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

MassHealth
Transmittal Letter AOH-33
January 2015

TO: Acute Outpatient Hospitals Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: *Acute Outpatient Hospital Manual* (Updated Gender Dysphoria and Sterilization Policies; Out-of-State Chronic Disease and Rehabilitation Hospitals)

This letter transmits revisions to the Acute Outpatient Hospital (AOH) regulations as they pertain to treatment for gender dysphoria, sterilization services, and out-of-state chronic disease and rehabilitation hospitals. This letter also transmits related updates to Subchapter 6 of the *Acute Outpatient Hospital Manual*. A subsequent transmittal letter will be issued to address regulatory changes regarding abortion services.

Gender Dysphoria Policy

This letter transmits revisions to the acute outpatient hospital regulations to allow coverage of treatment of gender dysphoria, including gender reassignment surgeries and hormone therapies.

Gender reassignment surgeries and certain hormone therapies require prior authorization. Providers should review the Guidelines for Medical Necessity Determination for Gender Reassignment Surgery, available at www.mass.gov/masshealth/guidelines, and the MassHealth Drug List, available at https://masshealthdruglist.ehs.state.ma.us/MHDL, for more information on prior authorization requirements.

Sterilization Provisions

This letter also transmits revisions to the sterilization provisions in the acute outpatient hospital regulations. MassHealth has clarified in its regulations that a provider does not need to submit a copy of the MassHealth Consent for Sterilization (CS-18 or CS-21) form with a claim for a medical procedure, treatment, or operation that is not for the purpose of rendering an individual permanently incapable of reproducing. If the appropriate service code used to bill for such a medical procedure, treatment, or operation may also be used to bill for a sterilization, the updated regulations provide that the claim will be denied unless at least one of the following justifications is present and documented on an attachment signed by the physician and attached to the claim:

(A) the medical procedure, treatment, or operation was unilateral and did not result in sterilization;

(B) the medical procedure, treatment, or operation was unilateral or bilateral, but the patient was previously sterile as indicated in the operative notes;

(C) the medical procedure, treatment, or operation was medically necessary for treatment of an existing illness or injury and was not performed for the purpose of sterilization; or

(D) the medical procedure, treatment, or operation was medically necessary for treatment of a life-threatening emergency situation and was not performed for the purpose of sterilization, and it was not possible to inform the member in advance that it would or could result in sterilization. The physician must also include the nature and date of the life-threatening emergency.

In addition, under the circumstances referenced in (A) and (C), above, the medical records must also document that the member consented to the medical procedure, treatment, or operation after being informed that it would or could result in sterilization.

These changes continue to conform to federal standards. MassHealth has also conformed relevant sterilization provisions to the other MassHealth provider regulations for consistency purposes, and has updated certain terminology and removed redundant definitions. Please see 130 CMR 410.431 through 410.433, and relevant definitions for more information and the applicable sterilization provisions.

Related Updates to Subchapter 6 of the *Acute Outpatient Hospital Manual*

This letter also transmits a revised Subchapter 6 of the *Acute Outpatient Hospital Manual*, reflecting updates, as necessary, related to the gender dysphoria regulatory changes referenced above. The gender dysphoria-related updates to Subchapter 6 include deletions of relevant service codes from Section 602, “Nonpayable CPT Codes.”

Out-of-State Chronic Disease and Rehabilitation Hospitals

This letter also transmits revisions to these regulations to specify MassHealth outpatient hospital participation requirements and payment provisions for chronic disease, rehabilitation, or similar hospitals with both out-of-state inpatient facilities and in-state outpatient facilities.

Effective Date

These regulatory amendments and Subchapter 6 updates are effective for dates of service on or after January 2, 2015.

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 the MassHealth Customer Service Center 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.)

Acute Outpatient Hospital Manual

Pages iv, iv-a, 4-1 through 4-18, 4-21 through 4-30, 4-39, 4-40, and 6-1 through 6-16

OBSOLETE MATERIAL

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

Acute Outpatient Hospital Manual

Page iv — transmitted by Transmittal Letter AOH-33

Pages 4-1, 4-2, 4-5, 4-6, and 4-27 through 4-30 — transmitted by Transmittal Letter AOH-31

Pages 4-3, 4-4, 4-14, 4-15, 4-16, 4-39, and 4-40 — transmitted by Transmittal Letter AOH-18

Pages 4-7 through 4-12, 4-17, 4-18, 4-21 through 4-26 — transmitted by Transmittal Letter AOH-10

Pages 4-13 and 4-14 — transmitted by Transmittal Letter AOH-15

Pages 6-1 through 6-16 — transmitted by Transmittal Letter AOH-32

4. Program Regulations

4. Program Regulations (cont.)

410.401: Introduction

130 CMR 410.000 establishes the requirements for the provision of services by hospital outpatient departments and hospital-licensed health centers under MassHealth. For the purposes of 130 CMR 410.000, "hospital outpatient department" refers to both hospital outpatient departments and hospital-licensed health centers. MassHealth pays for outpatient visits and ancillary services (such as radiographic views, laboratory tests, medical supplies, and pharmacy items) that are medically necessary and appropriately provided, as defined at 130 CMR 450.204: *Medical Necessity*. The quality of such services must meet professionally recognized standards of care.

410.402: Definitions

The following terms used in 130 CMR 410.000 have the meanings given in 130 CMR 410.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 410.402 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 410.000, and in 130 CMR 415.000: *Acute Inpatient Hospital Services* and 450.000: *Administrative and Billing Regulations.*

340B-Covered Entities – facilities and programs eligible to purchase discounted drugs through a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992.

340B Drug-Pricing Program – a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their patients.

Acupuncture – the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, with or without the application of an electric current, and with or without the application of heat to the needles, skin, or both.

Acute Inpatient Hospital – a facility that is licensed as a hospital by the Massachusetts Department of Public Health and that provides diagnosis and treatment for patients who have any of a variety of medical conditions requiring daily physician intervention as well as full-time availability of physician services; however, this does not include any facility that is licensed as a chronic disease and rehabilitation hospital, any hospital that is licensed primarily to provide mental health services, or any unit of a facility that is licensed as a nursing facility, a chronic disease unit, or a rehabilitation unit.

Controlled Substance – a drug listed in Schedules II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

Cosmetic Surgery – a surgical procedure that is performed for the exclusive purpose of altering appearance and is unrelated to disease or physical defect, or traumatic injury.

Drug – a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

Emergency – the unexpected onset of symptoms or a condition requiring immediate medical or surgical care, including, but not limited to, accidents and illnesses such as heart attack, stroke, poisoning, convulsions, loss of consciousness, and cessation of breathing.

Family Planning – any medically approved means, including diagnosis, treatment, and related counseling, that assists individuals of childbearing age, including sexually active minors, in determining the number and spacing of their children.

Functional Level – the degree to which an individual can function in the community. Progressive levels of impaired functioning are evaluated using a MassHealth-approved scale that has specific criteria for emotional stability, vocational/educational productivity, social relations, and self-care.

Functional Maintenance Program – a planned combination of social, vocational, and recreational services designed for individuals disabled by a chronic mental illness who need continuing services to maintain skills that allow them to function within the community but who do not require the more intensive care of inpatient or day treatment programs.

Hospital – a facility that is licensed or operated as a hospital by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health and that provides diagnosis and treatment on an outpatient basis for patients who have any of a variety of medical conditions.

Hospital-Licensed Health Center – a facility not physically attached to a hospital that operates under the hospital's license, falls under the fiscal, administrative, and clinical management of the hospital, and provides services to patients on an outpatient basis.

Hospital Outpatient Department – a department or unit within the physical framework of the hospital that operates under the hospital's license and provides services to members on an outpatient basis. Hospital outpatient departments include day-surgery units, primary-care clinics, specialty clinics, and emergency departments.

Inpatient Services – medical services provided to a member admitted to an acute inpatient hospital.

Institutionalized Individual – an individual who is either:

(1) involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or other facility for the treatment of mental illness; or

(2) confined under a voluntary commitment in a psychiatric hospital or other facility for the care and treatment of mental illness.

Interchangeable Drug Product – a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A-rated") by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

Maintenance Program – repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment and skill of a licensed therapist for safety and effectiveness.

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by the MassHealth agency. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 410.463(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 410.000.

Mental Illness – mental and emotional disorders as defined in the current *International Classification of Diseases, Clinical Modification* or the American Psychiatric Association's *Diagnostic and Statistical Manual* and manifested by impaired functioning in one or more of the following: emotional stability, vocational/educational productivity, social relations, and self-care.

Mentally Incompetent Individual – an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

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.

Non-Drug Product List – a section of the MassHealth Drug List comprised of those products not classified as drugs (i.e., blood testing supplies) that are payable by the MassHealth agency through the Pharmacy Program. Payment for these items is in accordance with rates published in Executive Office of Health and Human Services (EOHHS) regulations at 114.3 CMR 22.00: *Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment* and 101 CMR 317.00: *Medicine. The MassHealth Non-Drug Product List* also specifies which of the included products require prior authorization.

Observation Services – outpatient hospital services provided anywhere in an acute inpatient hospital, to evaluate a member's condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Occupational Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence, preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

Outpatient Hospital Services – medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, and day-surgery services.

Outpatient Services – medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home.

Outpatient Visit – an in-person encounter between an eligible member and a licensed practitioner (such as a physician, optician, optometrist, dentist, or therapist) or other medical professional under the direction of a licensed practitioner for the provision of outpatient services as defined in 130 CMR 410.402.

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. The MassHealth agency requires a prescription for both prescription drugs and over-the-counter drugs (see 130 CMR 410: 461(A))

Pharmacy Online Processing System (POPS) – the online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

Physical Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

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.

Reconstructive Surgery – a surgical procedure that is performed to correct, repair, or ameliorate the physical effects of disease or physical defect (for example, correction of a cleft palate), or traumatic injury.

Satellite Clinic – a facility that operates under a hospital's license, is subject to the fiscal, administrative, and clinical management of the hospital, provides services to members solely on an outpatient basis, is not located at the same site as the hospital's inpatient facility, and demonstrates to the MassHealth agency's satisfaction that it has CMS provider-based status in accordance with 42 CFR 413.65.

Sheltered Workshop – a program of vocational counseling and training in which the participants receive paid work experience or other supervised employment.

Speech/Language Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of the presence of a communication disability), and those that impair comprehension, or spoken, written, or other symbol systems used for communication.

Sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Trimester – one of three three-month terms in a normal pregnancy. If the pregnancy has existed for less than 12 weeks, the pregnancy is in its first trimester. If the pregnancy has existed for 12 or more weeks but less than 24 weeks, the pregnancy is in its second trimester. If the pregnancy has existed for 24 or more weeks, the pregnancy is in its third trimester. For the purposes of 130 CMR 410.000, the elapsed period of gestation is calculated in accordance with regulations of the Massachusetts Department of Public Health.

Unit-Dose Distribution System – a means of packaging or distributing drugs, or both, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken. Such unit doses may or may not be in unit-dose packaging.

Vocational Rehabilitative Services – services such as vocational assessments, job training, career counseling, and job placement.

410.403: Eligible Members

(A) (1) MassHealth Members. MassHealth covers outpatient hospital services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105: *Coverage Types* specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

410.404: Provider Eligibility

Payment for the services described in 130 CMR 410.000 is made only to hospital outpatient departments participating in MassHealth on the date of service.

(A) In-State.

(1) To participate in MassHealth, acute hospital outpatient departments and hospital-licensed health centers located in Massachusetts must

(a) operate under a hospital license issued by the Massachusetts Department of Public Health;

(b) have a signed provider agreement that specifies a payment methodology with the MassHealth agency; and

(c) participate in the Medicare program.

(2) To participate in MassHealth, nonacute hospital outpatient departments located in Massachusetts must

(a) operate under a hospital license issued by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health;

(b) have a signed provider agreement for participation in MassHealth; and

(c) participate in the Medicare program.

(B) Out-of-State

(1) Out-of-state hospital outpatient and hospital-licensed health center services provided to an eligible MassHealth member are covered in the following instances:

(a) emergency care hospital outpatient services provided to a member;

(b) hospital outpatient services provided to a member whose health would be endangered if the member were required to travel to Massachusetts;

(c) hospital outpatient services provided to a member when MassHealth determines on the basis of medical advice that the medical service is more readily available in the other state;

(d) it is general practice for members in a particular locality to use medical resources in another state;

(e) hospital outpatient services provided to a member who is authorized to reside or who is placed out of state by the Massachusetts Department of Social Services or by a Chapter 766 core team evaluation;

(f) hospital outpatient services provided to a member who has been authorized by the MassHealth agency to reside in an out-of-state nursing facility; or

(g) when prior authorization has been obtained from the MassHealth agency for nonemergency services provided to a member by an out-of-state hospital outpatient department that is more than 50 miles from the Massachusetts border.

(2) To participate in MassHealth, an out-of-state hospital outpatient department or hospital-licensed health center must obtain a MassHealth provider number and meet the following criteria:

(a) it operates under a hospital license from or is approved as a hospital by the governing or licensing agency in its state;

(b) it participates in the Medicare program; and

(c) it participates in that state's Medicaid program (or the equivalent).

(3) Payment for out-of-state hospital outpatient and hospital-licensed health center services is made in accordance with 130 CMR 450.233: *Rates of Payment to Out-of-State Providers*.

(C) Chronic Disease, Rehabilitation, or Similar Hospitals with Both Out-of-State Inpatient Facilities and In-State Outpatient Facilities

(1) To participate in MassHealth, chronic disease, rehabilitation, or similar hospitals with both out-of-state inpatient facilities and in-state outpatient facilities must meet the following criteria:

(a) Out-of-State Outpatient Facilities. The hospital's out-of-state outpatient facilities must comply with 130 CMR 410.404(B).

(b) In-State Outpatient Facilities. The hospital's in-state outpatient facilities must

(i) be appropriately licensed by the Massachusetts Department of Public Health;

(ii) have a signed provider agreement for participation in MassHealth; and

(iii) participate in Medicare as a provider-based satellite of the out-of-state hospital.

(2) Payment for outpatient services at chronic disease, rehabilitation, or similar hospitals with both out-of-state inpatient facilities and in-state outpatient facilities is made in accordance with 130 CMR 450.234(B): *Outpatient Services*.

410.405: Noncovered Services

(A) The MassHealth agency does not pay for any of the following services:
(1) nonmedical services, such as social, educational, and vocational services;
(2) cosmetic surgery;
(3) canceled or missed appointments;
(4) telephone conversations and consultations;
(5) court testimony;
(6) research or the provision of experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments;
(7) the provision of whole blood; however, administrative and processing costs associated with the provision of blood and its derivatives are covered; and
(8) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does pay for the diagnosis of infertility.

(B) The MassHealth agency does not pay for mental health services such as, but not limited to, the following (see 130 CMR 410.472):
(1) vocational rehabilitation services;
(2) sheltered workshops;
(3) recreational services;
(4) life-enrichment services; and
(5) alcohol or drug drop-in centers.

(C) The MassHealth agency does not pay for pharmacy services such as, but not limited to, the following (see 130 CMR 410.462 through 410.465):
(1) any drug used for the treatment of obesity;
(2) cough and cold preparations;
(3) less-than-effective drugs; and
(4) drugs related to the treatment of male or female infertility.

(D) The MassHealth agency does not pay for vision care services such as, but not limited to, the following (see 130 CMR 410.481 through 410.489):
(1) absorptive lenses of greater than 25% absorption;
(2) photochromatic lenses, sunglasses, or fashion tints;
(3) treatment of congenital dyslexia;
(4) extended-wear contact lenses;
(5) invisible bifocals; and
(6) the Welsh 4-Drop Lens.

(E) The MassHealth agency does not pay an independent practitioner for services provided to members in an outpatient department except when that practitioner has an active provider number issued by the MassHealth agency and meets one of the following criteria.
(1) The practitioner serves in an attending, visiting, or supervisory role at the hospital where the services are provided, is legally responsible for the management of the member's care, is physically present and actively involved in the treatment for which payment is claimed, and provides a service for which the MassHealth agency pays an independent practitioner when provided in an outpatient hospital setting. Supervisory surgeons must be scrubbed and physically present during the major portion of an operation.

(2) The independent practitioner, if serving as a salaried intern, resident, fellow, or house officer, provides services during off-duty hours at an institution that does not pay his or her salary.

(3) The independent practitioner receives a salary from an institution for administrative or teaching services, but not for delivery of care, and provides direct medical care to a member that meets the conditions set forth in 130 CMR 410.405(E)(1).

410.406: Payment

(A) Hospital outpatient departments and hospital-licensed health centers in Massachusetts are paid for services provided to eligible members according to the rate for services established in the signed MassHealth provider agreement, subject to the limitations set forth in 130 CMR 410.406.

(B) For purposes of making payments to hospital outpatient departments and hospital-licensed health centers in Massachusetts, the following limitations apply.

(1) The MassHealth agency does not pay for outpatient services provided to a member who is an inpatient at the same or a different hospital on the same day.

(2) The MassHealth agency pays only for emergency outpatient services provided to a member on the day that the member is discharged from the hospital, whether from the same or a different facility.

(3) If a member receives outpatient services at one facility and, later on the same day, is admitted as an inpatient to another facility, the MassHealth agency pays both hospitals for services.

(4) When a member is admitted to inpatient status through the emergency department or outpatient department, the hospital must bill for only the inpatient stay. The MassHealth agency does not pay for services furnished in the emergency department or outpatient department on the admitting day.

(C) Nonacute hospital outpatient departments in Massachusetts are paid for services provided to eligible members according to the rate of payment established for each hospital in the signed MassHealth provider agreement, subject to the limitations set forth in 130 CMR 410.406(C)(1) and (2).

(1) Charges.

(a) The MassHealth agency pays only those charges contained in the charge book that the hospital has currently filed with DHCFP and no more than those charges.

(b) For changes in charges, the appropriate regulations of the DHCFP apply.

(c) In those cases where a specific rate has been established by DHCFP for a specific service or program (such as for adult day health services), the MassHealth agency pays no more than that rate.

(2) Payments. For purposes of making payments to nonacute outpatient hospitals, the following limitations apply.

(a) The MassHealth agency does not pay for outpatient services provided to a member who is an inpatient at the same or a different hospital on the same day.

(b) The MassHealth agency pays only for emergency outpatient services provided to a member on the day that he or she is discharged from the hospital, whether from the same or a different facility.

(c) If a member receives outpatient services at one facility and, later on the same day, is admitted as an inpatient to another facility, the MassHealth agency pays both hospitals for services.

(d) When a member is admitted to inpatient status through the emergency department or outpatient department, the hospital must bill for only the all-inclusive per diem rate for that day. The MassHealth agency does not pay for services furnished in the emergency department or outpatient department on the admitting day.

(D) The MassHealth agency pays for laboratory services in accordance with 130 CMR 410.456.

410.407: Certification

(A) Hospital outpatient departments must receive certification from the MassHealth agency before providing the following services:

(1) adult day health services (for requirements, see 130 CMR 410.443);
(2) adult foster care services (for requirements, see 130 CMR 410.444); and
(3) psychiatric day treatment program services (for requirements, see 130 CMR 410.445).

(B) Hospital-based home health agencies must be certified by the Medicare program and must provide to the MassHealth agency, upon its request, documentation of that certification.

410.408: Prior Authorization

(A) For certain outpatient services described in 130 CMR 410.000, the MassHealth agency requires that the hospital outpatient department obtain prior authorization. No payment is made for outpatient services whenever a hospital is required, but fails, to obtain prior authorization from the MassHealth agency or its designee. It is the responsibility of the hospital to obtain the necessary prior authorization.

(B) Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as member eligibility or resort to health insurance payment.

(C) All requests for prior authorization must be submitted in accordance with the instructions in Subchapter 5 of the *Outpatient Hospital Manual*.

(D) Time requirements for response from the MassHealth agency and rules that apply in determining the period within which the MassHealth agency acts on specific requests for prior authorization are set forth in the MassHealth administrative and billing regulations in 130 CMR 450.000. A service is authorized on the date the MassHealth agency transmits its decision about the request for prior authorization to the provider.

(E) Written notification of the prior-authorization decision is sent to the provider and indicates approval, deferral because additional information is necessary, modification, or denial. In the case of a modification or denial, the member is also notified. Notification of denial includes the reason for the decision. The member or the provider has the right to resubmit a request and provide additional information. The member may appeal the modification or denial of a prior-authorization request within 30 days after the date of receipt of the notice of denial. Procedures for such an appeal are set forth in 130 CMR 610.000.

(F) Members enrolled with a MassHealth managed care provider require service authorization before certain behavioral health services are provided. For more information, see 130 CMR 450.124.

(G) The hospital must obtain prior authorization for the following outpatient therapy services:
(1) more than 20 occupational-therapy visits or 20 physical-therapy visits, including group-therapy visits, for a member within a 12-month period; and
(2) more than 35 speech/language therapy visits, including group-therapy visits, for a member within a 12-month period.

410.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any outpatient service covered by MassHealth is conditioned upon its full and complete documentation in the member's medical record. If the information in the member's record is not sufficient to document the service for which payment is claimed by the provider, the MassHealth agency will not pay for the service or, if payment has been made, will consider such payment to be an overpayment subject to recovery as defined in the MassHealth administrative and billing regulations in 130 CMR 450.000. Medical record requirements as set forth in 130 CMR 410.000 constitute the standard against which the adequacy of records is measured, as set forth in 130 CMR 450.000.

(B) The MassHealth agency may request, and the hospital outpatient department must provide, any and all medical records (or clear photocopies of such records) corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, § 38, and 130 CMR 450.000. All components of a member's complete medical record (such as lab slips and X rays) do not need to be maintained in one file as long as all components are accessible to the MassHealth agency upon its request.

(C) The medical record must contain sufficient data to document fully the nature, extent, quality, and necessity of the care provided to a member for each date of service claimed for payment, as well as any data that will update the member's medical course. The data maintained in the member's medical record must also be sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals.

(D) Although basic data collected during previous visits (such as identifying data, chief complaint, or history) need not be repeated in the member's medical record for subsequent visits, the medical records for hospital outpatient services provided to members must include at least the following information:
(1) the member's name and date of birth;
(2) the date of each service;
(3) the reason for the visit;
(4) the name and title of the person who performed the service;
(5) the member's medical history;
(6) the diagnosis or chief complaint;
(7) a clear indication of all findings, whether positive or negative, on examination;
(8) any tests administered and their results;
(9) a description of any treatment given;

(10) any medications administered or prescribed, including strength, dosage, regimen, and duration of use;
(11) any anesthetic agent administered;
(12) any medical goods or supplies dispensed or supplied;
(13) recommendations and referrals for additional treatments or consultations, when applicable;
(14) the federally required consent form for sterilization or hysterectomy, when applicable; and
(15) such other information as is applicable for the specific service provided, or as is otherwise required in 130 CMR 410.000.

(E) When a member is referred from a private physician to a hospital outpatient department exclusively for the purpose of a diagnostic test, the following information, at a minimum, must be included in the member's medical record:
(1) the member's name and date of birth;
(2) the signed referral from the private physician authorizing the procedure;
(3) the date of service;
(4) the name and title of the person who performed the service; and
(5) a clear indication of all findings, whether positive or negative.

(F) For therapist services, in addition to the applicable information required in 130 CMR 410.409(D), the member's medical record must include at least the following (see 130 CMR 410.453);
(1) a licensed physician's written referral for evaluation, referral for treatment, and renewal of referral (if applicable) every 60 days (see 130 CMR 410.451(B));
(2) the written comprehensive evaluation report (see 130 CMR 410.451(C));
(3) the name, address, and telephone number of the member's primary physician;
(4) a treatment notation for each date on which therapy was provided that includes at least the following:
(a) the specific therapeutic procedures and methods used;
(b) the amount of time spent in treatment; and
(c) the signature and title of the person who provided the service;
(5) at least weekly documentation of the following:
(a) the member’s response to treatment;
(b) any changes in the member’s condition;
(c) the problems encountered or changes in the treatment plan or goals, if any;
(d) the location where the service was provided if different from that in the evaluation report; and
(e) the signature and title of the therapist; and
(6) a discharge summary, when applicable.

(G) (1) For mental health services, in addition to the applicable information required in 130 CMR 410.409(D), the member’s medical record must include at least the following (see 130 CMR 410.478):
(a) the member’s case number, address, telephone number, sex, age, marital status, next of kin, and school or employment status (or both);
(b) the date of initial contact and, if applicable, the referral source;

(c) a report of a physical examination performed within six months (if such an examination has not been performed in that period, one must be given within 30 days after the member's request for services or, if the member refuses to be examined, the record must document the reasons for the exam postponement);
(d) the name and address of the member's primary physician or medical clinic (a physician or medical clinic must be recommended if there is not one currently attending the member);
(e) a description of the nature of the member's condition;
(f) the relevant medical, social, educational, and vocational history;
(g) a comprehensive functional assessment of the member;
(h) the clinical impression of the member and a diagnostic formulation, including a specific diagnosis using ICD-9-CM or DSM III diagnosis codes;
(i) the member's treatment plan, updated as necessary, including long-range goals, short-term objectives, and the proposed schedule of therapeutic activities;
(j) a schedule of dates for utilization review to determine the member's progress in accomplishing goals and objectives;
(k) the name, qualifications, and discipline of the primary therapist;
(l) a written record of utilization reviews by the primary therapist;
(m) documentation of each visit, including the member's response to treatment, written and signed by the person providing the service, and including the therapist's discipline and degree;
(n) all information and correspondence about the member, including appropriately signed and dated consent forms;
(o) a medication-use profile; and
(p) when the member is discharged, a discharge summary.

(2) A brief history is acceptable for emergency or walk-in visits when the treatment plan does not call for extended care.

(H) Hospital pharmacies must maintain a record for each member of the drug and amount dispensed, the date, and the original prescription (see 130 CMR 410.467).

(I) For vision care services, in addition to the applicable information required in 130 CMR 410.409(D), the record must fully disclose all pertinent information about the services provided, including the date of service, the dates on which materials were ordered and dispensed, and a description of materials (including the frame style and the manufacturer's name) ordered and dispensed (see 130 CMR 410.483).

(1) All health care findings resulting from a visual analysis, whether they are normal or abnormal, must be recorded. When extenuating circumstances prevent the use of one or more procedures normally done in a visual analysis, the record must contain the reasons that the tests were not performed.

(2) For comprehensive eye examinations and diagnoses, the record must contain the following information or test results:

(a) case history;
(b) visual acuity testing;
(c) ophthalmoscopy and external eye health examination;
(d) ocular mobility testing, heterophoria testing, and fusion testing;
(e) pupillary reflex testing;

(f) refraction (retinoscopy, subjective refraction, and keratometry);
(g) confrontation fields or other screening tests;
(h) tonometry, when medically indicated;
(i) case analysis and disposition; and
(j) biomicroscopy, when medically indicated.

(3) All consultation services must be fully documented in the record. A record for a consultation must contain the following information:
(a) the member's complaints and symptoms;
(b) the condition of the eye; and
(c) if applicable, the name of the person to whom a referral was made.

(4) All screening services must be fully documented in the record. A record for a screening service must note the chief complaint and must contain all findings of two or more of the following tests:
(a) visual acuity;
(b) distance vision and near vision;
(c) cover test;
(d) visual skills;
(e) tonometry; and
(f) biomicroscopy.

(J) For laboratory services, in addition to the applicable information required in 130 CMR 410.409(D) above, the member's medical record must contain a suitable record of each specimen and laboratory test result for at least six years from the date on which the results were reported to the prescriber (see 130 CMR 410.458):
(1) the name and any other means of identification of the person from whom the specimen was taken;
(2) the name of the prescriber or laboratory that submitted the specimen;
(3) the authorized requisition or order, or both;
(4) the location where the specimen was taken, if other than the hospital outpatient department;
(5) the date on which the specimen was collected by the prescriber or laboratory;
(6) the date on which the specimen was received in the laboratory;
(7) the condition of unsatisfactory specimens when received (for example, broken, leaked, hemolyzed, turbid, or insufficient sample size);
(8) the date on which the test was performed;
(9) the test name and the results of the test, or the cross-reference to results and the date of reporting; and
(10) the name and address of the laboratory to which the specimen was referred, if applicable.

410.410: Assurance of Member Rights

No provider shall use any form of coercion in the provision of any services (for example, abortion, sterilization, and family planning). Neither the MassHealth agency, nor any provider, nor any agent or employee of a provider, shall mislead any member into believing that a decision to receive any services reimbursable under these regulations will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for the confidentiality of patient records for all medical services reimbursable under MassHealth.

410.411: Emergency Services

(A) The MassHealth agency pays for emergency services provided in a hospital emergency room only when such services are medically necessary and the necessity is fully documented in the member's medical record.

(B) For services provided in the emergency department, handwritten or time-stamped documentation of the length of the member's stay in the emergency room must be kept in the member's record or on an easily accessible hospital log.

410.412: Utilization Management Program and Mental Health and Substance Abuse Admission Screening Requirements

(A) Utilization Management Program. The MassHealth agency will pay for procedures and hospital stays that are subject to the Utilization Management Program only if the applicable requirements of the program as described in 130 CMR 450.207 through 450.211 are satisfied. Appendix H of the *Acute Outpatient Hospital Manual* contains the name, address, and telephone number of the contact organization for the Utilization Management Program and describes the information that must be provided during the review process.

(B) Mental Health and Substance Abuse Admissions. The MassHealth agency pays for mental health and substance abuse services provided in an acute or nonacute inpatient setting only if the admitting provider has satisfied the screening requirements at 130 CMR 450.125.

410.413: Medical Services Required on Site at a Hospital-Licensed Health Center

In order to be reimbursed at the rates established for hospital-licensed health centers (HLHCs), an HLHC must provide on site the medical services specified in 130 CMR 410.413(D), (E), and (F), and at least two of the medical services described in 130 CMR 410.413(A), (B), and (C). It is not necessary that all of these services be available during all hours of the HLHC's operation, but all services must be available to members on a regularly scheduled basis with sufficient frequency to ensure access to care and continuity of care.

(A) Pediatric Services. The HLHC must provide pediatric services.

(B) Internal Medicine. The HLHC must provide internal medicine services.

(C) Obstetrics/Gynecology. The HLHC must provide obstetrical and gynecological services. When a family practitioner is employed in place of a medical specialist in obstetrics/gynecology, the family practitioner must have admitting privileges to a hospital for delivery and obstetrical and gynecological backup.

(D) Health Education. The HLHC must provide health education designed to prepare members for their participation in and reaction to specific medical procedures, and to instruct members in self-management of medical problems and in disease prevention. Health education may be provided by any health practitioner or by any other individual approved by the HLHC's professional services director as possessing the qualifications and training necessary to provide health education to members.

(E) Medical Social Services. The HLHC must provide medical social services designed to assist members in their adjustment to and management of social problems resulting from medical treatment, specific disease episodes, or chronic illness. Medical social services must be provided by a clinical social worker who is licensed by the Massachusetts Board of Registration. This individual must be on site sufficient hours and with sufficient frequency to provide medical social services to members.

(F) Nutrition Services. The HLHC must provide counseling in the purchase, preparation, and consumption of proper nutrients to members who have been determined to require such counseling because of their health problems or because they have a high potential for developing health problems that might be avoided or made less severe through proper nutrition. Each HLHC must employ either a nutrition professional with a bachelor's or master's degree in public health nutrition, community nutrition, or human nutrition, or a dietitian who is currently registered by the American Dietetic Association. This individual is responsible for planning, directing, and evaluating the nutrition services provided at the HLHC; for educating the HLHC's staff about nutrition; for supervising any nutrition aides; for consulting with practitioners and other staff members of the HLHC; and for counseling members referred for nutrition information. The nutrition professional or registered dietitian must be on site at least one day per calendar month.

410.414: Observation Services

(A) Reimbursable Services. MassHealth covers medically necessary observation services provided by acute inpatient hospitals. Reimbursable observation services may exceed 24 hours, and do not need to be provided in a distinct observation unit. To qualify for reimbursement of observation services, the medical record must specifically document when those services began and ended, the purpose of observation, and the name of the physician who ordered it. Acute inpatient hospitals will be reimbursed for these observation services on an outpatient basis in accordance with the signed provider agreement with the MassHealth agency.

(B) Nonreimbursable Services.

(1) Nonreimbursable observation services include but are not limited to:

(a) services that are not reasonable or necessary for the diagnosis or treatment of the member; and

(b) routine preparation and recovery services associated with diagnostic testing or outpatient surgery.

(2) The following services are not reimbursable as a separate service:

(a) postoperative monitoring during a standard recovery period that should be characterized as recovery-room services; and

(b) observation services provided concurrently with therapeutic services such as chemotherapy.

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

The MassHealth agency pays for all medically necessary chronic disease and rehabilitation outpatient hospital services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 410.000, and with prior authorization.

(130 CMR 410.416 through 410.419 Reserved)

410.420: Tobacco Cessation Services

(A) Introduction. MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 410.420(B) and pharmacotherapy treatment, including nicotine replacement therapy (NRT), in accordance with 130 CMR 406.000.

(B) Tobacco Cessation Counseling Services.

(1) MassHealth covers a total of 16 group and individual counseling sessions per member per 12-month cycle, without prior authorization. These sessions may be any combination of group and individual counseling. All individual counseling sessions must be at least 30 minutes, except for intake sessions, which must be at least 45 minutes. Intake sessions are limited to two per member per 12-month cycle, without prior authorization.

(a) Individual counseling consists of face-to-face tobacco cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobacco cessation services as set forth in 130 CMR 410.420(B) and (C).

(b) Group tobacco treatment counseling consists of a scheduled professional counseling session with a minimum of three and a maximum of 12 members and has a duration of at least 60 to 90 minutes.

(c) Individual and group counseling also includes collaboration with and facilitating referrals to other health care providers to coordinate the appropriate use of medications, especially in the presence of medical or psychiatric comorbidities.

(2) The individual and group tobacco cessation counseling services must include the following:

(a) education on proven methods for stopping the use of tobacco, including a:

(i) a review of the health consequences of tobacco use and the benefits of quitting;

(ii) a description of how tobacco dependence develops and an explanation of the biological, psychological, and social causes of tobacco dependence; and

(iii) a review of evidence-based treatment strategies and the advantages and disadvantages of each strategy;

(b) collaborative development of a treatment plan that uses evidence-based strategies to assist the member to attempt to quit, to continue to abstain from tobacco, and to prevent relapse, including:

(i) identification of personal risk factors for relapse and incorporation into the treatment plan;

(ii) strategies and coping skills to reduce relapse risk; and

(iii) a plan for continued aftercare following initial treatment; and

(c) information and advice on the benefits of nicotine replacement therapy or other proven pharmaceutical or behavioral adjuncts to quitting smoking, including:

(i) the correct use, efficacy, adverse events, contraindications, known side effects, and exclusions for all tobacco dependence medications; and

(ii) the possible adverse reactions and complications related to the use of pharmacotherapy for tobacco dependence.

(C) Provider Qualifications for Tobacco Cessation Counseling Services

(1) Qualified Providers.

(a) Physicians, registered nurses, nurse practitioners, nurse midwives, and physician assistants may provide tobacco cessation counseling services without additional experience or training in tobacco cessation counseling services.

(b) All other providers of tobacco cessation counseling services must be under the supervision of a physician, and must complete a course of training in tobacco cessation counseling by a degree granting institute of higher education with a minimum of eight hours of instruction.

(2) Supervision of Tobacco Cessation Counseling Services. A physician must supervise all non-physician providers of tobacco cessation counseling services.

(D) Tobacco Cessation Services: Claims Submission. An acute outpatient hospital may submit claims for tobacco cessation counseling services that are provided by physicians, or by mid-level providers under the supervision of a physician (i.e. nurse practitioner, registered nurse, nurse midwife, physician assistant, and MassHealth-qualified tobacco cessation counselor), according to 130 CMR 410.420(B) and (C). Acute outpatient hospital departments cannot bill separately for services provided by mid-level providers. See Subchapter 6 of the *Acute Outpatient Hospital Manual* for service codes and descriptions.

(130 CMR 410.421 through 410.430 Reserved)

410.431: Sterilization Services: Introduction

(A) Covered Services. The MassHealth agency pays for sterilization services performed by a licensed physician in an acute hospital outpatient department for a member only if all of the following conditions are met.

(1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 410.432, and such consent is documented in the manner described in 130 CMR 410.433.

(2) The member is at least 18 years old at the time consent is obtained.

(3) The member is not a mentally incompetent individual or an institutionalized individual.

(B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of sterilization services. The MassHealth agency, any provider, or any agent or employee of a provider, must not mislead any member into believing that a decision to have or not have a sterilization will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of member records for sterilization services as well as for all other medical services covered by MassHealth.

(C) Retroactive Eligibility. The MassHealth agency does not pay for a sterilization performed during the period of a member's retroactive eligibility unless all conditions for payment listed in 130 CMR 410.431(A) are met.

410.432: Sterilization Services: Informed Consent

A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained in accordance with the requirements specified in 130 CMR 410.432(A) and (B), and such consent is documented as specified in 130 CMR 410.433.

(A) Informed Consent Requirements.

(1) The person who obtains consent (a physician, nurse, or counselor, for example) must orally provide all of the following information and advice to the member requesting sterilization:

(a) advice that the member is free to withhold or withdraw consent for the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss of any federal- or state-funded program benefits to which the member otherwise might be entitled;

(b) a description of available alternative methods of family planning and birth control;

(c) advice that the sterilization procedure is considered irreversible;

(d) a thorough explanation of the specific sterilization procedure to be performed;

(e) a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

(f) a full description of the benefits or advantages that may be expected as a result of the sterilization; and

(g) advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in 130 CMR 410.432(B)(1).

(2) The person who obtains consent must also:

(a) offer to answer any questions the member may have about the sterilization procedure;

(b) give the member a copy of the consent form;

(c) make suitable arrangements to ensure that the information and advice required by 130 CMR 410.432(A)(1) are effectively communicated to any member who is blind, deaf, or otherwise handicapped;

(d) provide an interpreter if the member does not understand the language used on the consent form or the language used by the person obtaining consent; and

(e) allow the member to have a witness of the member's choice present when consent is obtained.

(B) When Informed Consent Must Be Obtained.

(1) A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member gave informed consent for the sterilization in the manner specified in 130 CMR 410.432. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

(2) A member's consent for sterilization will not be considered informed or voluntary if such consent is obtained or given while the member requesting sterilization is

(a) in labor or childbirth;

(b) seeking to obtain or obtaining an abortion; or

(c) under the influence of alcohol or other substances that affect the individual's state of awareness.

(3) Shortly before the performance of the sterilization procedure, the physician performing the procedure must orally inform the member of all of the information and advice specified in 130 CMR 410.432(A)(1).

410.433: Sterilization Services: Consent Form Requirements

Informed consent for sterilization must be documented by the completion of the MassHealth agency's Consent for Sterilization form in accordance with the following requirements. (Instructions for obtaining the Consent for Sterilization forms are located in Subchapter 5 of the *Outpatient Hospital Manual*.)

(A) Required Consent Form.

(1) One of the following Consent for Sterilization forms must be used:

(a) CS-18 – for members aged 18 through 20; or

(b) CS-21 – for members aged 21 and older.

(2) Under no circumstances will the MassHealth agency accept any other consent for sterilization form.

(B) Required Signatures. The member, the interpreter (if one was required), and the person who obtained the consent for sterilization must all sign and date the Consent for Sterilization form (CS-18 or CS-21) at the time of consent. After performing the sterilization procedure, the physician must sign and date the form.

(C) Required Distribution of the Consent Form. The Consent for Sterilization form (CS-18 or CS-21) must be completed and distributed as follows:

(1) the original must be given to the member at the time of consent; and

(2) a copy must be included in the member's permanent medical record at the site where the sterilization is performed.

(D) Provider Billing and Required Submissions.

(1) All providers must bill with the appropriate sterilization diagnosis and services codes, and must attach a copy of the completed Consent for Sterilization form (CS-18 or CS-21) to each claim made to the MassHealth agency for sterilization services. This provision applies to any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. When more than one provider is billing the MassHealth agency (for example, the physician and the hospital), each provider must submit a copy of the completed sterilization form with the claim.

(2) A provider does not need to submit a Consent for Sterilization form (CS-18 or CS-21) with a claim for a medical procedure, treatment, or operation that is not for the purpose of rendering an individual permanently incapable of reproducing. If the appropriate service code used to bill for such a medical procedure, treatment, or operation may also be used to bill for a sterilization, the claim will be denied unless at least one of the following justifications is present and documented on an attachment signed by the physician and attached to the claim:

(a) the medical procedure, treatment, or operation was a unilateral procedure and did not result in sterilization;

(b) the medical procedure, treatment, or operation was unilateral or bilateral, but the patient was previously sterile as indicated in the operative notes;

(c) the medical procedure, treatment, or operation was medically necessary for treatment of an existing illness or injury and was not performed for the purpose of sterilization; or

(d) the medical procedure, treatment, or operation was medically necessary for treatment of a life-threatening emergency situation and was not performed for the purpose of sterilization, and it was not possible to inform the member in advance that it would or could result in sterilization. Include the nature and date of the life-threatening emergency.

(3) In the circumstances set forth in 130 CMR 410.433(D)(2)(a) and (c), the medical records must also document that the member consented to the medical procedure, treatment, or operation after being informed that it would or could result in sterilization.

(4) When more than one provider is billing the MassHealth agency under the circumstances specified in 130 CMR 410. 433(D)(2) (for example, the physician and hospital), each provider must submit a copy of the signed attachment along with the claim.

410.434: Abortion Services: Reimbursable Services

The MassHealth agency pays for abortion services performed by a licensed physician in a hospital outpatient department only when all of the following conditions are met:

(A) the abortion is performed in accordance with law;

(B) the abortion is medically necessary, that is, according to the medical judgment of a licensed physician, necessary in light of all factors affecting the woman's health; and

(C) the abortion service is claimed according to the requirements in 130 CMR 410.435.

410.435: Abortion Services: Certification for Payable Abortion Form

All physicians and hospital outpatient departments must complete a Certification for Payable Abortion (CPA-2) form and retain the form in the member's record. (Instructions for obtaining the CPA-2 form are in Subchapter 5 of the *Outpatient Hospital Manual*.) To identify those abortions that meet federal reimbursement standards, the MassHealth agency must secure on the CPA-2 form the certifications described in 130 CMR 410.435(A), (B), and (C), when applicable. For all medically necessary abortions not included in 130 CMR 410.435(A), (B), or (C), the certification described in 130 CMR 410.435(D) is required on the CPA-2 form. The physician must indicate on the CPA-2 form which of the following circumstances is applicable, and must complete that portion of the form with the appropriate signatures.

(A) Life of the Woman Would Be Endangered. The attending physician must certify that, in his or her professional judgment, the life of the woman would be endangered if the pregnancy were carried to term.

(B) Severe and Long-Lasting Damage to the Woman's Physical Health. The attending physician and another physician must each certify that, in his or her professional judgment, severe and long-lasting damage to the woman's physical health would result if the pregnancy were carried to term. At least one of the physicians must also certify that he or she is not an "interested physician," defined herein as one whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(C) Victim of Rape or Incest. The physician is responsible for retaining signed documentation from a law enforcement agency or public health service certifying that the woman upon whom the procedure was performed was a victim of rape or incest that was reported to the agency or service within 60 days of the incident. (A public health service is defined as either an agency of the federal, state, or local government that provides health or medical services, or a rural health clinic, provided that the agency's principal function is not the performance of abortions.) The documentation must include the date of the incident, the date the report was made, the name and address of the victim and of the person who made the report (if different from the victim), and a statement that the report included the signature of the person who made the report.

(D) Other Medically Necessary Abortions. The attending physician must certify that, in his or her medical judgment, for reasons other than those described in 130 CMR 410.435(A), (B), and (C), the abortion performed was necessary in light of all factors affecting the woman's health.

410.436: Abortion Services: Out-of-State Abortions

The Division will pay for an abortion performed in an out-of-state facility only if the abortion meets the conditions specified in 130 CMR 410.434 and if prior authorization is requested and received from the Division.

(A) The recipient, the referring physician, the hospital outpatient department, or a referral agency may request prior authorization from the Division in writing. The request must be made in accordance with the instructions for requesting prior authorization for abortion services in Subchapter 5 of the *Outpatient Hospital Manual*.

(B) If the Division authorizes the abortion, it will issue a prior authorization slip directly to the out-of-state facility. The facility must attach the prior authorization slip to the claim form when requesting payment from the Division.

(C) Out-of-state abortion services will be authorized only when such services are not available in a Massachusetts facility.

(D) Prior authorization is not required for abortion services provided in the situations described in 130 CMR 410.404(B)(1).

410.437: Family Planning Services

(A) Reimbursable Services. The Division will pay for hospital outpatient services related to the timing and spacing of children. These services may include but are not limited to the following:

(1) nonpermanent contraceptive care;
(2) comprehensive medical examination;
(3) diagnosis and treatment of medical problems specific to reproduction as well as diagnosis of and appropriate referral for other medical problems;
(4) venereal disease testing and treatment;
(5) cervical cancer screening (Pap smear);
(6) breast examination;
(7) laboratory services related to family planning (for example, Pap smear, gonorrhea culture, vaginal culture and smear, blood test for venereal disease, hematocrit, complete blood count, urinalysis, and pregnancy testing); and
(8) family planning counseling, including discussions about family planning, human reproduction, and methods of contraception.

(B) The Norplant System of Contraception.

(1) Eligible Providers. The Division will pay outpatient departments for the insertion, reinsertion, and removal of the Norplant System of Contraception (Norplant) when the services are provided by a salaried physician, nurse practitioner, nurse midwife, or physician assistant. In order for the hospital to claim payment for Norplant services, the clinician performing the procedure must be trained by either the manufacturer of Norplant or another clinician who has been trained by the manufacturer.

(2) Patient Selection, Counseling Prior to Insertion, and Follow-Up.

(a) In order to prevent premature removal of Norplant, the Division requires careful patient selection and counseling prior to insertion. Counseling must be in accordance with the manufacturer's guidelines, and must include a detailed discussion of potential side effects, contraindications, benefits and risks, and other contraceptive options.

(b) A visit following insertion is also required as a condition of reimbursement. The visit must include an examination of the insertion site for complications, a review of potential side effects, and follow-up instructions. If more than one follow-up visit is necessary, the provider should bill each as a separate visit.

(c) The provider must make every effort possible to ensure that the recipient returns for the follow-up visit. This shall include, but not be limited to, scheduling the follow-up appointment on the day of insertion, recording the day of the follow-up appointment in the recipient's chart, mailing a reminder notice to the recipient, and reminding the recipient by telephone during the week of the scheduled appointment. The provider must document in the medical record the efforts made to ensure that the recipient returns for the follow-up visit. In order to ensure payment for the procedure, the provider must also document if the recipient fails to return for the follow-up visit.

(3) Service Limitations.

(a) The Division will pay for the insertion and reinsertion of Norplant for female recipients of childbearing age with menstrual histories. The Department will pay for the removal of Norplant for female recipients of all ages.

(b) The Division will pay for the insertion or reinsertion of Norplant only once per recipient per five-year period.

(c) If the recipient has a Norplant device implanted, no other form of contraception should be prescribed, with the exception of condoms. If the Norplant device is removed for any reason, however, the Division will pay for alternative types of contraception.

410.438: Acupuncture

(A) Introduction. MassHealth members are eligible to receive acupuncture for the treatment of pain as described in 130 CMR 410.438(C), for use as an anesthetic as described in 130 CMR 433.454(C): *Acupuncture as an Anesthetic*, and for use for detoxification as described in 130 CMR 418.406(C)(3): *Acupuncture Detoxification*.

(B) General. 130 CMR 410.438 applies specifically to acupuncture services rendered in a hospital by physicians and licensed practitioners of acupuncture.

(C) Acupuncture for the Treatment of Pain. MassHealth provides a total of 20 sessions of acupuncture for the treatment of pain per member per year without prior authorization. If the member's condition, treatment, or diagnosis changes, the member may receive more sessions of medically-necessary acupuncture treatment with prior authorization.

(D) Provider Qualifications for Acupuncture.

(1) Qualified Providers.

(a) Physicians

(b) Other practitioners who are licensed in acupuncture by the Massachusetts Board of Registration in Medicine under 243 CMR 5.00: *The Practice of Acupuncture*.

(2) Supervising Physicians. Supervising physicians must ensure that acupuncture practitioners for whom the physician will submit claims, possess the appropriate training, credentials, and licensure.

(E) Conditions of Payment. The MassHealth agency pays the hospital for services of an acupuncturist (in accordance with 130 CMR 410.438(F)) when the:

(1) services are limited to the scope of practice authorized by state law or regulation (including but not limited to 243 CMR 5.00: *The Practice of Acupuncture*);

(2) the acupuncturist has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine; and

(3) services are provided pursuant to a supervisory arrangement with a physician.

(F) Acupuncture Claims Submissions.

(1) Hospitals may submit claims for on-site acupuncture services when physicians provide those services to MassHealth members or as an exception to 130 CMR 450.301(A) when a licensed practitioner under the supervision of a physician provides those services directly to MassHealth members. See Subchapter 6 of the *Acute Outpatient Manual* for service code descriptions and billing requirements.

(2) For MassHealth members receiving services under any of the acupuncture codes on the same date of service as a visit, the hospital may bill for both the visit and the acupuncture services performed or supervised by a hospital-based physician.

(130 CMR 410.439 through 410.440 Reserved)

410.441: Early Intervention Program Services

(A) An early intervention program provides services such as therapy and social, medical, educational, and developmental services for children aged three years or younger who are at biological, environmental, or established risk, and for their families.

(B) The MassHealth agency pays for services provided as part of an organized early intervention program by hospital outpatient departments. These services must be furnished in compliance with the MassHealth regulations governing early intervention program services in 130 CMR 440.000. (See Subchapter 5 of the *Outpatient Hospital Manual* for instructions about obtaining the *Early Intervention Program Manual*, which contains the necessary regulations.)

(C) Acute and nonacute hospital-based early intervention programs are paid according to the regulations governing early intervention services in 130 CMR 440.000: *Early Intervention Program Services*.

410.442: Home Health Agency Services

(A) A home health agency is a public or private agency or organization, or a subdivision of such an agency or organization that is primarily engaged in furnishing part-time skilled nursing and other therapeutic services to patients in their homes.

(B) The MassHealth agency pays for home health services provided by hospital-based home health agencies. These services must be furnished in compliance with the MassHealth regulations governing home health agency services in 130 CMR 403.000: *Home Health Agency*. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the *Home Health Agency Manual*, which contains the necessary regulations.)

(C) Acute hospital-based home health agencies will be paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based home health agencies are paid according to the regulations governing home health services in 130 CMR 403.000: *Home Health Agency*.

410.443: Adult Day Health Program Services

(A) An adult day health program is an organized program of health care and supervision, restorative services, and social activities whose general goal is to provide an alternative to long-term institutional care.

(B) The MassHealth agency pays for services provided as part of an organized adult day health program by a hospital outpatient department. These services must be furnished in accordance with the MassHealth regulations governing adult day health programs in 130 CMR 404.000: Adult Day Health Services. (See Subchapter 5 of the Outpatient Hospital Manual for information about obtaining the Adult Day Health Manual, which contains the necessary regulations.)

(C) Acute hospital-based adult day health programs will be paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based adult day health programs will be paid according to the regulations governing adult day health services in 130 CMR 404.000: Adult Day Health Services.

410.444: Adult Foster Care Services

(A) An adult foster care program provides room, board, and personal care services in a family-like setting to elderly or disabled individuals who are at imminent risk of institutional placement.

(B) The MassHealth agency pays for services provided by hospital-based adult foster care programs. These services must be furnished in compliance with the "Adult Foster Care Guidelines" issued by the MassHealth agency. (See Subchapter 5 of the Outpatient Hospital Manual for information about obtaining the "Guidelines" and the Adult Foster Care Manual.)

(C) Acute hospital-based adult foster care programs will be paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based adult foster care programs will be paid according to the payment methodology established by the Office of Purchased Services in the Executive Office of Administration and Finance.

410.463: Pharmacy Services: Limitations on Coverage of Drugs

(A) Interchangeable Drug Products. The MassHealth agency pays no more for a brand-name interchangeable drug product than its generic equivalent, unless

(1) the prescriber has requested and received prior authorization from the MassHealth agency for a nongeneric multiple-source drug (see 130 CMR 410.408); and

(2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(B) Drug Exclusions. The MassHealth agency does not pay for the following types of drugs or drug therapy:

(1) Cosmetic. The MassHealth agency does not pay for any drug used for cosmetic purposes or for hair growth.

(2) Cough and Cold. The MassHealth agency does not pay for any drugs used solely for the symptomatic relief of cough or colds, including but not limited to, those that contain an antitussive or expectorant as a major ingredient, unless dispensed to a member who is a resident in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR).

(3) Fertility. The MassHealth agency does not pay for any drug used to promote male or female fertility.

(4) Obesity Management. The MassHealth agency does not pay for any drug used for the treatment of obesity.

(5) Less-Than-Effective Drugs. The MassHealth agency does not pay for any drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a Notice of Opportunity for Hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications.

(6) Experimental and Investigational Drugs. The MassHealth agency does not pay for any drug that is experimental, medically unproven, or investigational in nature.

(7) Drugs for Sexual Dysfunction. The MassHealth agency does not pay for any drug when used for the treatment of male or female sexual dysfunction.

(C) Service Limitations.

(1) MassHealth covers drugs that are not explicitly excluded under 130 CMR 410.463(B). The limitations and exclusions in 130 CMR 410.463(B) do not apply to medically necessary drugs for MassHealth Standard enrollees under age 21. The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 410.000. The MassHealth Drug List can be viewed online at www.mass.gov/druglist, and copies may be obtained upon request. *See* 130 CMR 450.303: *Prior Authorization*.

(2) The MassHealth agency does not pay for the following types of drugs or drug therapy without prior authorization:

(a) immunizing biologicals and tubercular (TB) drugs that are available free of charge through local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs; and

(c) drugs related to gender-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy.

(3) The MassHealth agency does not pay any additional fees for dispensing drugs in a unit-dose distribution system.

(4) The MassHealth agency does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the MassHealth agency determines to be consistent with current medical evidence.

(5) The MassHealth agency does not pay for any drugs that are provided as a component of a more comprehensive service for which a single rate of pay is established in accordance with 130 CMR 450.307: *Unacceptable Billing Practices*.

(D) Insurance Coverage.

(1) Managed Care Organizations. The MassHealth agency does not pay pharmacy claims for services to MassHealth members enrolled in a MassHealth managed care organization (MCO) that provides pharmacy coverage through a pharmacy network or otherwise, except for family planning pharmacy services provided by a non-network provider to a MassHealth Standard MCO enrollee (where such provider otherwise meets all prerequisites for payment for such services). A pharmacy that does not participate in the MassHealth member's MCO must instruct the MassHealth member to take his or her prescription to a pharmacy that does participate in such MCO. To determine whether the MassHealth member belongs to an MCO, pharmacies must verify member eligibility and scope of services through POPS before providing service in accordance with 130 CMR 450.107:*Eligible Members and the MassHealth Card* and 450.117: *Managed Care Participation*.

(2) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill the MassHealth agency for the primary insurer's member copayment for the primary carrier's preferred drug without regard to whether the MassHealth agency generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 410.463(C)(2)(a) and (c). In such cases, the prescriber must obtain prior authorization from the MassHealth agency in order for the pharmacy to bill the MassHealth agency for the primary insurer's member copayment. For additional information about third party liability, see 130 CMR 450.101: *Definitions* et seq. and the hospital's Request for Applications and Contract, if applicable.

(3) Medicare Part D.

(a) Overview. Except as otherwise required in 130 CMR 406.414(C)(2) and (3), for MassHealth members who have Medicare, the MassHealth agency does not pay for any Medicare Part D drugs, or for any cost-sharing obligations (including premiums, copayments, and deductibles) for Medicare Part D drugs, whether or not the member has actually enrolled in a Medicare Part D drug plan. Medications excluded from the Medicare Part D drug program continue to be covered for MassHealth members eligible for Medicare, if they are MassHealth-covered medications.

(b) Medicare Part D One-Time Supplies. The MassHealth agency pays for one-time supplies of prescribed medications, as described in 130 CMR 406.414(C)(2)(a) and (b), if the medication is a MassHealth-covered medication and the MassHealth member would otherwise be entitled to MassHealth pharmacy benefits but for being eligible for Medicare prescription drug coverage. MassHealth prior authorization does not apply to such one-time supplies. The MassHealth agency pays for the one-time supplies in all instances in which the pharmacist cannot bill a Medicare Part D prescription drug plan at the time the prescription is presented. The MassHealth agency pays for a one-time 72-hour supply of prescribed medications.

601 Introduction

MassHealth providers must refer to the official list of HCPCS codes and descriptions posted on the Centers for Medicare & Medicaid Services HCPCS website when billing for services provided to MassHealth members. For a list of billable revenue codes, please refer to Appendix F of the *Acute Outpatient Hospital Manual*.

CPT Codes

MassHealth pays for services billed using all medicine, radiology, laboratory, surgery, and anesthesia CPT codes in effect at the time of service, except for those codes listed in Section 602 of this subchapter, subject to all conditions and limitations described in MassHealth regulations at 130 CMR 410.000 and 450.000, and in the most current Acute Hospital Request for Application.

Level II HCPCS Codes

MassHealth pays for services billed using only those Level II HCPCS codes listed in Section 603 of this subchapter that are in effect at the time of service, subject to all conditions and limitations described in MassHealth regulations at 130 CMR 410.000 and 450.000, and in the most current Acute Hospital Request for Application.

Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)

An acute outpatient hospital provider may request prior authorization (PA) for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age, even if it is not designated as covered or payable in Subchapter 6 of the *Acute Outpatient Hospital Manual*.

602 Nonpayable CPT Codes

MassHealth does not ordinarily pay for services billed under the following codes and code ranges.

0001F	0052T	0101T	0142T	0172T
0005F	0053T	0102T	0143T	0173T
0012F	0071T	0103T	0155T	0174T
0014F	0072T	0104T	0156T	0175T
0015F	0073T	0105T	0157T	0176T
4002F	0075T	0106T	0158T	0177T
4006F	0076T	0107T	0159T	0178T
4009F	0078T	0108T	0160T	0179T
4011F	0079T	0109T	0161T	0180T
0016T	0080T	0110T	0163T	0181T
0017T	0081T	0111T	0164T	0182T
0019T	0085T	0123T	0165T	0183T
0030T	0092T	0124T	0166T	0184T
0042T	0095T	0126T	0167T	0185T
0048T	0098T	0130T	0168T	0186T
0050T	0099T	0140T	0169T	0187T
0051T	0100T	0141T	0171T	0188T

602 Nonpayable CPT Codes (cont.)

0189T	15847	21127	21620	22808
0190T	15876	21141	21627	22810
0191T	15877	21142	21630	22812
0192T	15878	21143	21632	22818
0193T	15879	21145	21705	22819
0195T	16036	21146	21740	22830
0196T	17340	21147	21750	22840
0197T	17360	21151	21810	22841
0198T	17380	21154	21825	22842
0199T	19271	21155	22010	22843
0200T	19272	21159	22015	22844
0201T	19305	21160	22110	22845
0202T	19306	21172	22112	22846
0203T	19316	21179	22114	22847
0204T	19355	21180	22116	22848
0205T	19361	21182	22206	22849
0206T	19364	21183	22207	22850
0207T	19367	21184	22208	22852
00100	19368	21188	22210	22855
through	19369	21193	22212	22856
01999	19396	21194	22214	22857
10040	20660	21196	22216	22861
11004	20661	21245	22220	22862
11005	20664	21246	22224	22864
11006	20802	21247	22226	22865
11008	20805	21248	22318	23200
11922	20808	21249	22319	23210
11950	20816	21255	22325	23220
11951	20824	21256	22326	23332
11952	20827	21268	22328	23472
11954	20838	21343	22526	23900
15756	20930	21344	22527	23920
15757	20931	21346	22532	24900
15758	20936	21347	22533	24920
15781	20937	21348	22534	24930
15782	20938	21366	22548	24931
15783	20955	21386	22554	24940
15786	20956	21387	22556	25900
15787	20957	21395	22558	25905
15788	20962	21422	22585	25909
15789	20969	21423	22590	25915
15792	20970	21431	22595	25920
15793	20985	21432	22600	25924
15819	21045	21433	22610	25927
15824	21120	21435	22630	26551
15825	21121	21436	22632	26553
15826	21122	21510	22800	26554
15828	21123	21615	22802	26556
15829	21125	21616	22804	26992

602 Nonpayable CPT Codes (cont.)

27005	27244	27590	32095	32850
27025	27245	27591	32100	32851
27030	27248	27592	32110	32852
27036	27253	27596	32120	32853
27054	27254	27598	32124	32854
27070	27258	27645	32140	32855
27071	27259	27646	32141	32856
27075	27268	27702	32150	32900
27076	27269	27703	32151	32905
27077	27280	27712	32160	32906
27078	27282	27715	32200	32940
27079	27284	27724	32225	32997
27090	27286	27725	32310	33015
27091	27290	27727	32320	33020
27120	27295	27880	32402	33025
27122	27303	27881	32440	33030
27125	27365	27882	32442	33031
27130	27445	27886	32445	33050
27132	27447	27888	32480	33120
27134	27448	28800	32482	33130
27137	27450	28805	32484	33140
27138	27454	31225	32486	33141
27140	27455	31230	32488	33202
27146	27457	31290	32491	33203
27147	27465	31291	32500	33236
27151	27466	31360	32501	33237
27156	27468	31365	32503	33238
27158	27470	31367	32504	33243
27161	27472	31368	32540	33250
27165	27477	31370	32650	33251
27170	27479	31375	32651	33254
27175	27485	31380	32652	33255
27176	27486	31382	32653	33256
27177	27487	31390	32654	33257
27178	27488	31395	32655	33258
27179	27495	31584	32656	33259
27181	27506	31587	32657	33261
27185	27507	31725	32658	33265
27187	27511	31760	32659	33266
27215	27513	31766	32660	33300
27217	27514	31770	32661	33305
27218	27519	31775	32662	33310
27222	27535	31780	32663	33315
27226	27536	31781	32664	33320
27227	27540	31786	32665	33321
27228	27556	31800	32800	33322
27232	27557	31805	32810	33330
27236	27558	32035	32815	33332
27240	27580	32036	32820	33335

602 Nonpayable CPT Codes (cont.)

33400	33519	33737	33910	34826
33401	33521	33750	33915	34830
33403	33522	33755	33916	34831
33404	33523	33762	33917	34832
33405	33530	33764	33920	34833
33406	33533	33766	33922	34834
33410	33534	33767	33924	34900
33411	33535	33768	33925	35001
33412	33536	33770	33926	35002
33413	33542	33771	33930	35005
33414	33545	33774	33933	35013
33415	33548	33775	33935	35021
33416	33572	33776	33940	35022
33417	33600	33777	33944	35045
33420	33602	33778	33945	35081
33422	33606	33779	33960	35082
33425	33608	33780	33961	35091
33426	33610	33781	33967	35092
33427	33611	33782	33968	35102
33430	33612	33783	33970	35103
33460	33615	33786	33971	35111
33463	33617	33788	33973	35112
33464	33619	33800	33974	35121
33465	33641	33802	33975	35122
33468	33645	33803	33976	35131
33470	33647	33813	33977	35132
33471	33660	33814	33978	35141
33472	33665	33820	33979	35142
33474	33670	33822	33980	35151
33475	33675	33824	33981	35152
33476	33676	33840	33982	35182
33478	33677	33845	33983	35189
33496	33681	33851	34001	35211
33500	33684	33852	34051	35216
33501	33688	33853	34151	35221
33502	33690	33860	34401	35241
33503	33692	33861	34451	35246
33504	33694	33863	34502	35251
33505	33697	33864	34800	35271
33506	33702	33870	34802	35276
33507	33710	33875	34803	35281
33510	33720	33877	34804	35301
33511	33722	33880	34805	35302
33512	33724	33881	34806	35303
33513	33726	33883	34808	35304
33514	33730	33884	34812	35305
33516	33732	33886	34813	35306
33517	33735	33889	34820	35311
33518	33736	33891	34825	35331

602 Nonpayable CPT Codes (cont.)

35341	35585	36469	39545	43351
35351	35587	36591	39560	43352
35355	35600	36592	39561	43360
35361	35601	36598	39599	43361
35363	35606	36660	41130	43400
35371	35612	36822	41135	43401
35372	35616	36823	41140	43405
35390	35621	37140	41145	43410
35400	35623	37145	41150	43415
35450	35626	37160	41153	43420
35452	35631	37180	41155	43425
35454	35636	37181	41870	43460
35456	35637	37182	41872	43496
35480	35638	37215	42426	43500
35481	35642	37616	42845	43501
35482	35645	37617	42894	43502
35483	35646	37618	42953	43520
35501	35647	37660	42961	43605
35506	35650	37765	42971	43610
35508	35651	37766	43045	43611
35509	35654	37788	43100	43620
35510	35656	38100	43101	43621
35511	35661	38101	43107	43622
35512	35663	38102	43108	43631
35516	35665	38115	43112	43632
35518	35666	38380	43113	43633
35521	35671	38381	43116	43634
35522	35681	38382	43117	43635
35523	35682	38562	43118	43640
35525	35683	38564	43121	43641
35526	35691	38724	43122	43644
35531	35693	38746	43123	43645
35533	35694	38747	43124	43752
35536	35695	38765	43135	43770
35537	35697	38770	43300	43771
35538	35700	38780	43305	43772
35539	35701	39000	43310	43773
35540	35721	39010	43312	43774
35548	35741	39200	43313	43775
35549	35800	39220	43314	43800
35551	35820	39499	43320	43810
35556	35840	39501	43324	43820
35558	35870	39502	43325	43825
35560	35901	39503	43326	43832
35563	35905	39520	43330	43840
35565	35907	39530	43331	43842
35566	36415	39531	43340	43843
35571	36416	39540	43341	43845
35583	36468	39541	43350	43846

602 Nonpayable CPT Codes (cont.)

43847	44203	45123	47350	48155
43848	44204	45126	47360	48160
43850	44205	45130	47361	48400
43855	44210	45135	47362	48500
43860	44211	45136	47380	48510
43865	44212	45395	47381	48520
43880	44227	45397	47400	48540
43881	44300	45400	47420	48545
43882	44310	45402	47425	48547
44005	44314	45540	47460	48548
44010	44316	45550	47480	48551
44015	44320	45562	47550	48552
44020	44322	45563	47570	48554
44021	44345	45800	47600	48556
44025	44346	45805	47605	49000
44050	44602	45820	47610	49002
44055	44603	45825	47612	49010
44110	44604	46705	47620	49020
44111	44605	46710	47700	49040
44120	44615	46712	47701	49060
44121	44620	46715	47711	49062
44125	44625	46716	47712	49203
44126	44626	46730	47715	49204
44127	44640	46735	47720	49205
44128	44650	46740	47721	49215
44130	44660	46742	47740	49220
44132	44661	46744	47741	49255
44133	44680	46746	47760	49425
44135	44700	46748	47765	49428
44136	44715	46751	47780	49605
44137	44720	47010	47785	49606
44139	44721	47015	48000	49610
44140	44800	47100	47801	49611
44141	44820	47120	47802	49900
44143	44850	47122	47900	49904
44144	44899	47125	48000	49905
44145	44900	47130	48001	49906
44146	44950	47133	48020	50010
44147	44955	47135	48100	50040
44150	44960	47136	48105	50045
44151	45110	47140	48120	50060
44155	45111	47141	48140	50065
44156	45112	47142	48145	50070
44157	45113	47143	48146	50075
44158	45114	47144	48148	50100
44160	45116	47145	48150	50120
44187	45119	47146	48152	50125
44188	45120	47147	48153	50130
44202	45121	47300	48154	50135

602 Nonpayable CPT Codes (cont.)

50205	50770	54135	58275	59852
50220	50780	54332	58280	59855
50225	50782	54336	58285	59856
50230	50783	54390	58293	59857
50234	50785	54411	58400	59897
50236	50800	54417	58410	60254
50240	50810	54430	58520	60270
50250	50815	54535	58540	60505
50280	50820	54650	58548	60521
50290	50825	55605	58605	60522
50300	50830	55650	58611	60540
50320	50840	55801	58700	60545
50323	50845	55810	58740	60600
50325	50860	55812	58750	60605
50327	50900	55815	58752	60650
50328	50920	55821	58760	61105
50329	50930	55831	58822	61107
50340	50940	55840	58825	61108
50360	51060	55842	58940	61120
50365	51525	55845	58943	61140
50370	51530	55862	58950	61150
50380	51550	55865	58951	61151
50400	51555	55866	58952	61154
50405	51565	56630	58953	61156
50500	51570	56631	58954	61210
50520	51575	56632	58956	61250
50525	51580	56633	58957	61253
50526	51585	56634	58958	61304
50540	51590	56637	58960	61305
50545	51595	56640	58970	61312
50546	51596	57111	58974	61313
50547	51597	57112	58976	61314
50548	51701	57270	59070	61315
50600	51702	57280	59072	61316
50605	51800	57296	59120	61320
50610	51820	57305	59121	61321
50620	51840	57307	59130	61322
50630	51841	57308	59135	61323
50650	51845	57311	59136	61332
50660	51860	57531	59140	61333
50700	51865	57540	59325	61340
50715	51900	57545	59350	61343
50722	51920	58140	59412	61345
50725	51925	58146	59514	61440
50727	51940	58152	59525	61450
50728	51960	58200	59620	61458
50740	51980	58210	59830	61460
50750	53415	58240	59850	61470
50760	53448	58267	59851	61480

602 Nonpayable CPT Codes (cont.)

61490	61582	61735	63078	63290
61500	61583	61750	63081	63295
61501	61584	61751	63082	63300
61510	61585	61760	63085	63301
61512	61586	61850	63086	63302
61514	61590	61860	63087	63303
61516	61591	61863	63088	63304
61517	61591	61864	63090	63305
61518	61592	61867	63091	63306
61519	61595	61868	63101	63307
61520	61596	61870	63102	63308
61521	61597	61875	63103	63700
61522	61598	62005	63170	63702
61524	61600	62010	63172	63704
61526	61601	62100	63173	63706
61530	61605	62115	63180	63707
61531	61606	62116	63182	63709
61533	61607	62117	63185	63710
61534	61608	62120	63190	63740
61535	61609	62121	63191	63752
61536	61610	62140	63194	64752
61536	61611	62141	63195	64755
61537	61612	62142	63196	64760
61538	61613	62143	63197	64809
61539	61615	62145	63198	64818
61540	61616	62146	63199	64866
61541	61618	62147	63200	64868
61542	61619	62148	63250	65273
61543	61624	62161	63251	65760
61544	61630	62162	63252	65765
61545	61635	62163	63265	65767
61546	61640	62164	63266	65771
61548	61641	62165	63267	65780
61550	61642	62180	63268	65781
61552	61680	62190	63270	65782
61556	61682	62192	63271	69090
61557	61684	62200	63272	69155
61558	61686	62201	63273	69535
61559	61690	62220	63275	69554
61563	61692	62223	63276	69950
61564	61697	62256	63277	71552
61566	61698	62258	63278	72159
61567	61700	62287	63280	72198
61570	61702	63043	63281	73225
61571	61703	63044	63282	74263
61575	61705	63050	63283	75571
61576	61708	63051	63285	75900
61580	61710	63076	63286	75952
61581	61711	63077	63287	75953

602 Nonpayable CPT Codes (cont.)

75954	81256	81374	88005	89344
75956	81257	81375	88007	89346
75957	81260	81376	88012	89352
75958	81261	81377	88014	89353
75959	81262	81378	88016	89354
76140	81263	81379	88020	89356
76496	81264	81380	88025	89398
76497	81265	81381	88027	90281
76498	81266	81382	88028	90283
78267	81267	81383	88029	90284
78268	81268	81400	88036	90287
78351	81270	81401	88037	90379
80100	81275	81402	88040	90384
80101	81280	81403	88045	90386
80104	81281	81404	88099	90389
80502	81282	81405	88125	90396
81200	81290	81406	88333	90586
81205	81291	81407	88334	90633
81206	81292	81408	88738	90634
81207	81293	81508	88749	90644
81208	81294	81511	89250	90645
81209	81295	82075	89251	90646
81210	81296	82962	89253	90647
81211	81297	83987	89254	90648
81212	81298	84145	89255	90653
81213	81299	84431	89257	90654
81214	81300	84793	89258	90665
81215	81301	86079	89259	90669
81216	81302	86305	89260	90670
81217	81303	86352	89261	90696
81220	81304	86780	89264	90698
81221	81310	86825	89268	90700
81222	81315	86826	89272	90701
81223	81316	86890	89280	90702
81224	81317	86891	89281	90708
81225	81318	86910	89290	90710
81226	81319	86911	89291	90712
81227	81330	86927	89300	90718
81228	81331	86930	89310	90720
81229	81332	86931	89320	90721
81240	81340	86932	89321	90723
81241	81341	86960	89322	90739
81242	81342	86985	89325	90743
81243	81350	87150	89329	90744
81244	81355	87153	89330	90748
81245	81370	87493	89331	90816
81250	81371	87903	89335	90817
81251	81372	87904	89342	90818
81255	81373	88000	89343	90819

602 Nonpayable CPT Codes (cont.)

90821	92633	97545	99149	99360
90822	92970	97546	99150	99374
90823	92971	97597	99172	99375
90824	92975	97598	99190	99377
90826	92992	97602	99191	99378
90827	92993	97605	99192	99379
90828	93660	97606	99199	99380
90829	93770	97755	99251	99401
90845	93786	97810	99252	99402
90865	94005	97811	99253	99403
90875	94011	97813	99254	99404
90876	94012	97814	99255	99406
90880	94013	98940	99288	99408
90885	94015	98941	99304	99409
90889	94774	98942	99305	99411
90901	94775	98943	99306	99412
90911	94776	98960	99307	99420
90940	94777	98961	99308	99429
90989	95052	98962	99309	99441
90993	95120	98966	99310	99442
90997	95125	98967	99315	99443
90999	95130	98968	99316	99444
91132	95131	98969	99318	99446
91133	95132	99000	99324	99447
92314	95133	99001	99325	99448
92315	95134	99002	99326	99449
92316	95824	99024	99327	99450
92317	95965	99026	99328	99455
92325	95966	99027	99334	99456
92352	95967	99050	99335	99466
92353	95992	99051	99336	99467
92354	96000	99053	99337	99468
92355	96001	99056	99339	99469
92358	96002	99058	99340	99471
92371	96003	99060	99341	99472
92531	96004	99071	99342	99477
92532	96150	99075	99343	99478
92533	96151	99078	99344	99479
92534	96152	99080	99345	99480
92540	96153	99082	99347	99499
92548	96154	99090	99348	99500
92550	96155	99091	99349	99501
92559	96376	99100	99350	99502
92560	96567	99116	99354	99503
92561	96902	99135	99355	99504
92562	96904	99140	99356	99505
92564	97005	99143	99357	99506
92570	97006	99144	99358	99507
92630	97537	99148	99359	99509

602 Nonpayable CPT Codes (cont.)

99510	99512	99601	99605	99607
99511	99600	99602	99606	

603 Payable Level II HCPCS Codes

The following Level II HCPCS codes represent services that are covered by MassHealth when provided by AOHs, including hospital-licensed health centers (HLHCs) and other satellite clinics.

A4641	J0586	J1300	J2265	J3010
A9500	J0587	J1320	J2270	J3030
A9502	J0588	J1438	J2271	J3095
A9503	J0592	J1440	J2275	J3110
A9505	J0597	J1441	J2300	J3120
A9512	J0598	J1460	J2310	J3130
A9537	J0638	J1557	J2315	J3230
G0105	J0640	J1559	J2323	J3240
G0108	J0690	J1561	J2355	J3243
G0109	J0694	J1562	J2357	J3250
G0121	J0696	J1566	J2358	J3262
G0202	J0697	J1569	J2405	J3301
G0204	J0702	J1571	J2430	J3302
G0206	J0715	J1580	J2440	J3303
G0270	J0718	J1599	J2469	J3357
G0271	J0775	J1626	J2503	J3360
G0378	J0780	J1630	J2505	J3385
G0379	J0833	J1650	J2507	J3396
G0424	J0834	J1655	J2510	J3410
G0431	J0840	J1670	J2515	J3411
G0434	J0881	J1710	J2550	J3430
J0129	J0882	J1720	J2560	J3487
J0131	J0885	J1725	J2562	J3490
J0135	J0886	J1740	J2675	J3590
J0171	J0897	J1743	J2680	J7030
J0207	J0900	J1745	J2760	J7060
J0215	J1020	J1750	J2778	J7070
J0221	J1030	J1786	J2785	J7131
J0256	J1040	J1790	J2788	J7302
J0257	J1055	J1800	J2790	J7303
J0290	J1056	J1826	J2792	J7304
J0295	J1060	J1885	J2793	J7307
J0348	J1070	J1890	J2794	J7309
J0456	J1080	J1950	J2796	J7312
J0461	J1094	J1956	J2820	J7321
J0475	J1100	J1990	J2910	J7323
J0476	J1160	J2060	J2916	J7324
J0490	J1170	J2150	J2920	J7325
J0558	J1200	J2175	J2930	J7326
J0561	J1260	J2248	J2940	J7335
J0585	J1290	J2250	J2941	J7599

603 Payable Level II HCPCS Codes (cont.)

J7608	J9035	J9216	J9355	Q4104
J7614	J9040	J9217	J9360	Q4105
J7620	J9041	J9218	J9370	Q4106
J7626	J9043	J9219	J9390	Q4107
J7633	J9045	J9228	J9395	Q4108
J7639	J9055	J9250	J9999	Q4110
J7644	J9060	J9260	L8614	Q4111
J7665	J9130	J9261	L8615	Q4112
J7669	J9155	J9263	L8616	Q4113
J7676	J9171	J9264	L8617	Q4114
J7682	J9178	J9265	L8618	Q4115
J7686	J9179	J9266	L8619	S0023
J7699	J9181	J9293	L8690	S0028
J7799	J9190	J9300	L8691	S0077
J8561	J9201	J9302	Q0081	S0302
J8562	J9202	J9305	Q0083	S2083
J9000	J9206	J9307	Q0084	
J9001	J9212	J9310	Q4100	
J9002	J9213	J9315	Q4101	
J9025	J9214	J9340	Q4102	
J9031	J9215	J9351	Q4103	

604 Modifiers

The following service code modifiers are allowed for billing under the MassHealth *Acute Outpatient Hospital Manual* for payable services.

Modifier	Description
22	Increased procedural services
24	Unrelated evaluation and management service by the same physician during a postoperative period
25	Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.
27	Multiple outpatient hospital E/M encounters on the same date
50	Bilateral procedure
51	Multiple procedures
52	Reduced services
53	Discontinued procedure
57	Decision for surgery
58	Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period
59	Distinct procedural service
63	Procedure performed on infants less than 4 kg
73	Discontinued outpatient procedure prior to anesthesia administration

604 Modifiers (cont.)

Modifier	Description
74	Discontinued outpatient procedure after anesthesia administration
76	Repeat procedure or service by same physician or other qualified health care professional
77	Repeat procedure or service by another physician or other qualified health care professional
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period
80	Assistant surgeon
90	Reference (outside) laboratory
91	Repeat clinical diagnostic laboratory test
99	Multiple modifiers
BL	Special acquisition of blood and blood products
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
CR	Catastrophe/disaster related
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
FA	Left hand, thumb
FB	Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)
GA	Waiver of liability statement issued as required by payer policy, individual case.
GG	Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
GH	Diagnostic mammogram converted from screening mammogram on the same day
LC	Left circumflex, coronary artery
LD	Left anterior descending coronary artery
LT	Left side (used to identify procedures performed on the left side of the body)
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services
RC	Right coronary artery

604 Modifiers (cont.)

Modifier	Description
RT	Right side (used to identify procedures performed on the right side of the body)
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great digit
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
TA	Left foot, great toe
U5	Medicaid level of care 5, as defined by each state
U6	Medicaid level of care 6, as defined by each state
U7	Medicaid level of care 7, as defined by each state
U8	Medicaid level of care 8, as defined by each state
U9	Medicaid level of care 9, as defined by each state

Modifiers for Behavioral Health Screening

The administration and scoring of standardized behavioral health screening tools selected from the approved menu of tools found in Appendix W of your MassHealth provider manual is covered for members (except MassHealth Limited) from birth to 21 years of age. Service Code 96110 must be accompanied by one of the modifiers listed below to indicate whether a behavioral health need was identified. “Behavioral health need identified” means the provider administering the screening tool, in her or his professional judgment, identified a child with a potential behavioral health services need.

U1	Completed behavioral-health screening using a standardized behavioral-health screening tool selected from the approved menu of tools found in Appendix W of your MassHealth provider manual with no behavioral health need identified.
U2	Completed behavioral-health screening using a standardized behavioral-health screening tool selected from the approved menu of tools found in Appendix W of your MassHealth provider manual and behavioral-health need identified.

604 Modifiers (cont.)

Modifiers for Tobacco-Cessation Services

The following modifiers are used in combination with Service Code 99407 to report tobacco-cessation counseling. Service Code 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) may also be billed without a modifier to report an individual smoking and tobacco use cessation counseling visit of at least 30 minutes.

HQ	Group counseling, at least 60-90 minutes
TF	Intermediate level of care, at least 45 minutes

Modifier for Child and Adolescent Needs and Strengths (CANS)

HA	Service code 90801 must be accompanied by this modifier to indicate that the Child and Adolescent Needs and Strengths is included in the assessment.

Modifiers for Provider Preventable Conditions That Are National Coverage Determinations

PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

For more information on the use of these modifiers, see Appendix V of your provider manual.

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