4. PROGRAM REGULATIONS

435.401: Introduction

All providers of chronic disease and rehabilitation inpatient hospital services participating in MassHealth must comply with the regulations of the Division governing MassHealth, including, but not limited to, Division regulations set forth in 130 CMR 435.000 and in 130 CMR 450.000.

435.402: Definitions

The following terms used in 130 CMR 435.000 shall have the meanings given in 130 CMR 435.402 unless the context clearly requires a different meaning.

Abuse — a nonaccidental physical injury to an individual inflicted by another person that causes or creates a substantial risk of death or protracted impairment of any bodily organ or function; or the commission of sex offenses against an individual, as defined in the criminal laws of Massachusetts.

Administrative Day — a day of hospitalization on which a member's care needs can be met in a setting other than a chronic-disease or rehabilitation hospital, as defined in 130 CMR 435.402, and on which a member is clinically ready for discharge.

Admission Screening — screening prior to hospital admission.

Agent — the Peer Review Organization (PRO), the hospital's utilization-review coordinator, or other party designated by the Division to act on its behalf in instances when the Division itself does not perform the required function.

Chronic-Disease Hospital — a facility, or a unit within a facility, with a majority of its beds licensed by the Massachusetts Department of Public Health to provide chronic-disease services.

Concurrent Review — the assessment of the medical necessity for continued hospital stay and for all services provided during such continued stay. Such review may be performed at any time subsequent to the member's admission.

Conversion — the assumption by the Division of responsibility for the health-care coverage of a patient who was receiving health-care coverage from a payer other than the Division at the time of hospital admission.

Conversion Screening — screening prior to conversion.

Day of Discharge — the day on which a member leaves the hospital, regardless of the hour. The day of death is also considered the day of discharge.

Discharge Planner — a registered nurse or a social worker who is licensed, or who is eligible for licensure and has submitted an application for licensure to the appropriate Massachusetts board of registration or licensing agency in its state, and whose primary responsibility is discharge planning.

Discharge Planning — the coordinated effort of the discharge-planning staff of a hospital to locate appropriate placement for members who no longer require hospitalization.

Leave-of-Absence Day — a day during which a bed in a hospital is reserved for a member who leaves the facility and for whom no formal discharge and readmission procedures occur.

Length of Stay — the duration of a member's inpatient hospital stay at a Medicare hospital level of care during a medical leave of absence.

Managed-Care Per Diem — a daily, all-inclusive fee, after deductions for the patient-paid amount and any third-party payments, paid monthly by the Division for managed-care services.

Managed-Care Program — a program under which a chronic-disease or rehabilitation hospital, for a per diem rate paid monthly by the Division, provides or arranges and pays for all managed-care services provided to all inpatients who are MassHealth members and who participate in the hospital's managed-care program in accordance with the terms and conditions stated in the provider agreement between the Division and the hospital.

Managed-Care Services — those services mandated by the Massachusetts Department of Public Health as a prerequisite for chronic-disease and rehabilitation bed licensure pursuant to 105 CMR 130.000, and all other services covered by MassHealth, except for acute-level days in an acute hospital.

Massachusetts Department of Public Health Hospital — a facility administered or supervised by the Massachusetts Department of Public Health.

Medical Absence — an absence from a chronic-disease or rehabilitation hospital that begins on the day a member is transferred to an acute inpatient hospital.

Medical Leave of Absence — an inpatient hospital stay of a member who is a resident of a nursing facility for up to 10 consecutive days in a hospital at a Medicare hospital level of care. The day on which a member is transferred from a nursing facility to a hospital for an inpatient stay shall be the first day of the medical leave of absence from the nursing facility. The day on which a member is transferred from a hospital back to a nursing facility or is otherwise discharged to a noninstitutional setting shall not be a medical leave-of-absence day.

Medicare Hospital Level of Care — a level of care that meets all criteria, as determined by the Health Care Financing Administration or its agent, for Medicare reimbursement for hospital care.

Neglect — failure by a financially able caretaker legally responsible for an individual to provide adequate food, clothing, shelter, education, medical care, proper supervision, or guardianship that results in the individual's present avoidable suffering. The caretaker is considered capable of providing adequate food, clothing, shelter, education, medical care, proper supervision, and guardianship if the caretaker is financially able to do so or is offered other reasonable means to do so.

Nursing Facility — a long-term-care institution that meets the provider eligibility and certification requirements of 130 CMR 456.005 or 456.006.

Reasonable Distance — generally, 25 miles from the home or usual noninstitutional residence of the member, provided, however, that greater distances may be considered reasonable under certain circumstances, including but not limited to those where:

(1) the residence is in a rural area;
(2) the member has no family or regular visitors; or
(3) the member requires specialized services only available at facilities located at greater distances.

Rehabilitation Hospital — a facility, or a unit within a facility, devoted to the provision of comprehensive services to patients whose handicaps are primarily physical, coordinated with efforts to minimize the patient's mental, social, and vocational disadvantages. The course of treatment is limited to the period in which the member continues to make progress toward his or her treatment goal, as described in the member's service plan.

Screening — the assessment of the medical necessity for a hospital admission or continued stay.

Utilization-Review Coordinator — an individual responsible for utilization review in a hospital.

Working Days — Monday through Friday except for legal holidays.

435.403: Eligible Members

(A) (1) MassHealth Members. The Division covers chronic disease and rehabilitation inpatient hospital services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, 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.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

435.404: Provider Eligibility

(A) Introduction. Payment for the services described in 130 CMR 435.000 will be made only to chronic-disease and rehabilitation hospitals participating in MassHealth as of the date of service.

(B) In State. To participate in MassHealth, a chronic-disease or rehabilitation hospital located in Massachusetts must:

(1) be licensed or operated by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health as a chronic-disease or rehabilitation hospital or unit;

(2) accept payment according to the methods and amounts as described in 130 CMR 435.405 as payment in full for services; and

(3) participate in the Medicare program.

(C) Out of State.

(1) Out-of-state chronic-disease or rehabilitation hospitalization is reimbursable on a prior-authorization basis only. The Division will consider a prior-authorization request submitted by an out-of-state chronic-disease or rehabilitation hospital only under one of the following circumstances.

(a) The hospital is located in Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont, is within 50 miles of the Massachusetts border, and provides services to a member who resides in a Massachusetts community near the border of that state.

(b) The hospital provides services to a member who is authorized to reside out of state by the Massachusetts Department of Social Services.

(c) The hospital provides a member with services that are not available from comparable resources in Massachusetts, that are generally acceptable medical practice, and that can be expected to benefit the member significantly.

(2) To participate in MassHealth, an out-of-state chronic-disease or rehabilitation hospital must obtain a MassHealth provider number and meet the following criteria:

(a) be approved as a chronic-disease or rehabilitation hospital by the governing or licensing agency in its state;

(b) participate in the Medicare program; and

(c) participate in that state's medical assistance program.

(D) Managed-Care Program. To participate in the chronic-disease and rehabilitation hospital managed-care program, a hospital must comply with 130 CMR 435.404(B) and must agree, by contract with the MassHealth agency, to provide or arrange and pay for all services covered by MassHealth, except acute-hospital services, for all MassHealth members who are inpatients of the chronic-disease or rehabilitation hospital and who participate in the hospital's managed-care program.

435.405: Rates of Payment

(A) Payments to in-state hospitals for services furnished to MassHealth members are equal to the rate established in the signed provider agreement with the MassHealth agency.

(B) Payments to out-of-state hospitals are made in accordance with 130 CMR 450.233. The Medicaid program rate methodology of that state applies when such methodology is compatible with the MassHealth agency's claims-processing system. Otherwise, the MassHealth agency and the out-of-state facility negotiate a rate comparable to the median or weighted average in-state rate for similar facilities.

(C) The hospital must accept the amount of payment established by 130 CMR 435.405 as payment in full for all care and services provided by the hospital for which payment is available under MassHealth.

435.406: Billing Exceptions

(A) The hospital may bill separately only for those drugs and durable medical equipment prescribed for take-home use that a member is unable to obtain directly from a pharmacy or durable medical equipment supplier. The charges for such drugs and durable medical equipment must be submitted on the claim form specified in the billing instructions.

(B) A hospital under contract to provide a managed-care program may not bill separately for take-home drugs and durable medical equipment.

435.407: Nonreimbursable Services

(A) The cost of any treatment or testing provided outside the hospital is allowed for in the rate-determination process and is not separately reimbursable.

(B) All administrative and processing costs associated with the provision of blood and its derivatives are allowed for in the rate-determination process and are not separately reimbursable.

(C) Private hospital rooms are not reimbursable except where medically necessary. Payment for medically necessary private hospital rooms is included in the rates of payment set forth under 130 CMR 435.405(A).

(D) Research and the provision of experimental procedures are not reimbursable.

(E) Leave-of-absence days taken by a member are not reimbursable. For billing purposes, leave-of-absence days are to be treated in the same way as discharge and admission days. Thus, the day on which the member leaves the chronic-disease or rehabilitation hospital to start a leave of absence is not reimbursable, regardless of the hour of discharge, while the day on which the member returns is reimbursable.

(F) Rest-home (level IV) services are not reimbursable.

(G) The first 45 administrative days of a member's admission or continued stay are not reimbursable.

435.408: Screening Program for Chronic-Disease and Rehabilitation Hospitals

(A) Introduction. The screening program applies to all in-state and out-of-state chronic-disease and rehabilitation hospitals, except those participating in a managed-care program for all inpatients (see 130 CMR 435.402). The screening program described in 130 CMR 435.408 is intended to ensure that medical and nursing services are medically necessary. The MassHealth agency pays for chronic-disease and rehabilitation hospital services only when the MassHealth agency or its agent determines, pursuant to a screening, that such services are medically necessary and authorizes such services prior to admission or conversion.

(B) Screening.

(1) To initiate admission or conversion screening, the hospital must telephone the MassHealth agency or its agent prior to the proposed admission or anticipated conversion and must:

(a) describe the medical condition that necessitates a chronic-disease or rehabilitation hospital admission or continued stay; and

(b) state the anticipated length of stay.

(2) The MassHealth agency or its agent applies the level-of-care criteria stated in 130 CMR 435.409 or 435.410, whichever is applicable, to determine the medical necessity of the proposed admission or continued stay, as well as the anticipated length of stay.

(3) If the MassHealth agency or its agent determines that the proposed admission or continued stay is not medically necessary and denies authorization for such admission or continued stay, the hospital may appeal the denial as stated in 130 CMR 435.408(C).

(4) If the MassHealth agency or its agent determines that the proposed admission or continued stay is medically necessary, the admission or continued stay will be authorized with a specified, approved length of stay, and the hospital will be issued a preapproved screening number to be used when billing for the hospital stay. Approval may be given by telephone; however, authorization for payment is contingent upon receipt of written authorization from the MassHealth agency or its agent. The MassHealth agency will not pay the hospital for any costs incurred after the expiration of the specified, approved length-of-stay period.

(5) Prior to the expiration of the approved length of stay, the hospital or attending physician may request an extension of the length of stay if the member continues to require hospitalization beyond the approved period. The Division or its agent will perform a concurrent review when such a request is made. Such request is subject to the screening program regulations in 130 CMR 435.408.

(6) The Division or its agent will send written notification of denial or written notification of authorization for payment and a preapproved screening number to the hospital within two working days after the completion of the screening.

(C) Review of Screening Decisions.

(1) If the Division or its agent determines that a hospital admission or continued stay is not medically necessary, the member, the referring or attending physician, or the hospital on behalf of the member, may verbally request reconsideration of the Division's determination. Requests for reconsideration must be made to the Division or its agent and will result in referral of the case to a physician consultant for decision within two working days after the date of the request.

(2) If the physician consultant determines that the hospital admission or continued stay is not medically necessary, the member, the referring or attending physician, or the hospital may request further review:

(a) by written request to the Division or its agent within seven calendar days after receipt of notice of the initial screening decision. This request must include all supporting documentation to justify the request for admission or continued stay. The Division or its agent will issue a final decision by written notice to the hospital, the member, and the referring or attending physician within two working days after the date the Division receives the request for further review; or

(b) by telephone request in order to expedite the review process. An expedited review will be conducted within one working day of receipt by the Division or its agent of the additional information requested during the telephone review. The Division or its agent will issue a final decision by telephone, followed by written notification to the hospital, the member, and the referring or attending physician.

(3) The member may appeal a decision to deny an admission or continued stay by requesting a fair hearing before the Board of Hearings in accordance with the provisions governing fair hearings (130 CMR 610.000 et seq.).

435.409: Level-of-Care Criteria for Members in Chronic Disease and Massachusetts Department of Public Health Hospitals

(A) Introduction. Services in chronic disease and Massachusetts Department of Public Health hospitals are reimbursable only when the member meets the level-of-care criteria in 130 CMR 435.409(B)(1) or (2).

(B) Level-of-Care Criteria. In determining medical necessity, the Division or its agent applies the criteria in 130 CMR 409(B)(1) and (2). In addition, the Medicare Adult Appropriateness Evaluation Protocol (AEP) utilized by the Peer Review Organization (PRO) is used as a guide. To be medically necessary, an admission to or continued stay in a chronic disease or Massachusetts Department of Public Health hospital must meet one of the following two criteria, in compliance with 130 CMR 450.204.

(1) The member must require services that:

(a) can be provided safely and effectively at a chronic disease hospital level. Such services must be ordered by a physician and documented in the member's record; and

(b) include at least daily physician intervention or the 24-hour availability of medical services and equipment available only in a hospital setting.

(2) The member's medical condition and treatment needs are such that no effective, less costly alternative placement is available to the member.

435.410: Level-of-Care Criteria for Rehabilitation Hospitals

(A) Introduction. A member is considered appropriate for rehabilitation hospital placement only when a medical need exists for an intensive rehabilitation program that includes a multidisciplinary approach to improve the member's ability to function to his or her maximum potential. Factors must be present in the member's condition that indicate the potential for functional movement or freedom from pain. A member who requires therapy solely to maintain function is not considered an appropriate rehabilitation hospital patient.

(B) Level-of-Care Criteria. The Medicare rehabilitation hospital level-of-care criteria and the criteria below are used by the Division or its agent to determine the medical necessity of rehabilitation hospital placement. The hospital must provide a rehabilitation program that:

(1) includes specialized skilled nursing services, physical therapy, occupational therapy, and any other services that are necessary for the rehabilitative program (such as speech therapy, prosthetic, or orthotic services);

(2) is organized and directed by a physician who is board-certified in rehabilitation medicine; and

(3) is designed to achieve specified goals within a given time frame.

(C) Team Conferences. The rehabilitation hospital must conduct team conferences for each member. The first team conference must occur within seven calendar days of the member's admission; successive team conferences must occur at least every 14 calendar days thereafter. All team members must be present during the team conferences. These conferences must assess the member's progress and rehabilitation goals, and adjust them when necessary, or terminate the rehabilitation program when the expected outcome is reached. A record must be maintained of:

(1) each team member's goals and progress notes from each conference;

(2) all decisions reached during each team conference; and

(3) the reason for any lack of progress on the part of the member in reaching specific goals.

435.411: Utilization Review

(A) The hospital must determine the medical or administrative necessity of each continued inpatient hospital stay of a member in accordance with the level-of-care criteria in 130 CMR 435.409 and 435.410. For those members requiring a less-than-hospital level of care, the hospital must determine the appropriate care in accordance with the MassHealth agency's medical eligibility criteria in 130 CMR 456.000.

(B) The MassHealth agency may designate an agent to determine the medical or administrative necessity of each inpatient hospital stay.

435.412: Reimbursable Administrative Days

(A) For members younger than 21 years old, the MassHealth agency will pay a hospital for up to 30 administrative days for each admission or each continued stay resulting from a conversion, as defined in 130 CMR 435.402. The MassHealth agency may pay a hospital for administrative days exceeding the 30-day limit for members younger than 21 years old, when the hospital can demonstrate, to the satisfaction of the MassHealth agency or its agent, that the hospital has

(1) experienced extraordinary difficulty in placing the member, including the specific reasons for such extraordinary difficulty; and
(2) exhaustively explored all potential appropriate placements.

(B) For members 21 years of age or older, the MassHealth agency will pay a hospital for administrative days for each admission or each continued stay resulting from a conversion, as defined in 130 CMR 435.402 only if they occur after the 45-day period described in 130 CMR 435.407(G) and where the hospital can demonstrate to the satisfaction of the MassHealth agency or its agent that the hospital has

(1) experienced extraordinary difficulty in placing the member, including the specific reasons for such extraordinary difficulty; and
(2) exhaustively explored all potential appropriate placements.

(C) An administrative day, as defined in 130 CMR 435.402, is reimbursable after the 45-day period described in 130 CMR 435.407(G) only if a hospital is making regular efforts to discharge the member to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 435.417 must be followed, but they do not preclude additional, effective discharge-planning activities.

(D) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

(1) A member is awaiting transfer to a nursing facility or any other institutional placement, and no appropriate nursing-facility bed is available.
(2) A member is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).
(3) A member is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.
(4) A member is awaiting results of a report of abuse or neglect made to any public agency

charged with the investigation of such reports.

(5) A member in the custody of the Department of Children and Families is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

(6) A member cannot be treated or maintained at home because the primary caregiver is absent due to a medical or psychiatric crisis, and a substitute caregiver is not available.

(7) A member is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to the following:

(a) maintenance of tube feedings;
(b) ventilator management;
(c) dressings, irrigations, packing, and other wound treatments;
(d) routine administration of medications;
(e) provision of therapies, such as respiratory, speech, physical, and occupational;
(f) insertion, irrigation, and replacement of catheters; and
(g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition).

435.413: Nonreimbursable Administrative Days

Administrative days after the 45-day period described in 130 CMR 435.407(G) are not reimbursable when:

(A) a hospitalized member is awaiting services or an appropriate placement is currently available, but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays;

(B) the MassHealth agency or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the member's noninstitutional (customary) residence and the member, the member's family, or any person legally responsible for the member refuses the placement or services; or

(C) the MassHealth agency or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the member's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the member.

435.414: Readmission after Medical Absence

When a member who was transferred for treatment to an acute inpatient hospital no longer needs acute inpatient hospital care but does meet the level-of-care criteria in 130 CMR 435.409(B) or 435.410(B), the chronic disease or rehabilitation hospital from which the member was transferred must readmit the member to the first available bed, in accordance with admission screening requirements (see 130 CMR 435.408).

435.415: Notification of Denial

The Division or its agent notifies the member, the hospital, and the member's attending physician whenever it determines that the hospital admission or continued stay, or any part thereof, is not medically or administratively necessary. The Division or its agent notifies the hospital and the member's attending physician whenever it determines that the hospital stay is no longer appropriate at a chronic disease or rehabilitation hospital level of care, but is administratively necessary. The Division or its agent notifies the member, the hospital, and the member's attending physician whenever it determines that the hospital stay is no longer administratively necessary due to the refusal of an appropriate placement in accordance with 130 CMR 435.413.

435.416: Fair Hearings

(A) A member may request a fair hearing before the Division in cases when the Division or its agent determines, as the result of a review, that there is no administrative necessity for a continued stay due to the availability of an appropriate placement as described in 130 CMR 435.413.

(B) A hospital may request a fair hearing before the Division when the Division or its agent determines, as the result of a review, that an admission or a continued stay, or any part thereof, is not medically necessary but is administratively necessary.

(C) A member or a hospital may request a fair hearing before the Division when the Division or its agent determines, as the result of a review, that an admission or continued stay, or any part thereof, is not medically or administratively necessary.

(D) Written notice of the right to a fair hearing and the manner in which and time within which a hearing must be requested will be provided at the time of the determination by the Division or its agent.

435.417: Discharge-Planning Standards

(A) Effective Date. The discharge-planning standards defined in 130 CMR 435.417 apply to members admitted on or after January 1, 1984.

(B) Exemptions from Discharge-Planning Standards. A chronic disease or rehabilitation hospital will be exempted from the discharge-planning standards defined in 130 CMR 435.417 if the hospital has filed an application with the Determination of Need Program of the Massachusetts Department of Public Health to relicense the entire facility or a distinct unit within the facility as a nursing facility.

(C) Staff.

(1) The hospital must assign in writing the responsibility for all discharge planning to one appropriate department (such as social services or continuing care). That department in turn must designate specific staff members whose primary duties are discharge planning.

(2) The discharge-planning staff must include either a registered nurse or a social worker who is licensed, or who is eligible for licensure and has submitted an application for licensure to the appropriate Massachusetts board of registration or licensing agency in its state, and is under the supervision of, or in consultation with, a licensed graduate-level nurse or social worker.

(3) Unless permitted a lower ratio by the Division, the hospital must employ one discharge planner or full-time equivalent for every 60 licensed beds. Visiting Nurse Association (VNA) or home health staff who are not employed by the hospital, but who regularly perform discharge-planning activities there, may be included in this ratio.

(4) The hospital must demonstrate to the Division that it provides formal in-service training programs and regular case conferences for all discharge-planning staff and all other personnel who affect the discharge-planning process.

(D) Operations and Procedures.

(1) The discharge-planning staff must maintain a chronological list of all members on administrative-day status, which must be updated on a daily basis. The list must contain the date administrative-day status commenced and a recommendation for institutional or noninstitutional care based on nursing facility medical eligibility criteria upon discharge. The discharge-planning department must use this chronological list to ensure that members who have spent the longest time on administrative-day status receive priority in placement attempts.

(2) The discharge-planning department must maintain up-to-date lists of the following:

(a) all licensed nursing facilities within a 25-mile minimum radius of the hospital. This list must show the number of beds, whether the facility is Medicare certified, and any other notable characteristics (for example, availability of bilingual staff). The list must also contain the name of the individual at that institution responsible for admissions; and

(b) all community-based organizations and resources within a 25-mile minimum radius of the hospital that provide services and support to members discharged to the community. Such resources include housing for the elderly, home health agencies, homemaker services, transportation services, friendly visitor programs, and meal programs.

(3) As a routine practice, admissions data, including but not limited to age and diagnosis, must be screened by discharge-planning staff within 24 hours of admission in accordance with written criteria that identify pertinent patient characteristics and any high-risk diagnoses. Discharge-planning activities must then commence within 72 working hours of admission for every member expected to require posthospital care or services.

(4) The hospital must have a written policy that allows discharge-planning staff access to all members and their medical records. If such access is medically contraindicated, the member's physician must sign a statement specifying the reason for the contraindication and the hospital must maintain the statement in the member's medical or discharge-planning record.
(5) The discharge-planning staff and the primary-care team must coordinate and document in writing a plan for each member who requires posthospital care that specifies the services or care expected to be required by the member, the frequency, intensity, and duration of such services, and the resources available to provide the care or services, including available family and community support. The plan must be updated if the member's condition changes significantly. If an institutional placement is recommended upon the member's discharge, the plan must state why available community resources are inadequate to meet the member's needs.
(6) Each visit to a member by discharge-planning staff must be noted in the member's discharge-planning record. The notation must include the date of the meeting, any discharge options discussed, any particular problems noted, any agreements reached with the member, and the future activities of the discharge-planning staff that address the problems raised or that continue preparation of the member for discharge.
(7) Whenever possible, the discharge-planning staff or primary-care team must contact the member's family to encourage its involvement in planning the member's discharge. Family members must be informed of the discharge options and community resources available to the member and provided with lists of nursing facilities and community resources in the area. When possible, these meetings or telephone consultations with the family must be held once every two weeks until the member is discharged. The dates of these meetings and other family contacts, items discussed, problems identified, and agreements reached must be entered on the member's discharge-planning record.
(8) The hospital must have written procedures for arranging posthospital services for members. At a minimum, these procedures must include frequent, systematic contacts (usually three times weekly) by telephone or in person to all nursing facilities and community-service providers within a 25-mile minimum radius of the hospital.

(a) The purpose of these contacts is to:
(i) determine what services at that location are or will soon become available and to ensure that the provider has current information, including medical and psychosocial status, on any member now or soon needing placement; and
(ii) arrange for placement or services or both for members awaiting discharge.

(b) These member-specific contacts must be documented as to their number, frequency, and outcome, and must be made by a registered nurse or by a social worker who is licensed, or who is eligible for licensure and has submitted an application for licensure to the appropriate Massachusetts board of registration or licensing agency in its state. The only exception in which such a call may be made by another person is when that person regularly works in the discharge-planning department, has received training in patient placement from a discharge planner, and consults all the relevant discharge documentation for the member when making the call. If, during the call, a question is asked that cannot be answered from the written data, it must be referred to a discharge planner.

(E) Nursing Facility Medical Eligibility Criteria. The member's physician and a registered nurse must determine the care required by a member upon discharge in accordance with the Division's nursing facility medical eligibility criteria. Both the member's medical and discharge-planning records must include the specific factors that indicate the recommended care and the names of the persons who determined it.

(F) Reporting Discrimination against Members. The hospital must have a formal written policy for the discharge-planning staff to use when reporting to the Division all suspected cases of discrimination against members by MassHealth providers.

(G) Disclosure Requirements. All written procedures and policies, lists, review criteria, discharge plans, and records used by the discharge-planning department in performing its duties must be made available for inspection by the Division.

435.418: Service Limitations

For MassHealth Family Assistance members who are not receiving premium assistance pursuant to 130 CMR 450.105(H)(1), the Division will cover chronic disease and rehabilitation inpatient services up to a maximum of 30 days per admission.

(130 CMR 435.419 through 435.423 Reserved)

435.424: Medical Leave of Absence: Responsibilities of the Hospital for the Transfer of a Member Who Is a Resident of a Nursing Facility

(A) The Division will pay a nursing facility to reserve a bed during a member's medical leave of absence if the admitting hospital meets the requirements of 130 CMR 435.424(B).

(B) Whenever a member is admitted to a hospital from a nursing facility, the hospital must comply with the following requirements.

(1) The hospital must ensure that the Division's nursing facility bed reservation form for medical leave of absence (hereafter referred to as "the bed reservation form") has been received from the nursing facility.

(2) Not later than the second working day of the member's hospital stay, the hospital must:

(a) review the member's medical record to determine the member's estimated length of stay;

(b) notify the nursing facility by telephone of the estimated number of days of the stay and document in the member's medical record the date of such telephone notification to the nursing facility; and

(c) complete the appropriate section of the bed reservation form, according to the instructions provided on the form.

(3) When the member's estimated length of stay will be 10 consecutive days or less, the facility must reserve a bed for the same number of days and the hospital must so notify its discharge-planning unit.

(4) When the member's estimated length of stay exceeds 10 consecutive days, the facility must not reserve a bed and the hospital must so notify its discharge-planning unit.

(C) The hospital must review the member's medical status on an ongoing basis. Whenever a change in the member's medical status occurs before the 10th day of the hospital stay, the hospital must:

(1) review the member's medical record;

(2) revise the estimated length of stay if the member's change in medical status so requires;

(3) immediately notify the nursing facility by telephone of the revised estimated length of stay, in accordance with 130 CMR 435.424(B); and

(4) complete the appropriate section of the bed reservation form, if applicable, according to the instructions provided on the form.

(D) If the member is transferred within the 10-day medical leave-of-absence period to another hospital:

(1) the transferring hospital must:

(a) notify the nursing facility immediately by telephone; and

(b) complete the appropriate section of the bed reservation form, according to the instructions provided on the form; and

(2) the receiving hospital must comply with all the requirements stated in 130 CMR 435.424.

(E) If the member is transferred within the 10-day medical leave-of-absence period to another nursing facility or noninstitutional setting, or if the member dies, the hospital must:

(1) notify the original nursing facility immediately by telephone; and

(2) complete the appropriate section of the bed reservation form according to the instructions provided on the form.

(F) Failure by the hospital to comply with any of the requirements set forth in 130 CMR 435.424 may result in administrative fines in accordance with the Division's administrative and billing regulations at 130 CMR 450.237 and 450.238.

REGULATORY AUTHORITY

130 CMR 435.000: M.G.L. c. 118E, ss. 7 and 12.

456.601: Personal Needs Allowance Account

MassHealth members have the right to manage their own financial affairs and the nursing facility must not require residents to deposit their personal funds with the facility. However, upon written request by a member, the facility must hold, safeguard, manage, and account for the member's personal funds deposited with the facility as specified in 130 CMR 456.601 through 456.615.

456.602: Management of the PNA Account

If requested by the member, a facility must assume responsibility for the PNA funds of a member. To do so, the facility must obtain and maintain on file a statement of authorization signed by the member or the member's authorized representative, such as a guardian, conservator, relative, or other responsible person acting on the member's behalf. The "other responsible person" must not be an employee of the facility or related to an employee of the facility in any way. Once a facility is trustee of a member's PNA account, it is responsible for the safekeeping of this money and must repay the member for any lost or stolen funds or for any money that cannot be accurately accounted for.

456.603: Autonomy of PNA Accounts

(A) If the facility assumes responsibility for a member's funds, the facility must deposit funds in excess of $50 into a PNA account, that is, an interest-bearing trustee account separate from any of the facility's operating accounts.

(B) The facility must ensure that PNA accounts are not available for any purpose except the personal needs of the member. The funds must not be lent or be used as collateral for a loan for anyone including the facility.

456.604: PNA Recordkeeping Requirements

(A) The facility must establish and maintain a system of recordkeeping that ensures a complete and separate accounting of the PNA funds according to generally accepted accounting principles. The system must prevent any commingling of the members' PNA funds with facility funds or with the funds of any other person other than another resident of the facility. If the facility does not manage the PNA funds for any member, it is not required to maintain such records.

(B) (1) The facility must ensure a separate accounting of each member's PNA funds, maintain a written record of all financial transactions involving the PNA funds, and allow the member or the member's authorized representative access to the accounting record.
(2) The bank-account statements and the general ledger must be in agreement and reconcilable at all times. All bank statements, canceled checks, and supporting documentation relating to the PNA account must be kept in the facility for at least four years from the date of the transaction.

(3) All checks or cash received on behalf of the member must be deposited into the PNA account no later than 30 days after the receipt of the money by the facility.
(4) The facility must maintain for each member with a PNA account a record of receipts and disbursements separate from other members' records. The facility must clearly label all PNA receipts and disbursements in the general ledger.
(5) At a minimum, all receipts and disbursements must be recorded in the ledger as follows:

Receipts	Disbursements
1. Date of entry 2. Amount 3. Source 4. Balance	1. Date of entry 2. Specific description (Avoid "misc.," "personal needs," etc.) 3. Amount 4. Signature of member or person receiving disbursement 5. Invoice number or date

(6) General ledger records must be updated at least once a month.
(7) The facility must ensure that funds are available to members in the form of actual cash or check for no less than 10 hours a week and on no less than three days a week. The facility must inform the members of the times when they may receive their money.
(8) All money disbursed to or on behalf of a member must be at the request of the member or the member's representative. The nursing facility may not make any disbursements on behalf of a member for a service that is covered by either Medicare or MassHealth.
(9) If a facility disburses money to a member by means of a check, or if the member signs petty cash vouchers, the facility does not need to obtain a signature in the ledger.
(10) The facility does not need to itemize cash disbursements to members.
(11) The facility must provide the member or the member's representative every three months and upon the member's request with an accounting of all financial transactions made on the member's behalf.

456.605: Petty Cash in the Facility

The facility may, if it chooses, maintain a petty cash fund in order to make direct cash distributions to residents. The total of this petty-cash fund must not exceed an amount equal to $5 per member for whom the facility manages a PNA account; however, a maximum of $250 is allowable regardless of the number of members.

456.606: Assurance of Financial Security

The facility must purchase a surety bond to assure the security of all personal funds of members deposited with the facility. The facility must keep this bond at the facility.

456.607: Availability of PNA Records to Division Personnel

All PNA records, including the accompanying bank statements, canceled checks, and supporting documentation, must be kept in the facility at all times and must be available to Division of Medical Assistance personnel upon request. The request may be made by telephone, in person, or by mail.

456.608: Member Signature

If the member cannot sign his or her own name, a staff member or business employee of the facility may sign as witness that the member has received cash from his or her PNA account.

456.609: Notification of Account Balance

(A) The facility must notify each member for whom it has established a PNA account when the balance reaches a total of $1800, which is $200 less than the maximum countable assets allowed per member. The notification must state that, if the member's countable assets exceed the maximum allowable amount of $2000, the member may lose MassHealth eligibility.

(B) If the member's balance exceeds the maximum allowable amount, the member may apply the excess to the cost of care in the facility.

456.610: Availability of PNA Records to Members

The facility must, within one working day of a request, allow the member or the member's authorized representative to examine the PNA records of the member.

456.611: PNA Funds of a Member Transferred to Another Facility

If a member is transferred to another facility, all of the member's funds held in trust by the facility must be sent to the new facility within 10 days of the transfer date.

456.612: PNA Funds of a Member Discharged to the Community

If a member has been discharged from the facility to the community, he or she must receive his or her bank book back from the facility or receive a check for the balance of his or her PNA account. The amount of the check must reflect the cash held on behalf of the member by the facility plus the bank balance.

456.613: Member Is Transferred to a Hospital and Does Not Return to the Facility

If a member is transferred to a hospital and does not return to the facility, the balance of the PNA account must be sent to the member at his or her new address within 10 days after he or she leaves the facility.

456.614: Death of a Member

(A) Upon the death of a MassHealth member, the facility must:
(1) render an accounting of the member's PNA funds. The funds must remain at the facility for 30 days after the death of a member to allow for the appointment of an administrator or executor of the estate and for the payment of burial expenses; and
(2) notify the next of kin or the person who served as the member's representative in official business with the facility of any remaining funds, determine whether or not an executor or administrator has been or will be appointed, and explain to the next of kin or the member's representative how to obtain the funds from the facility.
(a) If there is an outstanding balance due on a funeral bill, the funeral home may submit an itemized funeral bill to the facility and the facility may pay the bill from the PNA funds.
(b) If an executor or administrator is appointed within 30 days after the death of a member, the facility must send the balance of the PNA account and a final accounting of the member's account to the administrator or executor of the member's estate. If any payment has been made to the funeral home under 130 CMR 456.414(A)(2)(a), the final accounting must reflect that payment.

(B) If any funds still remain in the PNA account after 30 days, the facility must
(1) send a check for the balance and a final accounting of the member's account to the Division of Medical Assistance; and
(2) notify the next of kin or the member's representative of the amount of the funds and the address to which they are being sent and tell them they may apply for the funds, if they are appointed executor or administrator of the member's estate.

(C) A final accounting of the PNA funds must include any transactions that occurred during the previous three months and for the 30 days following the member's death. If there are no PNA funds, the facility is not required to submit the final accounting; however, the facility must maintain all member records according to 130 CMR 456.604.

(D) The facility must include with the returned PNA balance and the accounting the following information:
(1) the member's name and social security number;
(2) the member's date of birth and date of death;
(3) the name, address, and relationship of the next of kin or the member's representative ;
(4) the name, address, and MassHealth provider number of the facility; and
(5) the name and address of the funeral director.

456.615: Annual Accounting to the Division of the PNA Balance

(A) Annually, at least by each June 1, an accounting must be made to the Division of the balance of each PNA account. If the facility is not a trustee for any member's money, it must report this fact by each June 1 to the Division. The accounting to the Division must be submitted on the Statement of MassHealth Member's Personal Needs Account (PNA-1) and must be dated and signed under the pains and penalty of perjury by the administrator of the facility and mailed to the Division.

(B) The accounting must consist of the following:
(1) the member's name;
(2) the member's social security number;
(3) the amount of petty cash held in the facility for the member;
(4) the balance held in any individual bank account for the member;
(5) the balance held in the trustee account for the member;
(6) any other money being held by the facility for the member; and
(7) if funds are held in an aggregate trustee bank account, then a copy of the bank statement for that account must be submitted with the accounting.

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