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MASSHEALTH  
TRANSMITTAL LETTER ALL-122  
January 2004

**TO:** All Providers Participating in MassHealth  
**FROM:** Beth Waldman, Director, Office of Medicaid  
**RE:** *All Provider Manuals (Senior Care Options)*

*Beth Waldman*

Effective January 2, 2004, MassHealth members aged 65 and older will have the option of enrolling in a coordinated health plan called Senior Care Options (SCO). SCO is a comprehensive health plan that covers all of the services reimbursable under Medicare and MassHealth, through a senior care organization and its network of providers. Enrollment in SCO is voluntary.

Members who join SCO will have a primary care physician who is affiliated with the senior care organization. The member's primary care physician and a team of nurses, specialists, and a geriatric support services coordinator, will work with the member to develop a plan of care to address the specific needs of the member. Members enrolled in SCO will have 24-hour access to the team, geriatric support services, and active involvement in decisions about their health care.

MassHealth members who are enrolled in SCO will not be covered for any services provided outside the senior care organization and its network of providers. Members who are enrolled in SCO will be so identified through the MassHealth Recipient Eligibility Verification System (REVS). It is, therefore, important, as always, to check REVS before providing services. If a MassHealth member seeking care from you is enrolled in SCO, you should contact the senior care organization with which the member is enrolled before providing services. The telephone number of the senior care organization is given on REVS.

This letter transmits revisions to the Division's administrative and billing regulations that describe the rules about SCO.

This letter also transmits a minor, unrelated revision to the Primary Care Clinician (PCC) Plan provisions at 130 CMR 450.118(E)(1) to eliminate the requirement that all individual practitioners within a group practice sign the PCC contract.

These regulations are effective January 2, 2004.

**NEW MATERIAL**

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

**All Provider Manuals**

Pages i, 1-1 through 1-4, 1-7, 1-8, and 1-17 through 1-22

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages i, 1-17, and 1-18 — transmitted by Transmittal Letter ALL-118

Pages 1-1 through 1-4, 1-19, and 1-20 — transmitted by Transmittal Letter ALL-113

Pages 1-7 and 1-8 — transmitted by Transmittal Letter ALL-121

Pages 1-21 and 1-22 — transmitted by Transmittal Letter ALL-116

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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.

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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 care and certain other medical services to members on a capitated basis, including a senior care organization or 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.

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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.

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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.

Senior Care Organization – an organization that participates in MassHealth under a contract with the Division and the Centers for Medicare and Medicaid Services to provide a comprehensive network of medical, health-care, and social-service providers that integrates all components of care, either directly or through subcontracts. Senior care organizations are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

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.

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- (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).) Women described at 130 CMR 505.002(H), who receive MassHealth Standard as a result of a diagnosis of breast or cervical cancer, may only enroll in the PCC Plan.
- (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.
  - (d) MassHealth Standard members who participate in a senior care organization receive all behavioral health services only through the senior care organization.
- (5) Purchase of Health Insurance. The Division may purchase third-party health insurance for MassHealth Standard members, with the exception of members described at 130 CMR 505.002(H), 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.
- (6) Senior Care Organizations. MassHealth Standard members aged 65 and over may voluntarily enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008. The Division will not pay a provider other than a senior care organization for any services that are provided to the MassHealth member while the member is enrolled in a senior care organization.



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(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).

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(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)

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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.

(D) The Division's managed care options include a senior care organization for MassHealth Standard members aged 65 and over, who voluntarily enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008.

- (1) Members who participate in a senior care organization must select a primary care physician.
- (2) Members who participate in a senior care organization obtain all covered services through the senior care organization.
- (3) Members who are enrolled in a senior care organization are identified on REVS (see 130 CMR 450.107). For a MassHealth member enrolled with a senior care organization, REVS will identify the name and telephone number of the senior care organization. The Division will not pay a provider other than a senior care organization for any services that are provided to the MassHealth member while the member is enrolled in a senior care organization.

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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, pediatrics, 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
- (2) must assign each enrollee to an individual practitioner who meets the criteria under 130 CMR 450.118(B)(1) or (2).

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(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).

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(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.

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(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.

(N) PCC Contracts. Providers that are PCCs are bound by and liable for compliance with the terms of the most recent PCC contract issued by the Division, including amendments to the contract, as of the effective date specified in the PCC contract or amendment.

(130 CMR 450.119 through 450.123 Reserved)