgical site to become involved in another surgical procedure, he or she must arrange for another teaching physician to be immediately available to intervene as needed. The designee must be a physician (excluding a resident) who is not involved in or immediately available for any other surgical procedure. The following guidelines apply to specific types of surgery and related services:

(a) Concurrent Surgeries. To be paid for concurrent surgeries, the teaching physician must be present during the key portions of both operations. Therefore, the key portions must not occur simultaneously. When all of the key portions of the first procedure have been completed, the teaching physician may initiate his or her involvement in a second procedure. The teaching physician must personally document the key portions of both procedures in his or her notes to demonstrate that he or she was immediately available to return to either procedure as needed.

(b) Straightforward or Low-complexity Procedures. The teaching physician must be present for the decision-making portions of straightforward or low-complexity procedures.

(c) Endoscopy Procedures. For procedures performed through an endoscope (other than endoscopic operations, when the endoscopy performed is not the key portion of the surgical procedure), the teaching physician must be present during the entire viewing. The entire viewing includes the period of insertion through removal of the device. Viewing of the entire procedure through a monitor in another room does not meet the teaching-physician-presence requirement.

(d) Obstetrics. To be paid for the procedure, the teaching physician must be present for the delivery. In situations in which the teaching physician's only involvement was at the time of delivery, he or she may bill for the delivery only. To be paid for the global procedures, the teaching physician must be physically present, in accordance with the general requirements above and applicable program requirements.

(5) Anesthesia Services. If a teaching anesthesiologist is involved in a procedure with a resident, or with a resident and a non-physician anesthetist, the teaching physician must be present for induction and emergence. For any other portion of the anesthesia service, the teaching physician must be immediately, physically available to return to the procedure, as needed. The documentation in the medical records must indicate the teaching anesthesiologist's presence and participation in the administration of the anesthesia.

(6) Radiology Services. The interpretation of diagnostic tests must be performed or reviewed by a teaching physician. If the teaching physician's signature is the only signature on the interpretation, this indicates that he or she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed both the image and the resident's interpretation and either agrees with or edits the findings. The teaching physician's countersignature alone is not acceptable documentation.

(130 CMR 450.276 through 450.300 Reserved)

450.301: Claims

(A) Except as provided in other program regulations, a claim for a medical service may be submitted only by the provider that provided the service. In the absence of a specific exception or qualification, 130 CMR 450.301(A) and (B) apply.

(1) An individual practitioner may not claim payment under his or her own name and provider number for services actually provided by another individual, whether or not the individual who provided the service is also a participating provider, or is an associate, partner, or employee of the individual practitioner.

(2) An individual practitioner may not claim payment under his or her own name and provider number for medical services provided by the individual practitioner and for which the practitioner is paid by another entity (for example, hospital, clinic, long-term-care facility, pharmacy, home health agency, health maintenance organization, community health center, psychiatric day treatment program, day habilitation center, and adult day care center). In such cases, payment may be claimed only by the institution or facility.

(B) A provider may submit claims only where:

(1) the payment for the services claimed is not otherwise claimed by any other MassHealth provider; and

(2) payment or any other compensation for the delivery of such services is not received by any provider from any other source.

450.302: Claim Submission

(A) Claims for payment may be submitted either electronically or on paper, as designated by the Division.

(B) All claims submitted by a group practice must clearly identify by provider number the individual practitioner who actually provided the services being claimed.

(C) A group practice may only submit claims for services provided by individual practitioners who are MassHealth providers and who have been enrolled and approved by the Division as a participant in the group.

450.303: Prior Authorization

In certain instances, the Division requires providers to obtain prior authorization to provide medical services. These instances are identified in the billing instructions, program regulations, associated lists of service codes and service descriptions, provider bulletins, and other written issuances from the Division. Such information, including but not limited to the MassHealth Drug List, may be available on the Division's Web site, and copies may be obtained upon request. The provider must submit all prior-authorization requests in accordance with the Division's instructions. Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment, such as member eligibility or resort to health-insurance payment.

(A) The Division acts on appropriately completed and submitted requests for prior authorization within the following time periods.

(1) For pharmacy services—by telephone or other telecommunication device within 24 hours of the request for prior authorization. The Division will authorize at least a 72-hour supply of a prescription drug to the extent required by federal law. (See 42 U.S.C. 1396r-8(d)(5).)

(2) For transportation to medical services—within seven calendar days after a request for service, or the number of days, if less than seven, necessary to avoid any serious and imminent risk to the health or safety of the member that might arise if the Division did not act before the full seven days have elapsed.

(3) For private duty nursing services—within 14 calendar days after a request for service.

(4) For durable medical equipment—within 15 calendar days after a request for service.

(5) For all other MassHealth services—within 21 calendar days after a request for service.

(B) The following rules apply for prior-authorization requests.

(1) The date of any prior-authorization request is the date the request is received by the Division, provided that the request conforms to all applicable submission requirements, including but not limited to form, the address to which the request is sent, and required documentation.

(2) If a provider submits a request that does not comply with all submission requirements, the Division will inform the provider:

(a) of the relevant requirements, including any applicable program regulations;

(b) that the Division will act on the request within the time limits specified in 130 CMR 450.303 if the required information is received by the Division within four calendar days after the request; and

(c) that if the required information is not submitted within four calendar days, the Division's decision may be delayed by the time elapsing between the four days and when the Division receives the necessary information.

(3) A service is authorized on the date the Division sends a notice of its decision to the member or someone acting on the member's behalf.

(C) The Division will not act on requests for prior authorization for:

(1) covered services that do not require prior authorization; or

(2) noncovered services, except to the extent that the Division's regulations specifically allow for prior-authorization requests.

450.304: Claim Submission: Signature Requirement

Every paper claim form submitted for payment must be signed by the provider that provided the service or the provider's agent on behalf of the provider that provided the service. A provider that accepts payment of a claim is presumed to have authorized the submission of the claim on his or her behalf.

(130 CMR 450.305 and 450.306 Reserved)

450.307: Unacceptable Billing Practices

(A) No provider may claim payment in a way that may result in payment that exceeds the maximum allowable amount payable for such service under the applicable payment method.

(B) Without limiting the generality of 130 CMR 450.307(A), the following billing practices are forbidden:

(1) duplicate billing, which includes the submission of multiple claims for the same service by the same provider or multiple providers;

(2) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more-comprehensive service for which a single rate of payment is established; and

(3) submitting claims under an individual practitioner's provider number for services for which the practitioner is otherwise entitled to compensation.

(130 CMR 450.308 Reserved)

450.309: Time Limitation on Submission of Claims: General Requirements

(A) In accordance with M.G.L. c. 118E, §38, all claims must be received by the Division within 90 days from the date of service or the date of the explanation of benefits from another insurer. When a service is provided continuously on consecutive dates, the date from which the 90-day deadline is measured is the latest date of service.

(B) For claims that are not submitted within the 90-day period but that meet one of the exceptions specified below, a provider must request a waiver of the billing deadline (a 90-day waiver) pursuant to the billing instructions provided by the Division. The exceptions are:

(1) A medical service was provided to a person who was not a member on the date of service, but was later enrolled as a member for a period that includes the date of service.

(2) a medical service was provided to a member who failed to inform the provider in a timely fashion of the member's eligibility for MassHealth.

(C) When a medical service was provided to a MassHealth member in another state by a provider that is not enrolled in MassHealth, the Division will consider a claim for such service to have been timely submitted if all of the following apply:

(1) the medical service was provided in accordance with 130 CMR 450.109;

(2) the provider submits an application to the Division to become a participating provider within 90 days after the date of service and the Division approves the application; and

(3) the provider submits the claim for payment within 90 days after the date of the notice from the Division approving the provider's application.

(130 CMR 450.310 through 450.312 Reserved)

450.313: Time Limitation on Submission of Claims: Claims for Members with Health Insurance

If a provider delays submitting a claim in order to bill a member's health insurer (see 130 CMR 450.316 through 450.318), the claim will have been timely submitted if it is received:

(A) no later than the 90th day after the date of the notice of final disposition by the health insurer (if more than one insurer is involved, the submission period will be measured from the latest final disposition, and the period for making requests will be measured from the date of the notice of final disposition from the previous insurer); and

(B) no later than 18 months after the date of service.

450.314: Final Deadline for Submission of Claims

(A) Where the Division has denied a claim that was initially submitted within the 90-day deadline, the provider may resubmit the claim with appropriate corrections or supporting information.

(B) The Division, pursuant to M.G.L. c. 118E, § 38, will not pay any claim submitted or resubmitted for services provided more than 12 months before the date of submission or resubmission, except as provided in 130 CMR 450.313 and 450.323.

(130 CMR 450.315 Reserved)

450.316: Third-Party Liability: Requirements

All resources available to a member, including but not limited to all health and casualty insurance, must be coordinated and applied to the cost of medical services provided by MassHealth (see 42 CFR Part 433, Subpart D). Except to the extent prohibited by 42 U.S.C. 1396a(a)25(E) or (F), all providers must make diligent efforts to obtain payment first from other resources, including personal injury protection (PIP) payments, so that the Division will be the payer of last resort. The Division will not pay a provider and will recover any payments to a provider if it determines that, among other things, the provider has not made such diligent efforts. Under no circumstances may a provider bill a member for any amount for a MassHealth-covered service, except as provided by 130 CMR 450.130.

(A) "Diligent efforts" is defined as making every effort to identify and obtain payment from all other liable parties, including insurers. Diligent efforts include, but are not limited to:

(1) determining the existence of health insurance by asking the member if he or she has other insurance and by using insurance databases available to the provider;

(2) verifying the member's other health insurance coverage, currently known to the Division through REVS on each date of service and at the time of billing;

(3) submitting claims to all insurers with the insurer's designated service code for the service provided;

(4) complying with the insurer's billing and authorization requirements;

(5) appealing a denied claim when the service is payable in whole or in part by an insurer; and

(6) returning any payment received from the Division after any available third-party resource has been identified. The provider must bill all available third-party resources before resubmitting a claim to the Division.

(B) The Division will deem that the provider did not exercise diligent efforts pursuant to 130 CMR 450.316(A) if the insurer denies payment due to the provider's

(1) noncompliance with the insurer's billing and authorization requirements, including but not limited to errors in submission, failure to obtain prior authorization, failure to submit appropriate documentation and billing, providing services outside the service network, or untimely billing;

(2) request or provocation of a denial; or

(3) appeal of an insurer's favorable coverage determination.

(C) Failure to comply with the provisions of 130 CMR 450.316(A) may subject a provider to sanctions and liability for overpayments as determined by the Division in accordance with 130 CMR 450.235 through 450.240.

(D) Unless otherwise permitted by regulation, a provider is not entitled to receive or retain any MassHealth payment for a service provided to a member, if on that date of service the member had other health insurance, including Medicare, that may have covered the service, and the provider did not participate in the member's other insurance plan.

(E) If at any time a provider learns of health insurance not identified by REVS, the provider must copy both sides of the member's insurance card(s), or otherwise record the member's MassHealth identification number, insurance carrier, policy number, group number, and effective date of coverage, then send this information to the Division.

(F) If a third-party resource is identified after the provider has already billed and received payment from the Division, the provider must promptly return any payment it received from the Division. The provider must bill all third-party resources before resubmitting a claim to the Division.

(G) If a member is covered by more than one health insurer, the provider must request payment from all of the insurers prior to submitting a claim to the Division.

450.317: Third-Party Liability: Payment Limitations on Claim Submission

(A) Subject to compliance with all conditions of payment, for members who have health insurance in addition to MassHealth, the Division's liability is the lesser of:

(1) the member's liability, including coinsurance, deductibles, and copayments; or

(2) the provider's charges or maximum allowable amount payable under the Division's payment methodology, whichever is less, minus the insurance payments and contractual adjustments. For the purposes of 130 CMR 450.317, a contractual adjustment is the amount established in an agreement with any third party to accept payment for less than the amount of charges.

(B) Third party payments include the contractual adjustments that the provider has received along with any other payments made on behalf of the member for medical expenses.

(C) Unless specifically provided for in law or by contract or interagency service agreement with the Division, the Division is not liable for payment of a service for which a member is not liable, including, without limitation, services available through an agency of the local, state, or federal government, or through a legally obligated person or entity.

(D) The Division will deny a claim for a service payable in whole or in part by one or more other insurers unless the claim is accompanied by a final disposition from each insurer.

450.318: Third-Party Liability: Medicare Crossovers

(A) A crossover is defined as a claim for a member who has Medicare in addition to MassHealth, where Medicare has made a payment or has approved an amount that was applied to the member's deductible.

(B) To obtain crossover payment, a provider must

(1) bill the Medicare fiscal intermediary or carrier, as applicable, in accordance with their billing rules, including using the appropriate Medicare claim form and format;

(2) accept assignment according to Medicare instructions; and

(3) follow the Division's billing instructions relating to crossover claims.

(C) The Division's crossover liability will not exceed
(1) the coinsurance and deductible amounts as reported on the explanation of benefits or remittance advice from Medicare;
(2) the Division's maximum allowed amount for the service;
(3) the Medicare approved amount; or
(4) the Division's established rate for crossover payment.

(130 CMR 450.319 and 450.320 Reserved)

450.321: Third-Party Liability: Waivers

The Division may waive any requirements of 130 CMR 450.316 through 450.318, as applied to any provider, to institute information-gathering projects and to evaluate methods of exercising the third-party liability recovery options described in 42 CFR 433.139. The Division will grant waivers only for projects that are likely to increase the efficient and economical collection of third-party resources and will state the extent of any waiver in the documents establishing such projects.

(130 CMR 450.322 Reserved)

450.323: Appeals of Erroneously Denied or Underpaid Claims

Pursuant to M.G.L. c. 118E, § 38, the Division has established the following procedures for appealing claims that the provider believes were denied in error or underpaid. The Division's Final Deadline Appeals Board has exclusive jurisdiction to review appeals submitted by providers of claims for payment that were, as a result of Division error, denied or underpaid, and that cannot otherwise be timely resubmitted.

(A) Criteria for Filing an Appeal. To file an appeal with the Division's Final Deadline Appeals Board, the provider must meet all of the following criteria.

(1) The provider must have submitted the original claim in a timely manner, pursuant to 130 CMR 450.309 through 450.314.

(2) The provider must have exhausted all available corrective actions outlined in the billing instructions provided by the Division.

(3) The date of service for which the appeal is submitted must exceed the filing time limit of 12 months, unless third-party insurance is involved, in which case the filing time limit is 18 months (the final billing deadline).

(4) Claims for dates of service more than 36 months after the date of service are not eligible for an appeal.

(5) The provider must file the appeal within 30 days after the date on the remittance advice that first denied the claim for exceeding the final billing deadline.

(6) The provider must demonstrate that the claim was, as a result of Division error, denied or underpaid.

(B) Accompanying Documentation. Along with each appeal of a claim, the provider must submit the following information to substantiate the contention that the claim was, because of Division error, denied or underpaid:

(1) a statement outlining the nature of the appeal;

(2) evidence of the claim's original, timely submission and resubmission, if applicable;

(3) a copy of the applicable page from each remittance advice on which the claim was previously processed;

(4) a copy of the remittance advice that indicates that the final billing deadline has passed;

(5) a statement describing the nature of the Division error that resulted in the denial or underpayment of the claim;

(6) a legible and accurately completed paper claim; and

(7) any other documentation supporting the appeal, including any correspondence from the Division.

(C) Procedure for Deciding Appeals. All appeals are decided by the Division's Final Deadline Appeals Board based upon written evidence submitted by the provider. The provider has the burden of establishing by a preponderance of the evidence that the claims appealed were denied or underpaid because of Division error.

(D) Request for an Adjudicatory Hearing. A provider may submit a request for an adjudicatory hearing with an administrative appeal if there is a dispute about a genuine issue of material fact. The request must include a statement indicating the specific reasons why a hearing should be conducted. The request must include the following information:

(1) a statement identifying the material facts in dispute;

(2) a summary of the evidence that the provider would offer at the hearing to support his or her contentions; and

(3) a statement explaining why the evidence could only be presented at a hearing.

(E) Notification of Approval or Denial of Request for an Adjudicatory Hearing.

(1) If the Final Deadline Appeals Board determines that a hearing is justified, the Division will notify the provider of:

(a) the issues of fact for which a hearing has been justified; and

(b) the identity of the person or entity designated by the Division to conduct the hearing.

(2) Any hearing hereunder, whether conducted by the Final Deadline Appeals Board or its designee, shall be conducted in accordance with the provisions of 130 CMR 450.244 through 450.248.

(3) If the Final Deadline Appeals Board determines that a hearing is not justified, the Division will notify the provider of the reasons why it decided not to hold a hearing.

(F) Decisions of the Final Deadline Appeals Board. The Final Deadline Appeals Board will review each appeal that is properly submitted and notify the provider in writing of its decision. The notification will include a brief statement of the reasons for its decision. The decision will be a final agency action, reviewable pursuant to M.G.L. c. 30A.

450.324: Payment of Claims

The Division will make payment checks or electronic transfers payable only to the provider, except as required by law or at the Division's discretion.

(130 CMR 450.325 through 450.330 Reserved)

450.331: Billing Agencies

(A) The Division will process claims that are submitted by a billing agency on behalf of a provider. At the written request of a provider, the Division may also mail payments and remittance advices to a billing agency, but such payments shall be payable to the provider only, and in no event be payable to the billing agency. The Division will not make payments to a billing agency.

(B) The Division recognizes a billing agency solely and strictly as the provider's agent. A billing agency is not a "provider." A provider's use of a billing agency does not relieve the provider of any responsibility imposed elsewhere in these regulations for the claims that the provider submits or that are submitted on the provider's behalf. Any provider that engages a billing agency for the preparation and submission of claims to the Division is fully responsible to the Division for all acts by such billing agent with actual or apparent authority to perform such acts, notwithstanding any contrary provisions in any agreement between the provider and the billing agency. In case of any violations of laws, rules, or regulations, or of the provider contract arising out of the acts of the billing agent, the provider will be fully liable as though they were the provider's own acts.

REGULATORY AUTHORITY

130 CMR 450.000: M.G.L. c. 118E, §§7 and 12.

Pediatric preventive health-care visits must:

- contain the components explained in the descriptions in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Protocol and Periodicity Schedule; and
- occur at the following frequency, at a minimum: one to two weeks; one month; two months; four months; six months; nine months; 12 months; 15 months; 18 months; and then every year until the member's 21st birthday.

Initial or Interval Health History

- Initial – An initial history must be taken at the first EPSDT visit delivered to a member by a provider. The initial health history includes the family health history and baseline data on the member including, but not limited to:
  (a) growth and developmental history;
  (b) immunization history;
  (c) known reactions to medications and allergies; and
  (d) pertinent information about previous illnesses and hospitalizations, risk-taking behaviors, such as drug, alcohol, and tobacco use, sexual activity, and other medical and psychosocial problems.
- Interval – An interval history must be taken at each periodic EPSDT visit. The interval history includes an update of the member's medical history including, but not limited to:
  (a) a review of all systems, and any illnesses, diseases, or medical problems experienced by the member since the last visit; and
  (b) an updated assessment of lifestyle, risk behavior, sexual activity, and psychosocial concerns.

Comprehensive Physical Examination – Each EPSDT visit must include an unclothed physical examination to include:

- height, weight, and head-circumference measurements: head-circumference measurements are required until age two years. Measurements through puberty must be plotted on appropriate growth charts;
- blood pressure at age three years and older;
- gross hearing screening up to age four years, including the member's response to sound as observed by both the provider and the member's parent or guardian;
- gross vision screening up to age three years, including evaluation of fixation preference, alignment, and eye disease by age six months, and reevaluation between ages three and four years.
- observation of the teeth and gums as appropriate.

Nutritional Assessment

- Each EPSDT visit must include the evaluation of the member's nutritional health, to include:
  (a) history;
  (b) diet history;
  (c) physical examination;
  (d) height and weight;
  (e) head-circumference measurements as appropriate; and
  (f) laboratory tests to screen for iron deficiency, if indicated.
- Providers must make every effort to inform the member or his or her parent or guardian about the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), if the provider believes the child may be eligible for WIC. A referral to WIC should be made using the WIC Medical Referral Form (MRF), which may be obtained from the Massachusetts WIC Program.
- The member or parent or guardian may also be referred to the Food Stamp Program, which is administered by the Department of Transitional Assistance.

Developmental and Behavioral Assessment

- At each EPSDT visit, the provider must screen the member for delays or differences in functioning in the following areas, as appropriate to the member's age:
  (a) physical development, including gross motor development (strength, balance, and locomotion), fine motor development (hand-eye coordination), and sexual development;
  (b) cognitive development, including self-help and self-care skills and cognitive skills (problem-solving and reasoning abilities);
  (c) language development, including expression, comprehension, and articulation; and
  (d) psychosocial and behavioral development, including an assessment of social integration and peer relations, behavioral difficulties, such as sleep disturbances and aggression, psychological problems, such as depression, risk-taking behavior, and school performance.
- Essential components of the screening process include, but are not limited to:
  (a) sensitive attention to parent or guardian concerns about the member;
  (b) thoughtful inquiry about parent or guardian observations;
  (c) observation by the provider and the member's parent or guardian about the member's behaviors;
  (d) examination of specific developmental attainments; and
  (e) observation of member and parent or guardian interaction.
- In performing the developmental and behavioral screening, the provider may utilize specific developmental and behavioral screening instruments including, but not limited to the:
  (a) Denver Prescreening Developmental Questionnaire;
  (b) Denver Developmental Screening Test II;
  (c) Early Language Milestone Scale;
  (d) Ages and Stages Questionnaire;
  (e) BRIGANCE screens;
  (f) Child Development Inventories;
  (g) Parents Evaluation of Developmental Status; and
  (h) Pediatric Symptom Checklist.
- Providers must make every effort to inform the member's parent or guardian about the availability of Early Intervention services, if the provider believes the member may be eligible for an early intervention program.
- The member or parent or guardian may also be referred to the Massachusetts Department of Education for special education services.
- Providers should inform the member or the member's parent or guardian about the availability of behavioral health treatment services for any child who may require behavioral health treatment.

Hearing Screening – An objective hearing screening must be performed by audiometric test by an audiometer at the following frequencies: 1,000 Hz, 2,000 Hz, and 4,000 Hz tones at 20 dB HL, at the following ages: four, five, six, eight, 10, 12, 15, and 18 years.

- If the objective hearing screen is performed in another setting, such as a school, the screening does not need to be repeated by the provider, but the findings must be documented in the member's medical record.
- If the provider receives notification of a missed or failed newborn hearing screen, then the provider should ensure that a new screening or diagnostic follow-up takes place. Providers should contact the Massachusetts Department of Public Health's Universal Newborn Hearing Screening Program for additional information on the newborn hearing screening.

Vision Screening – An objective vision screening must be performed by the Snellen chart, Titmus machine, or equivalent, at the following ages: three, four, five, six, eight, 10, 12, 15, and 18 years.

- Other screens, such as the Tumbling E, the HOTV test, or the Allen card test, may be appropriate for preschool-aged children.
- If the objective vision screen is performed in another setting, such as a school, the screen does not need to be repeated by the provider, but the findings must be documented in the member's medical record.

Dental Assessment and Referral – The screening provider must encourage members to seek regular dental care from a dental provider, beginning at age three years, or earlier, if indicated, including examinations once every six months, preventive services, and treatment, as necessary.

- A dental assessment is required at each visit: detailed assessments before age three years must include information on fluoride supplementation, proper oral hygiene, and infant caries.
- Intraoral assessments after age three years should identify obvious dental problems and ensure that regular visits to a dental provider are occurring.

Cancer Screening and Examination

- The provider must offer an annual pelvic exam and Pap smear for female members beginning at age 18 years. If the female member is sexually active, such testing should begin at the age at which the member becomes sexually active.
- The provider must perform a breast exam at every visit for female members beginning at age 18 years. Breast self-exam instruction should be provided to the member at adolescent periodic visits.
- Testicular self-exam instruction should be provided to male members at adolescent periodic visits.
- The provider must screen all members for the presence of other cancers as indicated by member or family history.

Health Education and Anticipatory Guidance

- At every EPSDT visit, age-specific and appropriate counseling must be delivered to parents or guardians and members, if age appropriate, about common and expected developmental advancements and common physical problems.
- Effective discussion includes assessment and teaching based on a family-centered, culturally competent approach. Discussion topics should include, but not be limited to:
  (a) parents' or guardians' concerns;
  (b) developmental expectations and good parenting practices; and
  (c) behavioral risks, such as substance use and violence; sexuality; AIDS and other communicable diseases; depression; injury prevention; and nutrition.
- Educational activities and resources (such as printed brochures, audio-visual materials, class instruction, and health-risk questionnaires) can enhance comprehensive child and adolescent health supervision, but should not replace interaction between the provider and the member.
- The American Medical Association's Guidelines for Adolescent Preventive Services, the American Academy of Pediatrics' Guidelines for Health Supervision III, and Bright Futures provide lists of topics that may be discussed at periodic visits.

Immunization Assessment and Administration – At every EPSDT visit, the provider must assess the member's immunization status and administer all immunizations for which the member is due in accordance with the recommendations of DPH's Immunization Program.

Lead Toxicity Screening

- Providers must screen every member for lead toxicity according to the requirements for lead toxicity screening set forth by the Massachusetts Childhood Lead Poisoning Prevention Program (MCLPPP). These requirements can be found at 105 CMR 460.050 et seq.
- If a child is found to have a blood lead level equal to or greater than 10 micrograms per deciliter, providers should use their professional judgment, in accordance with the Centers for Disease Control and Prevention (CDC) guidelines regarding patient management and treatment, as well as follow-up blood tests.
- Physicians and other health-care providers must report all cases of childhood lead poisoning (equal to or greater than 10 micrograms per deciliter) known to them to the Director of the MCLPPP within three working days of identification, unless previously reported.
    (a) When a child has multiple episodes of lead poisoning, each episode must be reported.
    (b) Initiation of investigations to determine the source of lead in the child's environment is provided by the MCLPPP.

Tuberculin Test – The screening provider must administer a Mantoux test only to children determined to be at high risk for contracting tuberculosis.

- Providers should assess the child's risk at every periodic visit.
    (a) Children at low risk of infection need not be tested.
    (b) Children at high risk of infection should be tested in accordance with the recommendations of the American Academy of Pediatrics. Providers should arrange for any child tested to have their Mantoux test read by a clinician 48 to 72 hours after administration of the test.
- Providers should use the following questions in determining the child's risk status.
    (a) Has your child spent time with anyone who possibly or definitely has tuberculosis?
    (b) Does anyone in your child's household have a positive tuberculin skin test?
    (c) Did you, your child, or any other household member come to the United States from a high tuberculosis-prevalent country?
    (d) Has your child spent time with adults who were homeless, are HIV positive or have AIDS, used drugs, or lived in a correctional or health-care facility?

Hematocrit or Hemoglobin Test

- The screening provider must administer either the hematocrit or hemoglobin test for iron deficiency according to the following:
    (a) once between nine and 12 months of age; and
    (b) once during adolescence, but annually for all menstruating females.
- The screening provider should consider administering either the hematocrit or hemoglobin test for iron deficiency for all children between the ages of 15 months and five years who are at risk for anemia.

Sexually Transmitted-Disease-Related Testing – The screening provider should test the sexually active member annually for gonorrhea, HPV,and Chlamydia, and according to the member's risk and the provider's professional judgment for HIV, syphilis and any other sexually transmitted diseases.

Other Laboratory Testing

- The screening provider should administer other laboratory tests (urinalysis, urine culture, cholesterol, sickle cell screening, HIV testing, screening for metabolic disorders, and any others) according to the member's risk, the provider's professional judgment, and applicable state requirements for newborn screening tests.