



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



MassHealth  
Transmittal Letter ALL-223  
October 2017

**TO:** All Providers Participating in MassHealth

**FROM:** Daniel Tsai, Assistant Secretary for MassHealth

**RE:** *All Provider Manuals* (Federal Requirements for Ordering, Referring, and Prescribing Providers)

MassHealth is amending the All Provider Administrative and Billing regulations at 130 CMR 450.00 et. seq. to implement federal requirements regarding ordering, referring, and prescribing providers.

The amendments to 130 CMR 450.212 describe a new MassHealth provider type (nonbilling) for providers who do not wish, or are not eligible, to enroll as fully participating MassHealth providers, but whose National Provider Identifier (NPI) must be included on claims submitted by billing providers. In particular, the Affordable Care Act (ACA) requires that for services that require an order, referral, or prescription to be payable by the MassHealth agency, the NPI of the ordering, referring, or prescribing provider must be included on the claim and the ordering, referring, or prescribing provider must be enrolled with MassHealth. Also, HIPAA Version 5010 rules require, in certain circumstances, that the NPI of the attending, operating, and supervising provider be included on the claim. Offering a streamlined enrollment process through a nonbilling provider type decreases burden on those providers who choose not to fully participate in MassHealth.

The amendments to 130 CMR 450.231 require that, if under state or federal statute, regulation, billing instructions, or other subregulatory guidance, a provider's NPI is required on a claim submitted to MassHealth, then the NPI must be included on the claim and that provider must participate in MassHealth as either a billing or nonbilling provider in order for the claim to be payable. If the NPI of a provider who is not a MassHealth-participating provider is included on a claim for any reason, that claim may not be payable. Please note that MassHealth does not intend to begin denying such claims at this time and will notify providers in advance of the date that claims denials will begin.

To protect members' access to care and to facilitate payment to billing providers, state legislation was enacted (Chapter 118 of the Acts of 2012, §19-23 and 34 and Chapter 10 of the Acts of 2015, §22-27) to require all providers who are authorized to order, refer, and prescribe to apply to enroll with MassHealth at least as a nonbilling provider in order to obtain and maintain state licensure. The licensure requirement will go into effect when these implementing regulations are promulgated.

*(Continued on next page)*

In addition, the regulations require that providers who order, refer or prescribe services for MassHealth members include their NPI on written orders, referrals and prescriptions and provide their NPI to billing providers upon request.

The amendments to 130 CMR 450.212 also address specific MassHealth requirements regarding participation of providers in group practices. Finally, amendments to 130 CMR 450.118 update PCC referral requirements so that they are in compliance with the ACA Ordering and Referring requirements referenced above.

These regulations are effective November 3, 2017.

### **MassHealth Website**

This transmittal letter and attached pages are available on the MassHealth website at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### **Questions**

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at 1-800-841-2900, e-mail your inquiry to [providersupport@mahealth.net](mailto: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 1-21 through 26, 2-11 through 2-13, 2-13-a, 2-13-b, 2-14, 2-23, 2-23-a, 2-23-b, and 2-24

### **OBSOLETE MATERIAL**

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

#### **All Provider Manuals**

Pages 1-21 through 1-26 — transmitted by Transmittal Letter 222  
Pages 2-11 through 2-14 and 2-23, 24 — transmitted by Transmittal Letter 220

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(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 younger than 65 years of age and 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 except for MassHealth members who participate in one of the Money Follows the Person home- and community-based services waivers.

(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 benefits managers (including behavioral health management firms and pharmacy benefit managers) and other 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 of the 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 the Federal Mental Health Parity Law.

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(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 the 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: *Integrated Care Organizations*.

(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 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 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 enrolled member 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 identifies the name and telephone number of the ICO. The MassHealth agency does 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, or physician assistants participating pursuant to 130 CMR 433.434, 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. Such providers may enroll as nonbilling providers under 130 CMR 450.212(E). 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); A physician specialist must agree to provide primary care services to PCC Plan enrollees;

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(2) independent certified nurse practitioners who specialize in family practice, pediatrics, internal medicine, obstetrics, gynecology or obstetrics/gynecology, and have an arrangement with a MassHealth-participating physician for purposes of hospital admissions and as needed to satisfy scope of practice requirements. Such physician must meet the criteria of 130 CMR 450.118(B)(1) and be in the nurse practitioner's service area. An independent certified nurse practitioner specialist must agree to provide primary care services to PCC Plan enrollees;

(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 independent certified nurse practitioner who  
 (a) is enrolled and approved by the MassHealth agency as a participating provider in that group in accordance with 130 CMR 450.212(A)(8);  
 (b) meets the requirements of 130 CMR 450.118(B)(1) or (2); and  
 (c) has signed the PCC contract.

(6) Physician assistants employed by a group practice, if the group practice also employs at least one physician who supervises the physician assistant and meets the requirements of 130 CMR 450.118(B)(5). The supervisory arrangement must comply with 130 CMR 433.434(D) and 263 CMR 5.00.

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

(D) Hospital Outpatient Department Participation. When a hospital outpatient department participates as a PCC, it must assign each enrolled member 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 enrolled member to an individual practitioner who meets the criteria under 130 CMR 450.118(B)(1), (2), or (6).

(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

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(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 enrolled members to such practitioner and to reassign existing enrolled members 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). In order to make a referral, PCCs must follow the processes described in the PCC provider contract and must include the individual National Provider Identifier (NPI) number of an individual practitioner who meets the criteria of 130 CMR 450.118(B)(1), (2), or (6). Please refer to 130 CMR 450.231: *General Conditions of Payments* for additional requirements regarding referrals.

(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 and includes the individual National Provider Identifier (NPI) number of an individual practitioner who meets the criteria of 130 CMR 450.118(B)(1), (2), or (6).

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(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 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) clinical laboratory services;
- (d) diabetic supplies;
- (e) durable medical equipment (items, supplies, and equipment) described in 130 CMR 409.000: *Durable Medical Equipment Services*;
- (f) fiscal intermediary services as described in 130 CMR 422.419(B): *The Fiscal Intermediary*;
- (g) fluoride varnish administered by a physician or other qualified medical professional;
- (h) functional skills training provided by a MassHealth personal care management agency as described in 130 CMR 422.421(B): *Functional Skills Training*;
- (i) HIV pre- and post-test counseling services;
- (j) HIV testing;
- (k) hospitalization
  - 1. 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;
  - 2. 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;
- (l) obstetric services for pregnant and postpartum members provided up to the end of the month in which the 60-day period following the termination of pregnancy ends;
- (m) oxygen and respiratory therapy equipment;
- (n) pharmacy services (prescription and over-the-counter drugs);
- (o) radiology and other imaging services with the exception of magnetic resonance imaging (MRI) computed tomography (CT) scans, and positron emission tomography (PET) scans, and imaging services conducted at an independent diagnostic testing facility (IDTF), which do require a referral;
- (p) services delivered by a behavioral health provider (including inpatient and outpatient psychiatric services);
- (q) services delivered by a dentist;
- (r) services delivered by a family planning service provider, for members of child-bearing age;
- (s) services delivered by a hospice provider;
- (t) services delivered by a limited service clinic;
- (u) services delivered in a nursing facility;
- (v) services delivered by an anesthesiologist or a certified registered nurse anesthetist;
- (w) services delivered in an intermediate care facility for the mentally retarded (ICF-MR);

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- (x) services delivered to a homeless member outside of the PCC office pursuant to 130 CMR 450.118(K);
- (y) services delivered to diagnose and treat sexually transmitted diseases;
- (z) services delivered to treat an emergency condition;
- (aa) services provided under a home- and community-based waiver;
- (bb) sterilization services when performed for family planning services;
- (cc) surgical pathology services;
- (dd) tobacco-cessation counseling services;
- (ee) transportation to covered care;
- (ff) vision care in the following categories (*see* Subchapter 6 of the *Vision Care Manual*): visual analysis frames, single-vision prescriptions, bifocal prescriptions, and repairs; and
- (gg) additional services provided to members whose PCC participates in an Accountable Care Organization (ACO) subject to bulletins and other issuances more particularly describing applicable referral requirements.

(K) Services to Homeless Members. 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)



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(3) If the provider does not submit a request for agency review, the MassHealth Pay-for-Performance Payment Notice constitutes the MassHealth agency's final determination of the provider's pay-for-performance payment amounts. If a provider requests agency review but fails to timely comply with the requirements of 130 CMR 450.210(C)(1) and (2), the request for agency review may be denied. In either case, the MassHealth Pay-for-Performance Payment Notice constitutes the MassHealth agency's final determination, and the provider has no right to an adjudicatory hearing pursuant to 130 CMR 450.241 or judicial review because of the failure to exhaust its administrative remedies.

450.211: Medicaid Electronic Health Records Incentive Payment Program: Reconsideration and Appeals Process

(A) Applicability. The provisions set forth in 130 CMR 450.211 establish the MassHealth agency's review process for provider disputes concerning the Medicaid Electronic Health Records Incentive Payment Program established pursuant to § 4201 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5 and 42 CFR Part 495.

(B) Medicaid Electronic Health Records Incentive Payment Program Notice. The MassHealth agency will notify the provider in writing of the agency's determination of the provider's Medicaid Electronic Health Records Incentive Payment Program eligibility and payment amount. The notice will identify the provider's eligibility, determination of payment amount, and right to review. The MassHealth agency will notify the provider by letter, report, computer printout, electronic transmission, or other format. This notification is the Medicaid Electronic Health Records Incentive Payment Program Notice referred to in 130 CMR 450.211.

(C) Requesting MassHealth Agency Review of Medicaid Electronic Health Records Incentive Payment Program Determinations.

(1) To preserve its right to an adjudicatory hearing and judicial review, a provider must request MassHealth agency review of the agency's determination specified in the Medicaid Electronic Health Records Incentive Payment Program Notice. A provider's request for review may be based on either an alleged error in the MassHealth agency's determination of the provider's Medicaid Electronic Health Records Incentive Payment Program eligibility and payment amount or on information that was not initially supplied during the application process. The provider's request for review must be made in writing and be received by the MassHealth agency within 30 calendar days of the date appearing on the Medicaid Electronic Health Records Incentive Payment Program Notice. Only those determinations specifically identified in dispute by the provider in its request for an agency review are subject to review.

(2) A provider's request for review may request reconsideration of the following findings:

- (a) the provider's eligibility for incentive payments; and
- (b) incentive payment amounts.

(3) Any request for agency review submitted pursuant to 130 CMR 450.211(C)(1) must

- (a) identify with specificity all determinations with which the provider disagrees;
- (b) specify in sufficient detail the basis for the provider's disagreement with those determinations;
- (c) identify and address all issues in the Medicaid Electronic Health Records Incentive Payment Program Notice with which the provider disagrees; and
- (d) include any documentary evidence and information that the provider wants the MassHealth agency to consider.

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(D) MassHealth Agency’s Final Determination.

(1) The MassHealth agency will review a provider’s request for agency review only if it is submitted in compliance with the requirements of 130 CMR 450.211(C)(1) through (3). The MassHealth agency is not obligated to consider any information or documents that the provider failed to timely submit under time deadlines previously imposed by the MassHealth agency. The MassHealth agency will issue a final written determination of contested Medicaid Electronic Health Records Incentive Payment Program determinations based on its review, which will state the reasons for the determination, and inform the provider of the provider’s right to file a claim for an adjudicatory hearing in accordance with 130 CMR 450.241.

(2) Any findings specified in the Medicaid Electronic Health Records Incentive Payment Program Notice that are not specifically identified as in dispute in a provider’s request for agency review will, without further notice, constitute the MassHealth agency’s final determination. The provider has no right to an adjudicatory hearing pursuant to 130 CMR 450.241 or judicial review of such findings because of the failure to exhaust its administrative remedies.

(3) If the provider does not submit a request for agency review, the Medicaid Electronic Health Records Incentive Payment Program Notice constitutes the MassHealth agency’s final determination. If a provider requests agency review but fails to timely comply with the requirements of 130 CMR 450.211(C)(1) through (3), the request for agency review may be denied. In either case, the Medicaid Electronic Health Records Incentive Payment Program Notice constitutes the MassHealth agency’s final determination, and the provider has no right to an adjudicatory hearing pursuant to 130 CMR 450.241 or judicial review because of the failure to exhaust its administrative remedies.

450.212: Provider Eligibility: Eligibility Criteria

(A) To be eligible to participate in MassHealth as any provider type, a provider must

- (1) meet all statutory requirements applicable to such provider type;
- (2) meet all conditions of participation applicable to such provider type under Titles XVIII and XIX of the Social Security Act and regulations promulgated thereunder;
- (3) meet all conditions of participation applicable to such provider type. Program regulations applicable to specific provider types appear in 130 CMR 400.000 through 499.000. This requirement does not apply to providers participating pursuant to 130 CMR 450.212(D) and (E).
- (4) be fully licensed, certified, or registered as an active practitioner by the agency or board overseeing the specific provider type, and where the regulations define “specialist” credentials or require other credentials, providers must possess those credentials;
- (5) be registered with appropriate state and federal agencies to prescribe controlled substances, for any provider type that is legally authorized to write prescriptions for medications and biologicals;
- (6) never have been subject and never have had common parties in interest with any provider subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency, or board, including MassHealth or any other state’s Medicaid program. These include but are not limited to, revocation, suspension, termination, reprimand, censure, admonishment, fine, probation agreement, agreements not to practice or other practice limitation, practice monitoring, or remedial training or other educational or public service activities;

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(7) not have purchased or otherwise obtained its practice or business entity from any provider suspended or terminated from MassHealth participation due to violations of applicable laws, rules, or regulations; or from a provider that is currently subject to a withholding of payments for a credible allegation of fraud under 130 CMR 450.249 or who terminates or has its participation terminated while subject to such a withholding of payments;

(8) cooperate with the MassHealth agency during any application, revalidation of enrollment, or other review process, which may include, but not be limited to, permitting and facilitating site visits, as determined by the MassHealth agency. In addition, applicants and providers must, within 30 days upon request from CMS or the MassHealth agency, complete any requisite forms authorizing a criminal offender record check and ensure that the applicant or provider, or any person with a 5% or more direct or indirect ownership interest (as defined under 130 CMR 450.221) in the applicant or provider, submits a set of fingerprints in a form and manner determined by the MassHealth agency. Such applicants, providers, or persons may be required to pay costs associated with fingerprinting;

(9) not be subject to a moratorium on enrollment imposed in accordance with 42 CFR 455.470; and

(10) if the provider is a group practice, ensure that all individual practitioners in the group who provide services to MassHealth members and for whom the group practice bills MassHealth obtain an individual MassHealth provider number by completing a fully participating application, and meet all the requirements of 130 CMR 450.212(A)(1) through (9). Such practitioners may not enroll as nonbilling providers under 130 CMR 450.212(E). In addition, for a group practice to participate in MassHealth, it must file a group practice provider application with the MassHealth agency, and meet all of the following requirements.

- (a) It must be a recognized legal entity (for example, partnership, corporation, or trust). A sole proprietorship may not be a group practice.
- (b) It must satisfy at least one of the following:
  - 1. all of the beneficial interest in the group practice must be held by individual practitioners who are members of the group practice serviced by the group practice; or
  - 2. all members of the group practice must be employees or contractors of the group practice.
- (c) It must not be currently or have previously been suspended from MassHealth participation due to violations of applicable laws, rules, or regulations or have common parties in interest with any provider that is currently under suspension or has been suspended.

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(B) A provider who does not meet the requirements of 130 CMR 450.212(A)(6) through (9), or (10)(c) may, at the MassHealth agency’s discretion, participate in MassHealth only if, in the judgment of the MassHealth agency, such participation would neither

- (1) threaten the health, welfare, or safety of members; nor
- (2) compromise the integrity of MassHealth.

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

(D) A Qualified Medicare Beneficiaries (QMB)-only provider is a provider who provides medical services only to MassHealth Senior Buy-In members described in 130 CMR 519.010: *MassHealth Senior Buy-In* and in 130 CMR 505.007: *MassHealth Senior Buy-In and Buy-In* and certain MassHealth Standard members who are eligible for QMB benefits described in 130 CMR 519.002(A)(4)(c) and 130 CMR 505.002(O). QMB-only providers are subject to all regulations pertaining to providers participating in MassHealth except as provided below or as otherwise specified in 130 CMR 450.000. QMB-only providers may bill only for medical services for QMB members and Standard members eligible for QMB benefits, whether or not the associated medical services are specified in 130 CMR 400.000 through 499.000.

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(E) A non-billing provider is an individual provider who enrolls with MassHealth because his or her information (e.g., National Provider Identifier (NPI) is required on a claim submitted by a billing provider to MassHealth pursuant to state or federal statute, regulation, billing instruction or other subregulatory guidance or is included on a claim because of a billing provider’s own billing procedures, or is otherwise required or permitted by state or federal law to enroll with MassHealth for a limited purpose. A nonbilling provider must include his or her individual NPI on all orders, referrals, and prescriptions for services to MassHealth members, and must provide his or her individual NPI to a billing provider upon request in other circumstances in which the billing provider must include the nonbilling provider’s NPI on MassHealth claims. See also 130 CMR 450.231(F)

- (1) Nonbilling providers may enroll through a streamlined application process determined by the MassHealth agency.
- (2) Nonbilling providers may not submit claims to or receive payments from the MassHealth agency.
- (3) Nonbilling providers are not subject to certain provisions of the provider regulations relating to payments and claims processing. However, nonbilling providers are subject to all other applicable regulations pertaining to MassHealth billing providers including but not limited to those relating to ordering, prescribing, referring, screening, prior authorization, medical necessity, utilization management and recordkeeping and disclosure with respect to services ordered, referred, prescribed or provided to MassHealth members.
- (4) An individual who provides services to MassHealth members as part of a group practice, which bills on behalf of the individual, must enroll as a fully participating provider and may not enroll as a nonbilling provider under 130 CMR 450.212(E).

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

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450.213: Provider Eligibility: Termination of Participation for Ineligibility

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

450.214: Provider Eligibility: Suspension of Participation Pursuant to United States Department of Health and Human Services Order

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

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450.231: General Conditions of Payments

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

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

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

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

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(D) A provider is responsible for verifying a member’s eligibility status on a daily basis, including but not limited to members who are hospitalized or institutionalized. In order to receive MassHealth payment for a covered medical service, the person receiving such service must be eligible for MassHealth coverage on the date of service and the provider must comply with any service authorization requirements and all other conditions of payment. A provider’s failure to verify a member’s MassHealth status before providing services to the member may result in nonpayment of such services. For payment for services provided before a member’s MassHealth eligibility determination, see 130 CMR 450.309(B). For payment to out-of-state providers providing services on an emergency basis, see 130 CMR 450.309(C).

(E) Payments to QMB-only providers as defined in 130 CMR 450.212(D) may be made upon the MassHealth agency’s receipt of a claim for payment within the time limitations set forth in provisions, regulations, or rules under Title XVIII of the Social Security Act.

(F) Payment to all providers is made in accordance with the payment methodology applicable to the provider, established by EOHHS, subject to all applicable federal payment limits.



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(G) If under state or federal statute, regulation, billing instructions or other subregulatory guidance, a provider's National Provider Identifier (NPI) is required on a claim submitted to MassHealth, that information must be included on the claim, and that provider must participate in MassHealth for the claim to payable. If the NPI of a provider who is not a MassHealth participating provider is included on a claim for any reason or if an NPI is not provided in accordance with state or federal requirements, that claim may not be payable.

(H) When any participating MassHealth provider orders, refers, or prescribes a service for a MassHealth member, that provider must include his or her individual NPI on such orders, referrals, or prescriptions. Such provider must also provide his or her individual NPI to a servicing billing provider upon request in other circumstances in which the servicing billing provider must include the ordering, referring or prescribing provider's NPI on MassHealth claims.

(130 CMR 450.232 Reserved)

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

(A) Except as provided in 130 CMR 450.233(D) and 435.405(B), payment to an out-of-state institutional provider for any medical service payable by the MassHealth agency is the lowest of

- (1) the rate of payment established for the medical service under the other state’s Medicaid program;
- (2) the MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or
- (3) the MassHealth rate of payment established for a comparable provider in Massachusetts.

(B) An out-of-state institutional provider, other than an acute hospital, must submit to the MassHealth agency a current copy of the applicable rate schedule under its state’s Medicaid program.

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

(D) Payment to an out-of-state acute hospital provider for any medical service payable by the MassHealth agency is made as set forth in 130 CMR 450.233(D)(1) through (3). For purposes of 130 CMR 450.233(D), a “High MassHealth Volume Hospital” means any out-of-state acute hospital provider that had at least 150 MassHealth discharges during the most recent federal fiscal year for which complete data is available as determined by the MassHealth agency at least 90 days prior to the start of each federal fiscal year.

(1) Inpatient Services. Except as provided in 130 CMR 450.233(D)(3), out-of-state acute hospitals are paid for inpatient services as specified in 130 CMR 450.233(D)(1)(a) through (c).

(a) Payment Amount Per Discharge.

1. Out-of-state APAD: Out-of-state acute hospitals are paid an adjudicated payment amount per discharge (“out-of-state APAD”) for inpatient services. The out-of-state APAD is calculated using the sum of the statewide operating standard per discharge and the statewide capital standard per discharge both as in effect for in-state acute hospitals on the date of admission, which is then multiplied by the MassHealth DRG Weight assigned to the discharge based on the information contained in a properly submitted inpatient acute hospital claim.

a. “MassHealth DRG Weight” for purposes of 130 CMR 450.233(D) is the MassHealth relative weight determined by the MassHealth agency for each unique combination of APR-DRG and Severity of Illness (SOI).

b. “APR-DRG” or “DRG” for purposes of 130 CMR 450.233(D) refers to the All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned to a claim by the 3M APR-DRG Grouper.

2. Out-of-state Outlier Payment: If the calculated cost of the discharge exceeds the discharge-specific outlier threshold, then the out-of-state acute hospital is also paid an outlier payment for that discharge (“out-of-state outlier payment”). The out-of-state outlier payment is equal to the marginal cost factor in effect for in-state acute hospitals on the date of admission multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold.