Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
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Boston, MA 02111
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MASSHEALTH
TRANSMITTAL LETTER ALL-118
September 2003

TO: All Providers Participating in MassHealth

FROM: Douglas S. Brown, Acting Commissioner

RE: *All Provider Manuals* (New MassHealth Coverage Type: MassHealth Essential)

The Massachusetts Legislature has passed, and the Governor has signed into law, legislation allowing the Division of Medical Assistance to restore medical benefits to certain unemployed adults under the age of 65. This new coverage type will be known as MassHealth Essential.

Uninsured persons eligible for MassHealth Essential may enroll only with a Primary Care Clinician (PCC) in the PCC Plan and must enroll with a PCC before they can receive benefits.

These emergency regulations are effective October 1, 2003.

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

All Provider Manuals

Pages i, 1-7 through 1-10, 1-13 through 1-18, and 1-29 through 1-32

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(The pages listed here are no longer in effect.)

All Provider Manuals

Pages i, 1 -7 and 1-8 — transmitted by Transmittal Letter ALL-115

Pages 1-9, 1-10, 1-13 through 1-18, and 1-29 through 1-32 — transmitted by Transmittal Letter ALL-113

1. INTRODUCTION

(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 does 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 pays 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 pays 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. Basic members receive services through either the purchase of medical benefits or premium assistance.

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

(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) Premium Assistance. For adults who meet the eligibility requirements of MassHealth Basic, but who have health insurance, the Division pays part or all of the member's health insurance premium. The amount of the payment is based on the Division's determination of cost effectiveness. The Division does not pay for any other benefits for these members.

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

(a) The Division does 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 pays 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.

(5) 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 aged 65 or older or is institutionalized (see 130 CMR 519.010), the Division pays all of the member's Medicare Part B premium. The Division does not pay for any other benefit for these members.

(2) 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.

(3) 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.

(4) 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 pays the member's Medicare Part B premiums, and where applicable, Medicare Part A premiums. The Division also pays 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.

(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 does 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 pays 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.

(I) MassHealth Essential. Essential members receive services through either the purchase of medical benefits or premium assistance.

(1) Covered Services. The following services are covered for MassHealth Essential members (See 130 CMR 505.007).

(a) abortion services;
(b) acute inpatient hospital services;
(c) ambulatory surgery services;
(d) behavioral health (mental health and substance abuse) services;
(e) community health center services;
(f) dental services;
(g) durable medical equipment and supplies;
(h) family planning services;

(i) emergency ambulance services;
(j) laboratory services;
(k) nurse practitioner services;
(l) outpatient hospital services;
(m) oxygen and respiratory therapy equipment;
(n) pharmacy services;
(o) physician services;
(p) podiatrist services;
(q) prosthetic services;
(r) rehabilitation services (except in inpatient hospital settings);
(s) renal dialysis services;
(t) speech and hearing services;
(u) therapy services: physical, occupational, and speech/language; and
(v) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Essential members for whom eligibility is determined under 130 CMR 505.008 must enroll with a Primary Care Clinician as described in 130 CMR 450.117(B)(1). These members are eligible to receive services listed in 130 CMR 450.105(I)(1) only after enrolling with a Primary Care Clinician in accordance with 130 CMR 508.002(I)(2).

(3) Behavioral Health Services. MassHealth Essential 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.)

(4) Premium Assistance. For adults who meet the eligibility requirements for MassHealth Essential but have health insurance, the Division pays part or all of the member's health insurance premium. The amount of the payment is based on the Division's determination of cost effectiveness. The Division does not pay for any other benefits for these members.

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 notifies the affected providers in writing, at least 30 days prior to termination. Such termination does not affect payments to providers for services provided prior to the date of termination.

450.109: Out-of-State Services

(A) The Division covers 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 enroll only with a PCC.

(3) MassHealth Essential members described in 130 CMR 450.105(I)(2) can enroll only with a Primary Care Clinician.

(4) 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 pays 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;

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 was delivered 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 Essential, 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 450.140 through 450.150.

(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 Essential, 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)

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