Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-205
December 2013

TO: All Providers Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: _All Provider Manuals_ (Revisions to Regulations for the Affordable Care Act)

This letter transmits revisions to the administrative and billing regulations for all provider manuals. This transmittal letter communicates regulatory changes prompted by the requirements of the Affordable Care Act (ACA). The regulations are effective January 1, 2014. The changes include

- amending language to reflect changes to the MassHealth coverage types as a result of the ACA;
- discontinuing MassHealth Basic, MassHealth Essential, and MassHealth Prenatal coverage types as part of the transition to new coverage types under the ACA;
- creating the new coverage type MassHealth CarePlus, listing covered services, and describing CarePlus managed care requirements and premium assistance rules;
- describing operational processes for hospital-determined presumptive eligibility;
- revising copayment exclusions and caps to conform with 42 CFR 447;
- exempting 19- and 20-year-olds from premium and copayment requirements; and
- revising member eligibility rules for integrated care organizations (ICOs).

In addition, these changes update references to the Division of Health Care Finance and Policy.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

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

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

All Provider Manuals

Pages i and 1-1 through 1-40

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(The pages listed here are no longer in effect.)

All Provider Manuals

Page i — transmitted by Transmittal Letter ALL-185

Pages 1-1 through 1-12 and 1-17 through 1-18 — transmitted by Transmittal Letter ALL-203

Pages 1-13 and 1-14 — transmitted by Transmittal Letter ALL-178

Pages 1-15 through 1-16 — transmitted by Transmittal Letter ALL-194

Pages 1-19 and 1-20 — transmitted by Transmittal Letter ALL-122

Pages 1-21 and 1-22 — transmitted by Transmittal Letter ALL-182

Pages 1-23 through 1-26 — transmitted by Transmittal Letter ALL-189

Pages 1-27 and 1-32 — transmitted by Transmittal Letter ALL-171

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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 MassHealth agency 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 MassHealth agency of a provider's practices by means of an on-site visit, a review of the MassHealth agency'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 MassHealth agency 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 MassHealth agency, that contains information including member information, date of service, and description of service provided.

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.

Duals Demonstration Dual Eligible Individual — for purposes of the Duals Demonstration Program, a MassHealth member must meet all of the following criteria:

(1) be 21 through 64 years of age at the time of enrollment;
(2) be eligible for MassHealth Standard as defined in 130 CMR 450.105(A) or MassHealth CommonHealth as defined in 130 CMR 450.105(E);
(3) be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*; and
(4) live in a designated service area of an integrated care organization (ICO).

Duals Demonstration Program — the MassHealth state Demonstration to Integrate Care for Duals Demonstration Dual Eligible Individuals.

Eligibility Verification System (EVS) — the member eligibility verification system accessible to providers. EVS also may be referred to as the Recipient Eligibility Verification System (REVS).

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 MassHealth agency.

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 MassHealth agency'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.

Integrated Care Organization (ICO) — an organization with a comprehensive network of medical, behavioral-health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

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 and 130 CMR 508.000: *MassHealth: Managed Care Requirements*.

Managed Care Organization (MCO) — any entity with which the MassHealth agency contracts to provide and coordinate care and certain other medical services to members on a capitated basis, including a senior care organization (SCO), an integrated care organization (ICO), 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 MassHealth agency 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 Agency — the Executive Office of Health and Human Services in accordance with the provisions of M.G.L. c. 118E.

MassHealth Enrollment Center (MEC) — a regional office of the MassHealth agency 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 MassHealth agency 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 MassHealth agency.

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 MassHealth agency to be eligible for MassHealth.

Multiple-Source Drug — a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

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

Over-the-Counter-Drug — any drug for which no prescription is required by federal or state law. These drugs are sometimes referred to as nonlegend drugs.

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.

Prescription Drug — any drug for which a prescription is required by applicable federal or state law or regulation, other than MassHealth regulations. These drugs are sometimes referred to as legend drugs.

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 MassHealth agency 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 MassHealth agency. 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 MassHealth agency 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).

Sanction — an administrative penalty imposed by the MassHealth agency 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 (SCO) — an organization that participates in MassHealth under a contract with the MassHealth agency and the Centers for Medicare & Medicaid Services (CMS) to provide a comprehensive network of medical, health-care, and social-service providers and that integrates 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.

450.102: Purpose of 130 CMR 400.000 through 499.000

130 CMR 400.000 through 499.000 contain the MassHealth agency'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 applies to all MassHealth providers and services. The MassHealth agency also promulgates other regulations, and publishes other documents affecting these programs, including other chapters in 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 or the MassHealth agency.

450.103: Promulgation of Regulations

(A) All regulations of the MassHealth agency are promulgated in accordance with M.G.L. c. 30A. In the event of any conflict between the MassHealth agency's regulations and applicable federal laws and regulations, the MassHealth agency'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 MassHealth agency's regulations shall be construed so far as possible to make them consistent with the federal Health Insurance Portability and Accountability Act (HIPAA), including federal regulations promulgated thereunder. To implement and comply with HIPAA, the MassHealth agency, may issue billing instructions, provider bulletins, companion guides, or other materials, which shall be effective and controlling notwithstanding any MassHealth agency 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: *MassHealth Standard* and 519.002: *MassHealth Standard*).

(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 and 508.000: *MassHealth: Managed Care Requirements*.)

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

(a) The MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency'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 MassHealth agency's contract with the MCO.

(b) The MassHealth agency pays providers other than the MCO for those services listed in 130 CMR 450.105(A)(1) that are not covered by the MassHealth agency'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 MassHealth behavioral-health contractor. (See 130 CMR 450.124)

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

(c) MassHealth Standard members who are excluded from participating in managed care under 130 CMR 508.004: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization* or who have not enrolled in an MCO or with the MassHealth behavioral-health contractor may receive behavioral-health services from any participating MassHealth provider of such services.

(d) (i) MassHealth Standard members who participate in a senior care organization receive all behavioral-health services only through the senior care organization.
(ii) MassHealth Standard members who participate in an integrated care organization receive all behavioral-health services through the integrated care organization.

(e) MassHealth Standard members who are younger than 21 years old and who are excluded from participating in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(A) or (B) must enroll with the MassHealth behavioral-health contractor.

(f) MassHealth Standard members who are younger than 21 years old and who are excluded from participating in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(I), (J), or (K) are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.
(g) MassHealth members who are receiving services from the Department of Children and Families (DCF) or the Department of Youth Services (DYS) may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO must enroll with the MassHealth behavioral-health contractor.
(h) MassHealth members who receive Title IV-E adoption assistance described in 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance* may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth Standard members, with the exception of members described at 130 CMR 505.002(H): *Eligibility Requirements for Independent Foster-Care Adolescents*, if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency 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 65 years of age and older may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008: *Voluntary Enrollment in Senior Care Organizations*. The MassHealth agency does not pay a provider other than a SCO for any services that are provided to the MassHealth member while the member is enrolled in a SCO.

(7) Integrated Care Organizations. MassHealth Standard members 21 through 64 years of age who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level defined in 130 CMR 501.001: *Definition of Terms* may voluntarily enroll in integrated care organization (ICO) in accordance with the requirements at 130 CMR 508.007: *Eligibility and Enrollment in an Integrated Care Organization*. While enrolled in an ICO, MassHealth members who turn 65 years old and are eligible for MassHealth Standard may remain in an ICO after the age of 65. The MassHealth agency does not pay a provider other than the ICO for any services that are provided by an ICO while the member is enrolled in the ICO, except for family planning services that were not provided or arranged for by the ICO. It is the responsibility of the provider of services to determine if a MassHealth member is enrolled in an ICO. Upon request, the ICO must inform providers and enrollees of ICO-covered benefits. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

(B) MassHealth CarePlus.

(1) Covered Services. The following services are covered for MassHealth CarePlus members (see 130 CMR 505.008: *MassHealth CarePlus*.)

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

(2) Managed Care Member Participation. MassHealth CarePlus members must enroll with a MassHealth managed care provider in accordance with 130 CMR 508.001(A): *Member Participation*. (See also 130 CMR 450.117.)

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

(a) The MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency'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 MassHealth agency's contract with the MCO.

(b) The MassHealth agency pays providers other than the MCO for those services listed in 130 CMR 450.105(B)(1) that are not covered by the MassHealth agency'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. MassHealth CarePlus members enrolled in an MCO receive behavioral-health services only through the MCO. (See 130 CMR 450.117.)

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth CarePlus members, with the exception of members described at 130 CMR 505.002(H): *Eligibility Requirements for Independent Foster-Care Adolescents*, if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(B)(1) that are not available through the member's third-party health insurer.

(C) MassHealth Buy-In.

(1) For a MassHealth Buy-In member who is 65 years of age or older or is institutionalized (see 130 CMR 519.011: *MassHealth Buy-In*), the MassHealth agency pays all of the member's Medicare Part B premium. The MassHealth agency 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 MassHealth agency 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 MassHealth agency's managed care options pursuant to 130 CMR 508.004: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization*.

(D) MassHealth Senior Buy-In.

(1) Covered Services. For MassHealth Senior Buy-In members (see 130 CMR 519.010: *MassHealth Senior Buy-In*), the MassHealth agency pays the member's Medicare Part B premiums, and where applicable, Medicare Part A premiums. The MassHealth agency 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: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization*.

(E) MassHealth CommonHealth.

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

(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.

(a) MassHealth CommonHealth members must enroll with a MassHealth managed care provider unless excluded from participation in managed care. (See 130 CMR 450.117 and 508.000: *Managed Care Requirements*.)

(b) MassHealth CommonHealth members who are younger than 21 years old and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(A) or (B) must enroll with the MassHealth behavioral-health contractor.

(c) MassHealth CommonHealth members who are younger than 21 years old and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(I), (J), or (K) may choose to enroll with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(3) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for any MassHealth CommonHealth member if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays 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.

(4) Integrated Care Organizations. MassHealth CommonHealth members aged 21 through 64 who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level defined in 130 CMR 501.001: *Definition of Terms* may voluntarily enroll in an integrated care organization (ICO) in accordance with the requirements at 130 CMR 508.007: *Eligibility and Enrollment in an Integrated Care Organization*. The MassHealth agency does not pay a provider other than the ICO for any services that are provided by an ICO while the member is enrolled in the ICO, except for family planning services that were not provided or arranged for by the ICO. It is the responsibility of the provider of services to determine if a MassHealth member is enrolled in an ICO. Upon request, the ICO must inform providers and enrollees of ICO-covered benefits. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

(F) MassHealth Limited.

(1) Covered Services. For MassHealth Limited members (see 130 CMR 505.006: *MassHealth Limited* and 519.009: *MassHealth Limited*), the MassHealth agency pays 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 MassHealth agency does 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(F)(1).

(3) Managed Care Member Participation. MassHealth Limited members are excluded from participation in managed care pursuant to 130 CMR 508.004: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization*.

(G) MassHealth Family Assistance.

(1) Premium Assistance. The MassHealth agency 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) and (C), the only benefit the MassHealth agency provides is partial payment of the member's employer-sponsored health insurance, except as provided in 130 CMR 450.105(H).

(b) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater Than 150 and Less Than or Equal to 300 Percent of the Federal Poverty Level*, the MassHealth agency provides dental services as described in 130 CMR 420.000: *Dental Services*.

(c) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(D): *Eligibility Requirement for Adults and Young Adults Aged 19 and 20 Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household At or Below 300 Percent of the Federal Poverty Level*, the MassHealth agency 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) 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): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 150 and Less Than or Equal to 300 Percent of the Federal Poverty Level*, the MassHealth agency 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 Eligibility Verification System (EVS) to determine whether the MassHealth agency 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), (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): *Eligibility Requirement for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or equal to 200 Percent of the Federal Poverty Level,* must enroll with a Primary Care Clinician (PCC) or a MassHealth-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): *Eligibility Requirement for Disabled Adults Who Are Qualified Noncitizens Barred, Nonqualified Individuals Lawfully Present, and Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth Disabled Adult Household at or below 100 Percent of the Federal Poverty Level,* must enroll with a PCC (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 MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency'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 MassHealth agency's contract with the MCO.

(b) The MassHealth agency pays providers other than the MCO for those services listed in 130 CMR 450.105(H) that are not covered by the MassHealth agency'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 MassHealth behavioral-health contractor. (See 130 CMR 450.124)

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

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

(H) Children's Medical Security Plan. Children determined to be eligible for the Children's Medical Security Plan (CMSP) receive benefits described in 130 CMR 522.004(G): *Benefits Provided*.

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: *Physician Services*;

(2) community health center services specified in 130 CMR 405.000: *Community Health Center Services*;

(3) prescription drugs (those drugs that require a prescription under federal or state law) specified in 130 CMR 406.000: *Pharmacy Services*;

(4) insulins (the only over-the-counter 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: *Oxygen and Respiratory Therapy Equipment*;
(7) substance abuse treatment services as specified in 130 CMR 418.000: *Substance Abuse Treatment Services* 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. 118E, §13H 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: *Outpatient Hospital Services* and 415.000: *Acute Inpatient Hospital Services* 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. Eligibility for the EAEDC Program is determined pursuant to 106 CMR 320.000 through 321.000, 701.000 through 701.600, 705.000 through 705.950, and 706.000 through 706.710.

(B) Eligibility Verification System. The MassHealth agency uses the Eligibility Verification System (EVS) 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 MassHealth agency issues a plastic identification card for most MassHealth members. The MassHealth card contains information necessary to access EVS. Members for whom the MassHealth agency pays health insurance premiums only may not have a MassHealth card.

(D) Temporary MassHealth Eligibility Card. When necessary, the MassHealth agency 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 EVS, 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) Provisional Eligibility. The MassHealth agency will provide eligibility while the applicant provides to the MassHealth agency any outstanding verification, in accordance with 130 CMR 502.003: *Verification of Eligibility Factors*.

450.108: Selective Contracting

(A) Use of Selective Contracts. The MassHealth agency may provide some services through selective contracts where such contracts are permitted by federal and state law.
(B) Termination of Provider Contracts. The MassHealth agency may terminate, in whole or in part, existing provider contracts where selective contracts are in effect. In the event of any such termination, the MassHealth agency 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) MassHealth 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;
(3) it is the general practice for members in a particular locality to use medical resources in another state; or
(4) MassHealth determines on the basis of medical advice that the needed medical services, or necessary supplementary resources, are more readily available in the other state.

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

450.110: Hospital-Determined Presumptive Eligibility

(A) The MassHealth agency will provide coverage for certain individuals for a limited period of time, in accordance with 130 CMR 502.003(H): Hospital-Determined Presumptive Eligibility if, on the basis of attested information, a qualified hospital determines that the individual is presumptively eligible. Coverage for members with time-limited presumptive eligibility begins on the date on which a qualified hospital makes a determination regarding presumptive eligibility and continues until
1) the end of the month following the month in which the hospital determined presumptive eligibility, if the individual has not submitted a complete application as described in 130 CMR 502.001: Application for Benefits by that date, or
2) an eligibility determination is made based upon the individual's submission of a complete application as described in 130 CMR 502.001: Application for Benefits if the complete application was submitted prior to the end of the month following the month of the hospital presumptive eligibility determination.

(B) A qualified hospital, for purposes of 130 CMR 450.110, is a hospital that satisfies the following requirements, as more fully described in provider bulletins and other guidance that may be issued by the MassHealth agency:

(1) participates as a MassHealth provider;

(2) notifies the MassHealth agency of its election to make presumptive eligibility determinations;

(3) agrees to make presumptive eligibility determinations consistent with MassHealth policies and procedures;

(4) has Certified Application Counselors on site and available to assist individuals with the application process, including submitting the full application and understanding any documentation requirements; and

(5) has not been disqualified from making presumptive eligibility determinations.

(130 CMR 450.111 Reserved)

450.112: Advance Directives

(A) Provider Participation. All hospitals, nursing facilities, MCOs, home health agencies, personal care agencies, hospices, and the MassHealth behavioral-health contractor must

(1) provide to all adults 18 years of age or older, who are receiving medical care from the provider, the following written information concerning their rights, which information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change 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 younger than 65 years old are required to enroll in the Primary Care Clinician (PCC) Plan or a MassHealth-contracted MCO available for their coverage type unless they are excluded from such participation under 130 CMR 450.117(E) through (I) or 508.004: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization* provided however, that MassHealth CarePlus members are required to enroll in such MassHealth managed care providers in accordance with 130 CMR 508.001(A): *Member Participation.* Members excluded from managed care under 130 CMR 508.004: *Members Excluded from Participation in Various Managed Care Options* receive those MassHealth services for which they are eligible through any participating MassHealth provider.

(B) MassHealth 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 MassHealth 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 EVS (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 MassHealth agency 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) MassHealth 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: *Voluntary Enrollment in Senior Care Organizations*.

(1) Members who participate in a SCO 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 EVS (see 130 CMR 450.107). For a MassHealth member enrolled with a senior care organization, EVS will identify the name and telephone number of the senior care organization. The MassHealth agency 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.

(E) MassHealth Standard and CommonHealth members who are younger than 21 years old and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(A) (1) or (2) or (B) (1) or (2) must enroll with the MassHealth behavioral-health contractor.

(F) MassHealth members who are enrolled in the Kaileigh Mulligan Program described at 130 CMR 519.007(A): *The Kaileigh Mulligan Program* or who are enrolled in a home- and community-based services waiver may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(G) MassHealth members who are receiving services from the Department of Children and Families (DCF) or the Department of Youth Services (DYS) may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO must enroll with the MassHealth behavioral-health contractor.

(H) MassHealth members who are receiving Title IV-E adoption assistance described in 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance* may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(I) Individuals who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives and who participate in managed care under MassHealth may choose to receive covered services from an Indian health-care provider. All participating MCOs must provide payment for such covered services in accordance with the provisions of 42 U.S.C. 1396u-2(h) and comply with all other provisions of 42 U.S.C. 1396u-2(h). For the purposes of 130 CMR 450.117(I), the term Indian health-care provider means a health care program, including contracted health services, operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(J) MassHealth-contracted MCOs, SCOs, and integrated care organizations (ICOs), and their contracted behavioral health management firms or third party administrators, if any, must comply with and implement relevant provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Federal Mental Health Parity Law) , and implementing regulations and federal guidance, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations.

(1) Annual Certification of Compliance with Federal Mental Health Parity Law: The above referenced managed care entities must review their administrative and other practices, including the administrative and other practices of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions Federal Mental Health Parity Law, regulations and guidance.

(a) Managed care entities must submit a certification signed by the chief executive officer and chief medical officer stating that the managed care entity has completed a comprehensive review of the administrative practices of the managed care entity for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and Federal Mental Health Parity Law.

(b) If the managed care entity determines that all administrative and other practices were in compliance with relevant requirements of the Federal Mental Health Parity Law during the calendar year, the certification will affirmatively state that all relevant administrative and other practices were in compliance with Federal Mental Health Parity Law.

(c) If the managed care entity determines that any administrative or other practices were not in compliance with relevant requirements of the Federal Mental Health Parity Law during the prior calendar year, the certification will state that not all practices were in compliance with Federal Mental Health Parity Law, and will include a list of the practices not in compliance, and the steps the managed care entity has taken to bring these practices into compliance.

(2) A member enrolled in any of these managed care entities may file a grievance with MassHealth if the member believes that services are provided in a way that is not consistent with applicable Federal Mental Health Parity laws, regulations or federal guidance. Member grievances may be communicated for resolution verbally or in writing to MassHealth's customer services contractor.

(K) MassHealth managed care options include an integrated care organization (ICO) for MassHealth Standard and CommonHealth members who also meet the requirements for eligibility set forth under 130 CMR 508.007: *Eligibility and Enrollment in an Integrated Care Organization*.

(1) Members who participate in an ICO must choose or be assigned a primary care provider.

(2) Members who participate in an ICO obtain all covered services through the ICO.

(3) Members who enroll in the Duals Demonstration Program may continue to receive services from their current providers who accept current Medicare or Medicaid fee-for-service provider rates during a continuity-of-care period. A continuity-of-care period is a period beginning on the date of enrollment into the Duals Demonstration Program and extends to either of the following:

(a) up to 90 days, unless the comprehensive assessment and the individualized-care plan are completed sooner and the enrollee agrees to the shorter time period; or

(b) until the comprehensive assessment and the individualized-care plan are complete.

(4) Members who are enrolled in an ICO are identified on EVS (see 130 CMR 450.107). For a MassHealth member enrolled with an ICO, EVS will identify the name and telephone number of the ICO. The MassHealth agency will not pay an entity other than an ICO for any services that are provided to the MassHealth member while the member is enrolled in an ICO, except for family planning services that were not provided or arranged for by the ICO.

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 MassHealth agency, and must meet the requirements of the PCC provider contract. The following provider types may apply to the MassHealth agency 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 MassHealth agency 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).

(F) Waiver of Eligibility Requirements. The MassHealth agency 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 MassHealth agency 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 MassHealth agency'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 MassHealth agency 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 MassHealth agency pays PCCs an enhanced fee for primary care services, in accordance with the terms of the PCC provider contract.

(I) Termination.

(1) If the MassHealth agency determines that a PCC fails to fulfill any of the obligations stated in the MassHealth agency's regulations or PCC contract, the MassHealth agency 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 MassHealth agency determines that an individual practitioner within a PCC group practice fails to fulfill any of the obligations stated in the MassHealth agency's regulations or the PCC contract, the MassHealth agency 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. All services provided by a clinician or provider other than the PCC Plan member's PCC require referral from the member's PCC in order to be payable, unless the service is exempted under 130 CMR 450.118(J)(5). This referral requirement also applies to services delivered by individual practitioners who are part of a group practice PCC and who have not been identified by the group practice as providers who may be assigned PCC Plan members under 130 CMR 450.118(E). In order to make a referral, PCCs must follow the processes described in the PCC provider contract.

(2) Time Frames for Referral. Whenever possible, the PCC should make the referral before the member's receipt of the service. However, the PCC may issue a referral retroactively if the PCC determines that the service was medically necessary at the time of receipt.

(3) Payment for Services Requiring Referral. The MassHealth agency pays a provider other than the member's PCC for services that require a PCC referral only when a referral has been submitted by the member's PCC.

(4) Services Requiring Referrals. See 130 CMR 450.105 for a list of the services covered for each MassHealth coverage type and applicable program regulations for descriptions of covered services and specific service limitations. Prior-authorization requirements are described in 130 CMR 450.303, 450.144(A)(2), and applicable program regulations and subregulatory publications. Payment for services is subject to all conditions and restrictions of MassHealth, including but not limited to, the scope of covered services for a member's coverage type, service limitations, and prior-authorization requirements.

(5) Exceptions to Services Requiring Referrals. Notwithstanding 130 CMR 450.118(J)(4), the following services provided by a clinician or other provider other than the member's PCC do not require a referral from the member's PCC in order to be payable:

(a) abortion services;

(b) annual gynecological exams;

(c) chiropractor services;

(d) clinical laboratory services;

(e) diabetic supplies;

(f) durable medical equipment (items, supplies, and equipment) described in 130 CMR 409.000: *Durable Medical Equipment Services*;

(g) fiscal intermediary services as described in 130 CMR 422.419(B): *The Fiscal Intermediary;*

(h) fluoride varnish administered by a physician or other qualified medical professional;

(i) functional skills training provided by a MassHealth personal care management agency as described in 130 CMR 422.421(B): *Functional Skills Training*;

(j) hearing instrument specialist services;

(k) HIV pre- and post-test counseling services;

(l) HIV testing;

(m) hospitalization

(i) Elective Admissions. All elective admissions are exempt from the PCC referral requirement and are subject to the MassHealth agency'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) Nonelective Admissions. Nonelective admissions are exempt from the PCC referral requirement. The hospital must notify the member's PCC within 48 hours following a nonelective admission;

(n) medical nutrition therapy/diabetes self-management training;
(o) obstetric services for pregnant and postpartum members provided up to to the end of the month in which the 60-day period following the termination of pregnancy ends;
(p) orthotic services;
(q) oxygen and respiratory therapy equipment;
(r) pharmacy services (prescription and over-the-counter drugs);
(s) prosthetic services;
(t) radiology and other imaging services with the exception of magnetic resonance imaging (MRI) computed tomography (CT) scans, and positron emission tomography (PET) scans, which do require a referral;
(u) services delivered by a behavioral health (mental health and substance abuse) provider (including inpatient and outpatient psychiatric services);
(v) services delivered by a dentist;
(w) services delivered by a family planning service provider, for members of child-bearing age;
(x) services delivered by a hospice provider;
(y) services delivered by a limited service clinic;
(z) services delivered in a nursing facility;
(aa) services delivered by an anesthesiologist;
(bb) services delivered in an intermediate care facility for the mentally retarded (ICF-MR);
(cc) services delivered to a homeless member outside of the PCC office pursuant to 130 CMR 450.118(K);
(dd) services delivered to diagnose and treat sexually transmitted diseases;
(ee) services delivered to treat an emergency condition;
(ff) services provided under a home- and community-based waiver;
(gg) sterilization services when performed for family planning services;
(hh) surgical pathology services;
(ii) tobacco-cessation counseling services;
(jj) transportation to covered care; and
(kk) 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) <u>Services to Homeless Members</u>. To provide services to homeless members according to 130 CMR 450.118(J)(5)(cc), the provider must furnish written evidence of demonstrated experience in delivering medical care in a nonmedical setting, and request, in writing, designation from the MassHealth agency that the PCC is approved to provide services to homeless members. The MassHealth agency 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(L)(2).

(2) Reporting Requirements. The PCC who made the referral must obtain from the provider who furnished 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 MassHealth agency, 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)

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 paid solely by the MassHealth agency'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: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization.*

(130 CMR 450.125 through 450.129 Reserved)

450.130: Copayments Required by the MassHealth Agency

(A) Copayment Requirement. The MassHealth agency requires its members to make the copayments described in 130 CMR 450.130(B) up to the calendar-year maximum described in 130 CMR 450.130(C), except as excluded in 130 CMR 450.130(D) and (E). Providers may collect copayments only in the amounts and for the services listed in 130 CMR 450.130(B). If the usual-and-customary fee is less than the copayment amount, the member must pay the amount of the service. Members who are enrolled in MassHealth MCOs must make copayments in accordance with the MCO's MassHealth copayment policy. Those MCO copayment policies must

(1) be approved by the MassHealth agency;
(2) exclude the persons and services listed in 130 CMR 450.130(D) and (E);
(3) not exceed the MassHealth copayment amounts set forth in 130 CMR 450.130(B); and
(4) not exceed the calendar-year or quarterly maximums set forth in 130 CMR 450.130(C).
(See also 130 CMR 506.011 through 506.019, 130 CMR 508.016, and 520.036 through 520.040.)

(B) Services Subject to Copayments. MassHealth members are responsible for making the following copayments unless excluded in 130 CMR 450.130(D) or (E).

(1) Pharmacy Services. The copayment for pharmacy services is
(a) $1 for each prescription and refill for each generic drug and over-the-counter drug covered by MassHealth in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and
(b) $3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by MassHealth.
(2) Nonpharmacy Services. The copayment for nonpharmacy services is $3 for an acute inpatient hospital stay.

(C) Maximum Cost Sharing. Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B), up to the following maximums:

(1) $250 for pharmacy services per calendar year;
(2) $36 for nonpharmacy services per calendar year; and
(3) Five percent of the member's MAGI income of the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, in a given calendar quarter, including both copayments and any applicable premium payments.

(D) Excluded Individuals.

(1) The following individuals do not have to pay the copayments described in 130 CMR 450.130(B):
(a) members younger than 21 years old;
(b) members who are pregnant or 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);
(c) MassHealth Limited members;
(d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;

(e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded or who are admitted to a hospital from such a facility or hospital;
(f) members receiving hospice services;
(g) persons receiving medical services through the EAEDC Program pursuant to 130 CMR 450.106, if they do not receive MassHealth CarePlus or MassHealth Standard; and
(h) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral, in accordance with federal law.

(2) Members who have accumulated copayment charges totaling the calendar-year maximum of $250 on pharmacy services do not have to pay further MassHealth copayments on pharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for pharmacy services.
(3) Members who have accumulated copayment charges totaling the calendar-year maximum of $36 on non-pharmacy services do not have to pay further MassHealth copayments on nonpharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for nonpharmacy services.
(4) Members who have accumulated premium and copayment charges totaling an amount equal to five percent of the member's MAGI Income of the MassHealth MAGI household or the MassHealth Disabled Adult household, or the member's Countable Income as applicable, in a given calendar quarter do not have to pay further MassHealth copayments during the quarter in which the member reached the five percent cap.
(5) Members who have other comprehensive medical insurance, including Medicare, do not have to pay MassHealth copayments on nonpharmacy services.
(6) Members who are inpatients in a hospital do not have to pay a separate copayment for pharmacy services provided as part of the hospital stay.

(E) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 450.130(B):
(1) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
(2) nonpharmacy behavioral health services; and
(3) emergency services.

(F) Notice to Members about Exclusions from the Copayment Requirement. Pharmacies and hospitals must post a notice about MassHealth copayments in areas where copayments are collected. The notice must be visible to the public and easily readable and must specify the exclusions from the copayment requirement listed in 130 CMR 450.130(D) and (E), and instruct members to inform providers if members believe they are excluded from the copayment requirement.

(G) Collecting Copayments.

(1) A member must pay the copayment described in 130 CMR 450.130(B) at the time the service is provided unless the member is exempt under 130 CMR 450.130(D) or (E), claims that he or she is exempt from the copayment, or claims that he or she is unable to make the copayment at the time the service is provided. The member's inability to make the copayment at the time service is provided does not eliminate the member's liability for the copayment, and providers may bill the member for the copayment amount.

(2) The MassHealth agency 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(D) or (E). 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.

(H) Receipt. The provider must give the member a receipt identifying the provider, service, date of service, member, and amount paid.

(I) Recordkeeping. Providers must keep all records necessary to determine if a copayment was collected from a member for a service on a specific date.

(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, and notwithstanding any limitations implied or expressed elsewhere in MassHealth regulations or other publications, the MassHealth agency has established a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for MassHealth Standard and MassHealth CommonHealth members younger than 21 years old, 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 among other things, health, vision, dental, hearing, behavioral health, developmental 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

Dental Care — dental services customarily furnished by or through dental providers as defined in 130 CMR 420.000, to the extent the furnishing of those services is authorized by the MassHealth agency.

EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule) — a schedule (see Appendix W) developed and periodically updated by the MassHealth agency in consultation with recognized medical and dental organizations involved in child health care. The Dental Schedule consists of screening and treatment procedures arranged according to the intervals or age levels at which each procedure is to be provided.

EPSDT Medical Protocol and Periodicity Schedule (the Medical Schedule) — a schedule (see Appendix W of all MassHealth provider manuals) developed and periodically updated by the MassHealth agency in consultation with recognized medical and dental organizations involved in child health care. The Medical 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 Medical or the Dental 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 or treatment services delivered at an age other than one listed on the Medical or Dental Schedule to update the member's care according to the Medical or Dental Schedule; or
(3) additional screening or treatment services provided to a member whose care is already up-to-date according to the Medical or Dental Schedule.

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

Primary Care — health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, independent nurse practitioner, or independent nurse midwife, to the extent the furnishing of those services is legally authorized in the Commonwealth. Primary care does not include emergency or poststabilization services provided in a hospital or other setting.

Primary Care Providers — a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, independent nurse practitioner or independent nurse midwife.

450.142: EPSDT Services: Medical Protocol and Periodicity Schedule and Dental Protocol and Periodicity Schedule

(A) Providers of Periodic and Interperiodic Visits.

(1) Primary care providers must offer to conduct periodic and medically necessary interperiodic visits to screen all members under age 21 (except members enrolled in MassHealth Limited) in accordance with the Medical Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.
(2) Hospitals and community health centers that provide primary care services must offer to conduct periodic and medically necessary interperiodic visits to screen all members under age 21 (except members enrolled in MassHealth Limited) in accordance with the Medical Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.
(3) The health assessments described in the Medical Schedule are payable when provided by a physician, independent nurse practitioner, independent nurse midwife, hospital, community health center, or nurse practitioner, nurse midwife, or physician assistant under a physician's supervision.

(B) Providers of Dental Services.

(1) Dental care providers must offer to provide services listed in Appendix W to all members under age 21 (except members enrolled in MassHealth Limited) in accordance with the Dental Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.

(2) The dental services described in the Dental Schedule are payable when provided by dental providers as described in 130 CMR 420.000.

(C) Explanation of Procedures.

(1) The Medical 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) The Medical Schedule explains procedures that must be documented in the medical record.

(3) The Dental Schedule is a tool to help dental providers identify members with suspected or actual dental problems that may require additional investigations, diagnosis, or treatment.

450.143: EPSDT Services: Description of Medical Protocol and Periodicity Schedule Visits (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, behavioral health, 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 Medical Schedule as appropriate for the member's age.

(B) EPSDT Periodic Visit.

(1) An EPSDT periodic visit consists of all exams, assessments, screenings, and laboratory work indicated on the Medical 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 Medical 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 Medical 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 Medical Schedule. Such visits may be either

(1) preventive health-care visits provided at an age or age interval not indicated on the Medical 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) needed to correct or ameliorate physical or mental illnesses and conditions discovered by a screening, whether or not such services are covered under the State Plan; and

(b) payable for MassHealth Standard and MassHealth CommonHealth members under age 21 years, if the service is determined by the MassHealth agency 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, nurse practitioner, or nurse midwife documenting the medical need for the requested service. If the MassHealth agency approves such a request for service for which there is no established payment rate, the MassHealth agency will establish the appropriate payment rate for such service on an individual-consideration basis in accordance with 130 CMR 450.271. If the request is for a member who is enrolled in a MassHealth-contracted managed care organization, as defined in 130 CMR 508.000, the requestor must submit the request to the managed care organization according to the managed care organization's prior-authorization process. If the request is for a behavioral health service for a member who is enrolled with MassHealth's behavioral health contractor, as defined in 130 CMR 508.000, the requestor must submit the request to the behavioral health contractor according to the behavioral health contractor's prior authorization process.

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

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

(2) make a referral to another provider who can provide the appropriate assessment, diagnosis, or treatment as soon as the referring 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 assessment, 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 initial 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 Medical 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, Independent Nurse Midwife and Community Health Center Providers 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 initial, periodic, or interperiodic visit, a provider must submit a completed claim according to the billing instructions in Subchapter 5 of the applicable MassHealth provider manual.

450.146: EPSDT Services: Claims for Laboratory Services, Audiometric Hearing Tests, Vision Tests, and Behavioral Health Screening (Physician, Independent Nurse Practitioner, Independent Nurse Midwife, and Community Health Center Providers Only)

(A) Laboratory Services. 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 initial, periodic, or interperiodic visit, when they are performed and interpreted in the office of the provider who performed the initial, periodic, or interperiodic visit.

(B) Audiometric Hearing and Vision Tests. Payments for the audiometric hearing tests and the bilateral quantitative screening test of visual acuity that are listed in Appendix Z of all MassHealth provider manuals and included in the Medical Schedule, is not included in the fee for an initial, periodic, or interperiodic visit. Payment for these tests may be claimed separately.

(C) Behavioral Health Screening. Payment for the administration and scoring of one of the standardized behavioral health screening tools that is listed in Appendix Z of all MassHealth provider manuals and set forth in the Medical Schedule is not included in the fee for an initial, periodic, or interperiodic visit.

(130 CMR 450.147 Reserved)

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 MassHealth Customer Service 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 MassHealth 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 Appendix W 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 Medical Schedule that was delivered by another provider.

(B) Determination of Compliance with Medical Standards. The MassHealth agency 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 (PPHSD) Services for Certain MassHealth Members

(A) MassHealth has established a program of preventive pediatric health-care screening and diagnosis services for MassHealth members younger than 21 years old who are enrolled in MassHealth Family Assistance. MassHealth Standard and MassHealth CommonHealth 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 Medical 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 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)