Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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MASSHEALTH
TRANSMITTAL LETTER COH-1
November 2006

TO: Chronic Disease and Rehabilitation Outpatient Hospitals Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: *Chronic Disease and Rehabilitation Outpatient Hospital Manual* (Renamed Manual)

There are various outpatient hospital manuals for hospital providers participating in MassHealth. This letter is intended to clarify the hospital manual that applies to chronic disease and rehabilitation hospitals by reissuing the existing *Outpatient Hospital Manual* under the new name, *Chronic Disease and Rehabilitation Outpatient Hospital Manual*.

Chronic Disease and Rehabilitation Outpatient Hospital Manual

Previously, chronic disease and rehabilitation outpatient hospitals used the *Outpatient Hospital Manual,* which is the same provider manual as one of two manuals used by acute outpatient hospitals and hospital-licensed health centers. To avoid confusion, MassHealth has decided to change the name *Outpatient Hospital Manual* to *Chronic Disease and Rehabilitation Outpatient Hospital Manual*.

The attached *Chronic Disease and Rehabilitation Outpatient Hospital Manual* contains no new information. The only changes to these pages are to the title in the banner from "Outpatient Hospital Manual" to "Chronic Disease and Rehabilitation Outpatient Hospital Manual." The dates in the banner reflect the dates of the pages that were originally issued in the now obsolete *Outpatient Hospital Manual*.

Please note that the regulations listed in Subchapter 4 of the attached provider manual are 130 CMR 410.000. These regulations apply to both acute outpatient hospitals and chronic disease and rehabilitation outpatient hospitals. Since these regulations have not changed, there are references to the "*Outpatient Hospital Manual*." MassHealth will update those references at a later date to reflect the appropriate provider manual.

Please note that MassHealth has not changed the billing instructions appearing in Subchapter 5 of the attached manual. However, MassHealth plans to update and reissue these billing instructions soon.

Please begin using this new provider manual, and discard any copies of the *Outpatient Hospital Manual* that you may have. The *Chronic Disease and Rehabilitation Outpatient Hospital Manual*, along with all other MassHealth provider manuals, is on the Web at www.mass.gov/masshealthpubs. Click on Provider Library, then on MassHealth Provider Manuals.

MassHealth Hospital Manuals

The following table lists the three different outpatient hospital provider manuals along with an explanation of who should use each. Please note that for each outpatient manual, there is a corresponding inpatient version.

Provider Manual	Audience
Chronic Disease and Rehabilitation Outpatient Hospital Manual (formerly *Outpatient Hospital Manual*)	All chronic disease and rehabilitation outpatient hospital providers participating in MassHealth. **Note:** Chronic disease and rehabilitation outpatient hospitals that have signed an RFA with MassHealth must refer to the RFA for additional requirements.
Acute Outpatient Hospital Manual	All acute outpatient hospital providers participating in MassHealth, regardless of whether they have signed an RFA with MassHealth. **Note:** Acute outpatient hospitals that have signed an RFA with MassHealth must refer to the RFA for additional requirements.
Psychiatric Outpatient Hospital Manual	All psychiatric outpatient hospitals participating in MassHealth. **Note:** Psychiatric outpatient hospitals should see 130 CMR 450.124 of the administrative and billing regulations for important information about service authorization and payment for behavioral health services for MassHealth members.

Bulletins

MassHealth issues provider bulletins to communicate information that is not contained in the provider manual. Provider bulletins typically provide clarifications or describe procedures. Provider bulletins are listed on the Web at www.mass.gov/masshealthpubs. MassHealth will no longer issue "Outpatient Hospital Bulletins." Instead, MassHealth will issue "Chronic Disease and Rehabilitation Outpatient Hospital Bulletins," "Acute Outpatient Hospital Bulletins," and "Psychiatric Outpatient Hospital Bulletins" as needed.

Provider Manual Appendices

MassHealth has not moved Appendices E, G, and H of the obsolete *Outpatient Hospital Manual* to the *Chronic Disease and Rehabilitation Outpatient Hospital Manual*. Appendix E is obsolete, and Appendices G and H do not apply to chronic disease and rehabilitation outpatient hospitals.

Questions

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

NEW MATERIAL

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

Chronic Disease and Rehabilitation Outpatient Hospital Manual

Pages iv, iv-a, vi, vii, and 4-1 through 4-60

OBSOLETE MATERIAL

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

Outpatient Hospital Manual

This entire manual is now obsolete.

4. Program Regulations

4. PROGRAM REGULATIONS (cont.)

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Manuals in the series contain administrative regulations, billing regulations, program regulations, service codes, administrative and billing instructions, and general information. MassHealth regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. MassHealth regulations are assigned Title 130 of the Code. The regulations governing provider participation in MassHealth are assigned Chapters 400 through 499 within Title 130. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For chronic disease and rehabilitation outpatient hospitals, those matters are covered in 130 CMR Chapter 410.000, reproduced as Subchapter 4 in the *Chronic Disease and Rehabilitation Outpatient Hospital Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which furnish instructions for making changes by hand ("pen-and-ink" revisions), and by substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth’s effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and its members.

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. The quality of such services must meet professionally recognized standards of care. See 130 CMR 450.140 et seq. for regulations concerning Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

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 and 450.000.

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.

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 physical disease or 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.

Legend Drug – any drug for which a prescription is required by applicable federal or state law or regulation.

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 for any purpose by a federal, state, or local court of jurisdiction, unless the individual has been declared competent 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.

Nonlegend Drug – any drug for which no prescription is required by federal or state law.

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.

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.

Reconstructive Surgery – a surgical procedure that is performed to correct, repair, or ameliorate the physical effects of physical disease or 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 EOHHS'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 presence of a communication disability), and those that impair comprehension, spoken, written, or other symbol systems used for communication.

Sterilization – any medical procedure, treatment, or operation performed to make 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.

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 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.

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

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 the MassHealth program; 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 are provided to a member;

(b) hospital outpatient services are provided to a member who lives in a community near the border of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont and for whom the out-of-state hospital is nearer than one in Massachusetts providing equivalent medical services;

(c) hospital outpatient services are 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;

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

(e) 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 the Medicaid (or equivalent) fee schedule of that state.

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, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, the MassHealth agency will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993;

(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).

(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;
(4) hormone therapy related to sex-reassignment surgery; and
(5) 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 percent 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 recipient'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 Recipient Rights

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

410.411: Emergency Services

(A) The Division will pay for emergency services provided in a hospital emergency room only when such services are medically necessary and the necessity is fully documented in the recipient's medical record.

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

(C) For recipients participating in MassHealth Managed Care who are enrolled in the PCC Plan (see 130 CMR 450.101), the Division pays for urgent care and for emergency care in accordance with 130 CMR 450.118(I).

(D) The Division requires under certain conditions that recipients make a copayment to the hospital for nonemergency services provided in an emergency room. The copayment requirements are detailed in the Division's administrative and billing regulations at 130 CMR 450.130.

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

(A) Utilization Management Program. The Division 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 *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 Division will pay 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. Appendix E of the *Outpatient Hospital Manual* contains the name, address, and telephone number of the contact organization for the screening program.

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.

(130 CMR 410.415 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)

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410.431: Sterilization Services: Introduction

(A) Eligible Recipients. Medical Assistance recipients in categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8 are eligible for sterilization services as described in 130 CMR 410.431 through 410.433. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), see 130 CMR 450.111.

(B) Definitions. The following definitions apply to sterilization services:

(1) Sterilization – any medical procedure, treatment, or operation that renders an individual permanently incapable of reproducing. A sterilization is "nontherapeutic" when the individual has chosen sterilization as a permanent method of contraception. A sterilization is "therapeutic" when it occurs as a necessary part of the treatment of an existing illness or injury or is medically indicated and performed in conjunction with surgery upon the genito-urinary tract.

(2) 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.

(3) Institutionalized Individual – an individual who is:

(a) 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 care and treatment of mental illness; or

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

(C) Reimbursable Services. The Division will pay for a male or a female sterilization performed by a licensed physician in a hospital outpatient department only if all of the following conditions are met.

(1) The recipient 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 recipient is at least 18 years old at the time consent is obtained.

(3) The recipient is not mentally incompetent or institutionalized.

(D) Assurance of Recipient Rights. No provider shall use any form of coercion in the provision of sterilization services. Neither the Division nor any provider, nor any agent or employee of a provider, shall mislead any recipient into believing that a decision to have or not to have a sterilization will adversely affect the recipient's entitlement to benefits or services for which the recipient would otherwise be eligible. The Division has strict requirements for confidentiality of recipient records for sterilization services as well as for all other medical services reimbursable under the Medical Assistance Program.

(E) Retroactive Eligibility. The Division will not pay for a sterilization performed during the period of a recipient's retroactive eligibility unless all conditions for payment listed in 130 CMR 410.431(C) are met.

410.432: Sterilization Services: Informed Consent

A recipient'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).

(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 recipient requesting sterilization:

(a) advice that the recipient 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 recipient 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 recipient may have concerning the sterilization procedure;

(b) give the recipient 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 recipient who is blind, deaf, or otherwise handicapped;

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

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

(B) When Informed Consent Must Be Obtained.

(1) A recipient'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 recipient may not be sterilized at the time of a premature delivery or emergency abdominal surgery unless at least 72 hours have passed since the recipient gave informed consent for the sterilization in the manner specified in 130 CMR 410.432(A). 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 recipient's consent for sterilization will not be considered informed or voluntary if such consent is obtained or given while the recipient 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 recipient 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 Division'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 recipients aged 18 through 20; or
(b) CS-21 – for recipients aged 21 and older.
(2) Under no circumstances will the Division accept any other consent for sterilization form.

(B) Required Signatures. The recipient, 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 Submission and 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 recipient at the time of consent;
(2) a copy must be included in the recipient's permanent medical record at the site where the sterilization is performed; and
(3) all providers must attach a copy of the completed Consent for Sterilization form (CS-18 or CS-21) to each claim made to the Division for sterilization services. When more than one provider is billing the Division (for example, the physician and the hospital), each provider must submit a copy of the completed consent form.

410.434: Abortion Services: Reimbursable Services

The Division will pay for first- and certain second-trimester abortions 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 M.G.L. c. 112, ss. 12K through 12U, except as provided under 130 CMR 484.005(B);

(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 attach a completed Certification for Payable Abortion (CPA-2) form to each claim form submitted to the Division for a payable abortion. (Instructions for obtaining the Certification for Payable Abortion form are in Subchapter 5 of the *Outpatient Hospital Manual*.) To identify those abortions that meet federal reimbursement standards specified in 42 CFR, the Division 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 who performs the abortion 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 submitting with the claim form 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 106 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 106 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.

(106 CMR 410.438 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 program services in 130 CMR 440.000.

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. (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 will be paid according to the regulations governing home health agency services in 130 CMR 403.000.

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. (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.

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.

410.445: Psychiatric Day Treatment Program Services

(A) A psychiatric day treatment program is a planned combination of diagnostic, treatment, and rehabilitative services provided to mentally or emotionally disturbed persons who need more active or inclusive treatment than is typically available through a weekly visit for outpatient mental health services, but who do not need full-time hospitalization or institutionalization. Such a program uses multiple, intensive, and focused activities in a supportive environment to enable these individuals to acquire more realistic and appropriate behavior patterns, attitudes, and skills for eventual independent functioning in the community.

(B) The MassHealth agency pays for services provided as part of an organized psychiatric day treatment program by hospital outpatient departments that are enrolled with MassHealth as psychiatric day treatment programs. These services must be provided in compliance with the MassHealth regulations governing psychiatric day treatment program services in 130 CMR 417.000. (See Subchapter 5 of the *Outpatient Hospital Manual* for instructions about obtaining the *Psychiatric Day Treatment Program Manual*, which contains the necessary regulations.)

(C) Acute hospital-based psychiatric day treatment programs are paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based psychiatric day treatment programs are paid according to the regulations governing psychiatric day treatment services in 130 CMR 417.000.

410.446: Dental Services

(A) The MassHealth agency pays for dental services provided by hospital outpatient departments. These services must be provided in compliance with the MassHealth regulations governing dental services in 130 CMR 420.000. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the *Dental Manual*, which contains the necessary regulations.)

(B) Acute hospital-based providers of dental services are paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(C) Nonacute hospital-based providers of dental services are paid according to the regulations governing dental services in 130 CMR 420.000.

(130 CMR 410.447 through 410.450 Reserved)

410.451: Therapist Services: Covered Services

(A) The MassHealth agency pays for occupational, physical, and speech/language therapy provided in hospital outpatient departments by or under the supervision of licensed therapists. Therapist services include the following:

(1) individual treatment;
(2) comprehensive evaluation;
(3) group therapy; and
(4) design and fitting of an adaptive device.

(B) All therapy must be provided subsequent to a written referral from a licensed physician or licensed nurse practitioner. The MassHealth agency pays for continuing physical, occupational, or speech/language therapy only when the referral is renewed in writing every 60 days, subject to the prior-authorization requirements described in 130 CMR 410.408(G).

(C) Before therapy is initiated, a comprehensive evaluation of the member's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop a treatment plan. A comprehensive evaluation must include preparation of a written report for the member's medical record that contains at least the following information:

(1) the member's name and address;
(2) the name of the referring physician or nurse practitioner;
(3) objective evaluation findings;
(4) a detailed treatment plan prescribing the type, amount, estimated frequency, and duration of therapy and indicating the diagnosis and anticipated goals, or the reason treatment is not indicated;
(5) a description of any conferences with the member, the member's family or clinician, or other interested persons;
(6) other health care evaluations, as indicated;
(7) a description of the member's psychosocial and health status that includes:
    (a) the present effects of the disability on both member and family;
    (b) a brief history, the date of onset, and any past treatment of the disability;
    (c) the member's level of functioning, both current and before onset of the disability, if applicable; and
    (d) any other significant physical or mental disability that may affect therapy;
(8) for speech/language therapy only:
    (a) assessments of articulation, stimulability, voice, fluency, and receptive and expressive language;
    (b) a description of the member's cognitive functioning; and
    (c) a description of the member's communication needs and motivation for treatment;
(9) for physical or occupational therapy only: a description of the member’s physical limitations; and
(10) the therapist's signature and the date of the evaluation.

(D) The hospital must obtain prior authorization as a prerequisite to payment for certain outpatient therapy services pursuant to 130 CMR 410.408(G).

410.452: Therapist Services: Service Limitations

(A) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 410.452(B).

(B) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

(C) For each type of therapy, the MassHealth agency pays for no more than one individual visit and one group therapy session for a member per day.

410.453: Therapist Services: Recordkeeping Requirements

In addition to the information required in 130 CMR 410.409, the member's record must include the following:

(A) a licensed physician's or licensed nurse practitioner's written referral for evaluation, referral for treatment, and renewal of referral (if applicable) every 60 days (see 130 CMR 410.451(B));

(B) the written comprehensive evaluation report (see 130 CMR 410.451(C));

(C) the name, address, and telephone number of the member's primary physician;

(D) a treatment notation for each date on which therapy was provided that includes at least the following:
(1) the specific therapeutic procedures and methods used;
(2) the amount of time spent in treatment; and
(3) the signature and title of the person who provided the service;

(E) at least weekly documentation of the following:
(1) the member's response to treatment;
(2) any changes in the member's condition;
(3) the problems encountered or changes in the treatment plan or goals, if any;
(4) the location where the service was provided if different from that in the evaluation report; and
(5) the signature and title of the therapist; and

(F) a discharge summary, when applicable.

(130 CMR 410.454 Reserved)

410.455: Laboratory Services: Introduction

(A) 130 CMR 410.455 through 410.459 establish the requirements and procedures for clinical laboratory services provided by hospital outpatient departments. A clinical laboratory service includes the following types of services: microbiological, serological, chemistry, hematological, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

(B) The MassHealth agency does not pay separately for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipuncture; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue.) Specimen collection and preparation is considered part of the laboratory service.

410.456: Laboratory Services: Payment

(A) Maximum Allowable Fee. The maximum allowable payment for an acute or nonacute hospital outpatient department or hospital-licensed health center laboratory service is the lowest of the following:

(1) the amount in effect for the date of service in the DHCFP Clinical Laboratory Services fee schedule at 114.3 CMR 20.00 and 114.3 CMR 16.00;

(2) the amount that would be recognized under 42 U.S.C. 1395l(h) for tests performed for a person with Medicare Part B benefits; or

(3) the usual and customary fee.

(B) Usual and Customary Fee. The term usual and customary means the lowest fee charged by a hospital outpatient department laboratory for any laboratory service (including both individual and profile tests) specified in the hospital outpatient department's charge book or by such hospital, with the exception of a fee offered for a bulk purchase. (A bulk purchase is a single purchase of a laboratory service (one or more tests) to be uniformly and concurrently performed on a minimum of 40 specimens of the same type. A single purchase of various, non-uniform laboratory services, such as by a physician, is not considered a bulk purchase, regardless of the number of specimens presented by such a purchaser to the hospital outpatient department laboratory.)

(C) Profile or Panel Tests.

(1) A profile or panel test is any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified recipient on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the hospital outpatient department laboratory performing the tests.

(b) The group of tests is performed by the hospital outpatient department laboratory at a usual and customary fee that is lower than the sum of that hospital outpatient department laboratory's usual and customary fees for the individual tests in that group.

(2) In no event shall a hospital outpatient department laboratory bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that hospital outpatient department laboratory or requested by an authorized person.

410.457: Laboratory Services: Request for Services

The hospital outpatient department must have either a written requisition or a written order for the laboratory service signed by an authorized prescriber (that is, a licensed physician or dentist, or a registered nurse practitioner) before performing the service. A written requisition signed only by an unauthorized prescriber is not acceptable. Any failure or inability to make the authorized requisition or order available to the Division for review will be sufficient reason to deny or recover payment for all services based on that requisition or order. The hospital outpatient department may send disclosures concerning the test only to the prescriber, to the referring laboratory, if applicable, to the Division, and, at the written request of the prescriber, to the recipient.

410.458: Laboratory Services: Recordkeeping Requirements

In addition to meeting the recordkeeping requirements specified in 130 CMR 410.409, the hospital outpatient department must keep 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. Such a record must contain the following information:

(A) the name and any other means of identification of the person from whom the specimen was taken;

(B) the name of the prescriber or laboratory that submitted the specimen;

(C) the authorized requisition or order, or both;

(D) the location where the specimen was taken, if other than the hospital outpatient department;

(E) the date on which the specimen was collected by the prescriber or laboratory;

(F) the date on which the specimen was received in the laboratory;

(G) the condition of unsatisfactory specimens when received (for example, broken, leaked, hemolyzed, turbid, or insufficient sample size);

(H) the date on which the test was performed;

(I) the test name and the results of the test, or the cross-reference to results and the date of reporting; and

(J) the name and address of the laboratory to which the specimen was referred, if applicable.

410.459: Laboratory Services: Specimen Referral

A hospital outpatient department may refer a specimen to an independent laboratory that is eligible to participate in the Medical Assistance Program, or to another hospital laboratory that is eligible to participate in the Medical Assistance Program. To be eligible, a hospital laboratory must be in a hospital that is licensed by the Massachusetts Department of Public Health and that is an approved Medicare provider. The referring hospital outpatient department laboratory must inform the prescriber of the name and address of the testing laboratory. The testing laboratory must inform the referring hospital outpatient department laboratory of the results of the test. Only the referring laboratory is authorized to bill the Division.

(l30 CMR 410.460 Reserved)

410.461: Pharmacy Services: Prescription Requirements

(A) Legal Prescription Requirements. The MassHealth agency pays for legend drugs, nonlegend drugs, and those medical supplies listed at 130 CMR 410.462(C) only if the pharmacy has in its possession a prescription that meets all requirements for a legal prescription under all applicable federal and state laws and regulations. Each prescription, regardless of drug schedule, must contain the prescriber's unique DEA number. For Schedule VI drugs, if the prescriber has no DEA registration number, the prescriber must provide the state registration number on the prescription.

(B) Emergencies. When the pharmacist determines that an emergency exists, the MassHealth agency will pay a pharmacy for at least a 72-hour, nonrefillable supply of the drug in compliance with state and federal regulations. Emergency dispensing to a MassHealth member who is enrolled in the Controlled Substance Management Program (CSMP) must comply with 130 CMR 406.442(C)(2).

(C) Refills.

(1) The MassHealth agency does not pay for prescription refills that exceed the specific number authorized by the prescriber.

(2) The MassHealth agency pays for a maximum of 11 monthly refills, except in circumstances described in 130 CMR 410.461(C)(3).

(3) The MassHealth agency pays for more than 11 refills within a 12-month period if such refills are for less than a 30-day supply and have been prescribed and dispensed in accordance with 130 CMR 410.461(D).

(4) The MassHealth agency does not pay for any refill dispensed after one year from the date of the original prescription.

(5) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

(6) The MassHealth agency does not pay for any refill without an explicit request from a member or caregiver for each filling event. The possession by a provider of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription.

(D) Quantities.

(1) Days' Supply Limitations. The MassHealth agency requires that all drugs be prescribed in a 30-day supply, unless the drug is available only in a larger minimum package size, except as specified in 130 CMR 410.461(D)(2).

(2) Exceptions to Days' Supply Limitations. The MassHealth agency allows exceptions to the limitations described in 130 CMR 410.461(D)(1) for the following products:

(a) drugs in therapeutic classes that are commonly prescribed for less than a 30-day supply, including but not limited to antibiotics and analgesics;

(b) drugs that, in the prescriber's professional judgement, are not clinically appropriate for the member in a 30-day supply;

(c) drugs that are new to the member, and are being prescribed for a limited trial amount, sufficient to determine if there is an allergic or adverse reaction or lack of effectiveness. The initial trial amount and the member's reaction or lack of effectiveness must be documented in the member's medical record;

(d) drugs packed in such a way that the smallest quantity that may be dispensed is larger than a 30-day supply (for example, inhalers, ampules, vials, eye drops, and other sealed containers not intended by the manufacturer to be opened by any person other than the end user of the product);
(e) drugs in topical dosage forms that do not allow the pharmacist to accurately predict the rate of the product's usage (for example, lotions or ointments);
(f) products generally dispensed in the original manufacturer's packaging (for example, fluoride preparations, prenatal vitamins, and over-the-counter drugs); and
(g) methylphenidate and amphetamine prescribed in 60-day supplies.

(E) Prescription-Splitting. Providers must not split prescriptions by filling them for a period or quantity less than that specified by the provider. For example, a prescription written for a single 30-day supply may not be split into three 10-day supplies. The MassHealth agency considers prescription-splitting to be fraudulent. (See 130 CMR 450.238(B)(6).)

(F) Excluded, Suspended, or Terminated Clinicians. The MassHealth agency does not pay for prescriptions written by clinicians who:
(1) have been excluded from participation based on a notice by the U.S. Department of Health and Human Services Office of Inspector General; or
(2) the MassHealth agency has suspended, terminated, or denied admission into its program for any other reason.

410.462: Pharmacy Services: Covered Drugs and Medical Supplies for MassHealth Members

(A) Drugs. The MassHealth Drug List specifies the drugs that are payable under MassHealth. In addition, the MassHealth agency pays only for legend drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8.

(B) Medical Supplies. The MassHealth agency pays only for the medical supplies listed in 130 CMR 410.462(B)(1) through (6):
(1) blood and urine testing reagent strips used for the management of diabetes;
(2) disposable insulin syringe and needle units;
(3) insulin cartridge delivery devices and needles or other devices for injection of medication (for example, Epipens);
(4) lancets;
(5) drug delivery systems for use with metered dose inhalers (for example, aerochambers); and
(6) alcohol swabs.

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 legend or nonlegend preparations for cosmetic purposes or for hair growth.

(2) Cough and Cold. The MassHealth agency does not pay for legend or nonlegend 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 an institutionalized member.

(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 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 drugs 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)(1) through (5) do not apply to medically necessary drug therapy 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. The MassHealth agency will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List accordingly. See 130 CMR 450.303.

(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 sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. The MassHealth agency, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(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 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.

(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 and 450.117.

(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 et seq. and the hospital's Request for Applications and Contract, if applicable.

(3) Medicare Part D. 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.

410.464: Pharmacy Services: Drugs and Medical Supplies Provided by Hospital-Based Pharmacies

Drugs and medical supplies provided by hospital-based pharmacies must be provided and billed in accordance with MassHealth regulations governing pharmacy services in 130 CMR 406.000.

410.465: Pharmacy Services: Drugs and Medical Supplies for Members in Institutions

(A) MassHealth does not pay for nonlegend drugs or medical supplies provided to an institutionalized member, except in circumstances described in 130 CMR 410.465(C).

(B) MassHealth pays for legend drugs provided to an institutionalized member.

(C) MassHealth pays for insulin prescribed for members who are residents of a nursing facility or rest home.

410.466: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from MassHealth for drugs identified by MassHealth in accordance with 130 CMR 450.303. If the limitations on covered drugs specified in 130 CMR 410.462(A) and 410.463(A) and (C) would result in inadequate treatment for a diagnosed medical condition, the prescriber may submit a written request, including written documentation of medical necessity, to MassHealth for prior authorization for an otherwise noncovered drug.

(B) All prior-authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Outpatient Hospital Manual*. If MassHealth approves the request, it will notify both the pharmacy and the member.

(C) MassHealth will authorize at least a 72-hour emergency supply of a prescription drug to the extent required by federal law. (See 42 U.S.C. 1396r-8(d)(5).) MassHealth acts on requests for prior authorization for a prescribed drug within a time period consistent with federal regulations.

(D) Prior authorization does not waive any other prerequisites to payment such as, but not limited to, member eligibility or requirements from other health insurers.

(E) 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 410.461 through 410.466. MassHealth will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List.

410.467: Pharmacy Services: Member Copayments

Under certain conditions, MassHealth requires that members make a copayment to the dispensing pharmacy for each original prescription and for each refill for all drugs (whether legend or nonlegend) covered by MassHealth. The copayment requirements are detailed in 130 CMR 450.130.

410.468: Participation in the 340B Drug-Pricing Program for Outpatient Pharmacies

(A) Notification of Participation. A hospital outpatient department or a hospital-licensed health center that is a 340B-covered entity may provide drugs to MassHealth members through the 340B drug-pricing program provided that it notifies MassHealth by submitting to MassHealth a copy of the form used to register with the Health Resources and Services Administration, Office of Pharmacy Affairs (OPA), as a 340B-covered entity and, if applicable, a copy of the OPA form used to certify the contracted pharmacy services. The hospital may provide and bill for 340B drugs to MassHealth members, provided directly or through a subcontract, after MassHealth confirms, in writing, its receipt of the hospital's notification and a copy of the OPA registration form, in accordance with 130 CMR 410.468(A).

(B) Subcontracting for 340B Outpatient Pharmacy Services.

(1) A hospital outpatient department or hospital-licensed health center that is a 340B-covered entity may contract with a MassHealth pharmacy provider to dispense 340B drugs for the 340B-covered entity's MassHealth patients. All such subcontracts between the 340B-covered entity and a pharmacy provider must be in writing, ensure continuity of care, specify that the hospital pays the pharmacy, specify that such payment constitutes payment in full for 340B drugs provided to MassHealth members, be consistent with all applicable provisions of 130 CMR 406.000, and are subject to MassHealth approval. The 340B-covered entity must comply with the requirements of 130 CMR 410.468(A) by submitting to MassHealth a copy of the form used to register with the Health Resources and Services Administration, Office of Pharmacy Affairs (OPA), as a 340B-covered entity and a copy of the OPA form used to certify the contracted pharmacy services for the 340B drug-pricing program.

(2) The hospital is legally responsible to MassHealth for the performance of any subcontractor. The hospital must ensure that every pharmacy subcontractor is licensed by the Massachusetts Board of Registration in Pharmacy, is a MassHealth pharmacy provider, and that services are furnished in accordance with MassHealth pharmacy regulations at 130 CMR 406.000 and all other applicable MassHealth requirements, including but not limited to, those set forth in 130 CMR 450.000.

(C) Termination or Changes in 340B Drug-Pricing Program Participation. A hospital outpatient department or hospital-licensed health center must provide MassHealth 30 days' advance written notice of its intent to discontinue, or change in any way material to MassHealth, the manner in which it provides 340B outpatient drugs for its MassHealth patients.

(D) Payment for 340B Outpatient Pharmacy Services. MassHealth pays the 340B-covered entity for outpatient hospital pharmacy services, whether provided and billed directly or through a subcontractor, at the rates established in DHCFP regulations at 114.3 CMR 31.00.

(130 CMR 410.469 through 410.470 Reserved)

410.471: Mental Health Services: Introduction

A mental health program is a comprehensive group of diagnostic and treatment services, as outlined in 130 CMR 410.474, furnished to mentally or emotionally disabled persons and their families under the direction of a licensed psychiatrist. The Division pays for mental health services provided in hospital outpatient departments subject to the restrictions and limitations in 130 CMR 410.472 through 410.479.

410.472: Mental Health Services: Noncovered Services

(A) Nonmedical Services. The Division does not pay for nonmedical mental health services. These services include, but are not limited to, the following:

(1) vocational rehabilitation services;
(2) sheltered workshops;
(3) educational services;
(4) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is covered);
(5) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and
(6) telephone conversations.

(B) Nonmedical Programs. The Division does not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other nonreimbursable services. Such programs include alcohol or drug drop-in centers.

(130 CMR 410.473 Reserved)

This page is reserved.

410.474: Mental Health Services: Definitions

The following terms used in 130 CMR 410.471 through 410.479 shall have the meanings given in 130 CMR 410.474 unless the context clearly requires a different meaning. When provided in a hospital outpatient department, services that are defined below must conform to the definitions given.

(A) Diagnostic Services – the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan.

(B) Psychological Testing – the use of standardized test instruments to evaluate aspects of an individual's functioning, including aptitudes, educational achievements, cognitive processes, emotional conflicts, and type and degree of psychopathology, subject to the limitations of 130 CMR 410.479(H).

(C) Long-Term Therapy – a combination of diagnostics and individual, couple, family, and group therapy planned to last more than 17 sessions.

(D) Short-Term Therapy – a combination of diagnostics and individual, couple, family, and group therapy planned to end within 17 sessions.

(E) Individual Therapy – therapeutic services provided to an individual.

(F) Couple Therapy – therapeutic services provided to a couple whose primary complaint is the disruption of their marriage, family, or relationship.

(G) Family Therapy – the treatment of more than one member of a family simultaneously in the same session.

(H) Group Therapy – the application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

(I) Medication Visit – a recipient visit specifically for prescription, review, and monitoring of medication by a psychiatrist or administration of prescribed intramuscular medication by qualified personnel.

(J) Case Consultation – a preplanned meeting of at least one-half hour's duration concerning a recipient who is either:

(1) a client of the hospital outpatient department to whom it is the primary provider of therapeutic services; or

(2) one for whom evaluation and assessment have been requested by another agency or program involved in treatment or management of the recipient.

(K) Family Consultation – a preplanned meeting with the parent or parents of a child who is being treated, when the parent or parents are not clients.

(L) Crisis Intervention/Emergency Services – immediate mental health evaluation, diagnosis, hospital prescreening, treatment, and arrangements for further care and assistance as required, provided during all hours to clients showing sudden, incapacitating emotional stress. The Division will pay only for face-to-face contact; telephone contacts are not reimbursable.

(M) Home Visit – crisis intervention, individual, group, or family therapy, and medication provided in the recipient's residence (excluding a medical institution), when the recipient is unable to be served at the hospital outpatient department.

410.475: Mental Health Services: Staffing Requirements

(A) Provider Responsibilities.
(1) The hospital outpatient department must employ a balanced interdisciplinary staff to furnish mental health services under the direction of a licensed psychiatrist.
(2) The hospital outpatient department must designate a professional staff member as director of clinical services and a licensed psychiatrist as medical director.
(3) A licensed psychiatrist must be on call during all hours of operation.
(4) Although the Division does not require that the hospital outpatient department employ mental health professionals from all the disciplines listed in 130 CMR 410.475(B), staff members who provide services to recipients must be qualified as set forth in 130 CMR 410.475(B) for their respective disciplines.

(B) Staff Qualifications.
(1) Psychiatrist. At least one staff psychiatrist must be either currently certified by the American Board of Psychiatry and Neurology or eligible for such certification. Any additional psychiatrists must be, at the minimum, licensed physicians in their second year of a psychiatric residency program accredited by the Council on Medical Education of the American Medical Association. Such physicians must be under the direct supervision of a licensed psychiatrist.
(2) Psychologist. At least one staff psychologist must be licensed by the Massachusetts Board of Registration of Psychologists with a specialization listed in clinical or counseling psychology or a closely related specialty. Additional staff members trained in the field of clinical or counseling psychology or a closely related specialty must:
(a) have a minimum of a master's degree or the equivalent graduate study in clinical or counseling psychology or a closely related specialty from an accredited educational institution;
(b) be currently enrolled in or have completed a doctoral program in clinical or counseling psychology or a closely related specialty; and
(c) have had two years of full-time supervised clinical experience subsequent to obtaining a master's degree in a multidisciplinary mental health setting. (One year of supervised clinical work in an organized graduate internship program may be substituted for each year of experience.)

(3) Social Worker.

(a) At least one staff social worker must be licensed or have applied for and have a license pending as an independent clinical social worker by the Massachusetts Board of Registration of Social Workers.

(b) Any additional social workers on the staff must provide services under the direct and continuous supervision of an independent clinical social worker. Such additional social workers must be licensed or applying for licensure as certified social workers by the Massachusetts Board of Registration of Social Workers and have received a master's degree in social work and completed two years of full-time supervised clinical work in an organized graduate internship program.

(4) Psychiatric Nurse. At least one psychiatric nurse must be currently registered by the Massachusetts Board of Registration in Nursing and must have a master's degree in nursing from an accredited National League of Nursing graduate school with two years of full-time supervised clinical experience in a multidisciplinary mental health setting and be eligible for certification as a clinical specialist in psychiatric/mental health nursing by the American Nursing Association. Any other nurses must have a bachelor's degree from an educational institution accredited by the National League of Nursing and two years of full-time supervised skilled experience in a multidisciplinary mental health setting subsequent to that degree, or a master's degree in psychiatric nursing.

(5) Counselor. A counselor must have a master's degree in counseling education, counseling psychology, or rehabilitation counseling from an accredited educational institution and two years of full-time supervised clinical experience in a multidisciplinary mental health setting subsequent to obtaining the master's degree. (One year of supervised clinical work in an organized graduate internship program may be substituted for each year of full-time experience.)

(6) Occupational Therapist. An occupational therapist must be currently licensed by the Massachusetts Division of Registration of Allied Health Professions and registered by the American Occupational Therapy Association and must have either:

(a) a master's degree in occupational therapy from an accredited program in occupational therapy; or

(b) a bachelor's degree in occupational therapy from an accredited program in occupational therapy and a master's degree in a related field such as psychology, social work, or counseling.

410.476: Mental Health Services: Treatment Procedures

(A) A professional staff member must conduct a comprehensive evaluation of each recipient prior to initiation of therapy.

(B) The hospital outpatient department must accept for treatment, refer for treatment elsewhere, or both, any recipient for whom the intake evaluation substantiates a mental or emotional disorder.

(C) One professional staff member (the primary therapist) shall assume primary responsibility for each recipient. This responsibility shall include:

(1) within four client visits, preparation of a comprehensive written treatment plan that is based on the initial evaluation, incorporates short- and long-term treatment goals, and establishes criteria for determining when termination of treatment is appropriate;

(2) ongoing utilization review; and

(3) review of each case at termination of treatment and preparation of a termination summary that describes the course of treatment and any aftercare program or resources in which the recipient is expected to participate.

(D) The hospital outpatient department shall make provisions for responding to persons needing services on a walk-in basis.

(E) The hospital outpatient department shall take appropriate steps to facilitate uninterrupted and coordinated recipient care whenever it refers a recipient elsewhere for concurrent or subsequent treatment.

(F) Before referring a recipient elsewhere, the hospital outpatient department shall, with the recipient's consent, send a summary of or the actual record of the recipient to that referral provider.

410.477: Mental Health Services: Utilization Review Plan

A mental health program must have a utilization review plan that is acceptable to the Division and that meets the following conditions.

(A) A utilization review committee is to be formed, composed of the clinical director (or a designee), a psychiatrist, and one other professional staff member from each core discipline represented who meets all the qualifications for the discipline, as outlined in 130 CMR 410.475.

(B) The utilization review committee is to review a representative sample of cases at least in the following circumstances:

(1) within 90 days after initial contact;

(2) when a recipient has required more than 50 visits every 12 months and has not required hospitalization or extensive crisis intervention during that period; and

(3) following termination.

(C) The utilization review committee is to verify for a representative sample of cases that:
(1) the diagnosis has been adequately documented;
(2) the treatment plan is appropriate and specifies the methods and duration of the projected treatment program;
(3) the treatment plan is being or has been carried out;
(4) the treatment plan is being or has been modified as indicated by the recipient's changing status;
(5) there is adequate follow-up when a recipient misses appointments or drops out of treatment; and
(6) there is progress toward achievement of short- and long-term goals.

(D) No staff member is to participate in the utilization review committee's deliberations about any recipient that staff member is treating directly.

(E) The program is to maintain minutes that are sufficiently detailed to show the decisions of each review and the basis on which any decisions are made so that the Division may conduct such audits as it deems necessary.

(F) Based on the utilization review, the director of clinical services or a designee is to determine whether continuation, modification, or termination of treatment is necessary and promptly communicate this decision to the primary therapist.

410.478: Mental Health Services: Recordkeeping Requirements

(A) The hospital outpatient department must obtain, upon the initiation of treatment, written authorization from each recipient or the recipient's legal guardian to release information obtained by the provider to hospital staff, federal and state regulatory agencies, and, when applicable, referral providers, to the extent necessary to carry out the purposes of the program and to meet regulatory requirements, including provider audits.

(B) In addition to the information required in 130 CMR 410.409, each recipient's record must include the following information:
(1) the recipient's case number, address, telephone number, sex, age, marital status, next of kin, and school or employment status (or both);
(2) the date of initial contact and, if applicable, the referral source;
(3) 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 recipient's request for services or, if the recipient refuses to be examined, the record must document the reasons for the exam postponement);
(4) the name and address of the recipient's primary physician or medical clinic (a physician or medical clinic must be recommended if there is not one currently attending the recipient);

(5) a description of the nature of the recipient's condition;
(6) the relevant medical, social, educational, and vocational history;
(7) a comprehensive functional assessment of the recipient;
(8) the clinical impression of the recipient and a diagnostic formulation, including a specific diagnosis using ICD-9-CM or DSM III diagnosis codes;
(9) the recipient's treatment plan, updated as necessary, including long-range goals, short-term objectives, and the proposed schedule of therapeutic activities;
(10) a schedule of dates for utilization review to determine the recipient's progress in accomplishing goals and objectives;
(11) the name, qualifications, and discipline of the primary therapist;
(12) a written record of utilization reviews by the primary therapist;
(13) documentation of each visit, including the recipient's response to treatment, written and signed by the person providing the service, and including the therapist's discipline and degree;
(14) all information and correspondence regarding the recipient, including appropriately signed and dated consent forms;
(15) a medication-use profile; and
(16) when the recipient is discharged, a discharge summary.

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

410.479: Mental Health Services: Service Limitations

(A) Length and Frequency of Sessions.
(1) The Division will pay for diagnostic and treatment services only when a professional staff member personally provides these services to the recipient or the recipient's family, or personally consults with a professional outside of the hospital outpatient department. The services must be provided to the recipient on an individual basis.
(2) The Division will pay for only one session of the types of services listed in 130 CMR 410.479(C) through (H) provided to an individual recipient on one date of service. Return visits on the same date of service are not reimbursable.

(B) Diagnostic Services. Payment for diagnostic services provided to a recipient is limited to a maximum of four hours or eight units.

(C) Individual Therapy. Payment for individual therapy is limited to a maximum of one hour per session per day.

(D) Family Therapy.

(1) Payment for family therapy is limited to a maximum of one-and-one-half hours per session per day.

(2) Payment shall also be limited to one payment per family therapy visit, regardless of the number of staff members or recipients who are present.

(E) Case Consultation.

(1) The Division will pay only for case consultation that lasts at least 30 minutes and involves a personal meeting with a professional of another agency. Payment is limited to a maximum of one hour per session.

(2) The Division will pay for case consultation only when telephone contact, written communication, and other nonreimbursable forms of communication clearly will not suffice. Such circumstances must be documented in the recipient's record and also in the prior authorization request, if applicable. Such circumstances are limited to situations in which both the hospital outpatient department and the other party are actively involved in treatment or management programs with the recipient (or family members) and where a lack of face-to-face communication would impede a coordinated treatment program.

(3) The Division will not pay for court testimony.

(F) Family Consultation. The Division will pay for consultation with the natural or foster parent or legal guardian of a recipient less than 21 years of age who lives with the child, is responsible for the child's care, and is not an eligible recipient, when such consultation is integral to the treatment of the recipient.

(G) Group Therapy.

(1) The Division will pay only for a group therapy session that has a minimum duration of one and one-half hours and a maximum duration of two hours.

(2) Payment is limited to one fee per group member with a maximum of 10 recipients per group regardless of the number of staff members present.

(3) The Division will not pay for group therapy when it is performed as an integral part of a psychiatric day treatment program.

(H) Psychological Testing. The Division will pay for psychological testing only when the following conditions are met.

(1) A psychologist who is licensed by the Massachusetts Board of Registration of Psychologists with a specialization listed in clinical or counseling psychology or a closely related specialty either personally administers the testing or personally supervises such testing during its administration by an unlicensed psychologist.

(2) A battery of tests is performed. These tests must meet the following standards:

(a) the tests are published, valid, and in general use, as evidenced by their presence in the current edition of the *Mental Measurement Yearbook* or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological Association;
(b) a personality evaluation contains the findings of at least two of the following test types or their age-appropriate equivalents: Rorschach, TAT (Thematic Apperception Test), TED (Tasks of Emotional Development), or MMPI (Minnesota Multiphasic Personality Inventory), and one or more of the following test types: figure drawing, Bender-Gestalt, or word association;
(c) intelligence testing includes either a full Wechsler or Stanford-Binet instrument or an equivalent; and
(d) assessment of brain damage contains at least the findings of a Wechsler Intelligence Scale and tests of recent memory, visual-space perception, and other functions commonly associated with brain damage.

(3) Except as explained below, the Division will not pay for:
(a) self-rating forms and other paper-and-pencil instruments, unless administered as part of a comprehensive battery of tests;
(b) group forms of intelligence tests;
(c) an intelligence test performed at the same time as a brain assessment;
(d) short-form, abbreviated, or "quick" intelligence tests administered at the same time as the Wechsler or Stanford-Binet tests; otherwise, such tests are reimbursable only at a lower rate than standard intelligence tests on an individual consideration basis; or
(e) a repetition of any psychological test or tests provided to the same recipient within the preceding six months, unless accompanied by documentation demonstrating that the purpose of the repeated testing is to ascertain changes following such special forms of treatment or intervention as electroshock therapy or psychiatric hospitalization (periodic testing to measure the recipient's response to psychotherapy is not reimbursable); or relating to suicidal, homicidal, toxic, traumatic, or neurological conditions. Submission of such documentation with the claim for payment is sufficient when the psychological test or tests are to be performed on the same recipient a second time within a six-month period. Further repetitions will be paid for by the Division only if this documentation is submitted and prior authorization granted by the Division prior to the testing (see 130 CMR 410.473).

(4) Testing of a recipient requested by responsible parties, such as but not limited to physicians, clinics, hospitals, schools, courts, group homes, or state agencies, must be documented in the recipient's record. Such documentation must include the referral source and the reason for the referral.

(I) Medication Visits. The Division will not pay for a medication visit as a separate service when it is performed as part of another treatment service (for example, a diagnostic assessment or individual or group therapy performed by a psychiatrist).

(J) Home Visits.

(1) The Division will pay for intermittent home visits. Payment will also be made for home visits made for diagnostic purposes.

(2) Home visits are reimbursable on the same basis as comparable services provided at the hospital outpatient department. Travel time to and from the recipient's home is not reimbursable.

(3) A report of the home visit must be entered into the recipient's record.

(K) Multiple Therapies. The Division will pay for more than one mode of therapy used for a recipient during one week only if clinically justified; that is, when any single approach has been shown to be necessary but insufficient. The need for additional modes of treatment should be documented in the recipient's record.

(L) Outreach Services Provided in Nursing Facilities. The Division will pay for diagnostic and treatment services provided in a nursing facility to a recipient who resides in that nursing facility only in the following circumstances:

(1) the nursing facility specifically requests treatment and the recipient's record at the nursing facility documents this request;

(2) the treatment provided does not duplicate services usually provided in the nursing facility;

(3) such services are generally available through the hospital outpatient department to recipients not residing in that nursing facility; and

(4) the recipient either cannot leave the nursing facility or is sufficiently mentally or physically incapacitated to be unable to come to the hospital outpatient department alone.

(130 CMR 410.480 Reserved)

410.481: Vision Care Services: General Requirements

(A) Introduction.

(1) The regulations in 130 CMR 410.481 through 410.489 establish the requirements and procedures for vision care services provided by hospital outpatient departments. Vision care services are the professional care of the eyes for purposes of diagnosing and correcting refractive errors, analyzing muscular anomalies, and determining pathological conditions. They include eye examinations, vision training, and the prescription and dispensing of ophthalmic materials. Professional and technical services shall be provided in accordance with the established standards of quality and health care necessity recognized by the vision care industry and licensing agencies in Massachusetts.

(2) The Division covers the following services only when provided to eligible MassHealth members under age 21: ophthalmic materials, specifically including, but not limited to, complete eyeglasses or eyeglass parts; the dispensing of ophthalmic materials; contact lenses; and other visual aids, except that this age limitation does not apply to visual magnifying aids for use by members who are both diabetic and legally blind. Visual magnifying aids do not include eyeglasses or contact lenses.

(B) Definitions. The following terms used in 130 CMR 410.481 through 410.489 shall have the meanings given in 130 CMR 410.481 unless the context clearly requires a different meaning.

(1) Dispensing Practitioner – any optician, optometrist, ophthalmologist, or other participating provider authorized by the Division to dispense eyeglass frames, lenses, and other vision care materials to recipients.

(2) Optical Supplier – the optical laboratory contracted by the Division to supply the following ophthalmic materials and services:

(a) eyeglass frames;
(b) eyeglass lenses;
(c) frame cases;
(d) tints, coatings, ground-on prisms, and prisms by decentration; and
(e) repair parts.

(3) Order – the process by which a dispensing practitioner requests ophthalmic materials (completed eyeglasses, repair parts, and other services) from the optical supplier.

(4) Order Form – the form used by the dispensing practitioner to request ophthalmic materials (completed eyeglasses, repair parts, and other services) from the optical supplier. The required form is specified in the billing instructions in Subchapter 5 of the *Outpatient Hospital Manual*.

(5) Prescriber – any optometrist, ophthalmologist, or other practitioner licensed and authorized to write prescriptions for eyeglass frames, lenses, and other vision care services.

(C) Nonreimbursable Circumstances. Vision care services are not reimbursable to a vision care provider when the services were furnished in a state institution, in an inpatient hospital, or in a hospital-affiliated teaching institution, and when the services are among those for which the provider is compensated by the state or institution.

(D) Prior Authorization.

(1) For certain vision care services specified in 130 CMR 410.484 through 410.487, the Division requires the provider to obtain prior authorization as a prerequisite to payment.

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

410.482: Vision Care Services: Prescription and Dispensing Requirements

(A) Eyeglasses and other visual aids may be dispensed only upon a written and dated prescription. The prescription must be based upon the results of a vision examination performed by the prescriber. The prescription must include all information that is necessary to enable a dispensing practitioner to order the prescription.

(B) The prescriber must provide the recipient with a signed copy of the prescription without extra charge. The date or dates on which the prescription is filled or refilled must be recorded on the recipient's copy of the prescription.

(C) The prescriber may order the prescription or may refer the recipient to another vision care provider.

(D) For a dispensing practitioner to be paid for dispensing a prescription involving ophthalmic materials and services available through the optical supplier, all such materials and services must be ordered from the optical supplier. These ophthalmic materials include a specific selection of eyeglass frames for men, women, and children. When eyeglasses are being ordered, recipients must choose from this selection of frames. Information describing all of the ophthalmic materials and services furnished by the optical supplier is published by the optical supplier under the title "Vision Care Materials" and is distributed to vision care providers by the Division.

(E) To receive payment for dispensing an item, the dispensing practitioner must take all necessary measurements, verify lens characteristics, and adjust the completed appliance to the individual. At no additional charge, the dispensing practitioner must continue to make necessary adjustments to the completed appliance for six months after the dispensing date.

(F) The optical supplier will replace free of charge any lens containing any defect or error caused by the optical supplier. Such defects or errors include lenses that are broken, scratched, or chipped at the time of receipt by the dispensing practitioner, or lenses that deviate from the dispensing practitioner's prescription beyond the deviation standards permitted in the American National Standards Institute Z80 rulings. This provision will be effective only if the defective or incorrect lens is received by the optical supplier from the dispensing practitioner within seven working days after the date on which the optical supplier sent the completed order to the dispensing practitioner, and only if it is accompanied by a copy of the original order form containing a notation of the defect or error. In the event of a dispute between the optical supplier and a dispensing practitioner regarding lens deviation, the Division will determine whether the lens in dispute exceeds deviation standards.

(G) Although contractual arrangements are in effect between the Division and the optical supplier, all regulations regarding reimbursable and nonreimbursable services, including prior authorization requirements, are applicable to all dispensing practitioners.

(H) An order to the optical supplier for prescribed items shall constitute a representation by the dispensing practitioner that the person for whom the prescribed item is ordered is an eligible recipient as of the date of the order. Payment to the optical supplier for items provided pursuant to an order from the dispensing practitioner shall be chargeable to the dispensing practitioner when the practitioner failed to ascertain recipient eligibility in accordance with 130 CMR 450.000 and with the service limitations in 130 CMR 410.484 through 410.487.

410.483: Vision Care Services: Recordkeeping Requirements

(A) A vision care provider must maintain a suitable health care record for each recipient. The record must fully disclose all pertinent information regarding the services furnished, 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. 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.

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

(1) case history;
(2) visual acuity testing;
(3) ophthalmoscopy and external eye health examination;
(4) ocular mobility testing, heterophoria testing, and fusion testing;
(5) pupillary reflex testing;
(6) refraction (retinoscopy, subjective refraction, and keratometry);
(7) confrontation fields or other screening tests;
(8) tonometry, when medically indicated;
(9) case analysis and disposition; and
(10) biomicroscopy, when medically indicated.

(C) All consultation services must be fully documented in the record. A record for a consultation must contain the following information:

(1) the recipient's complaints and symptoms;
(2) the condition of the eye; and
(3) if applicable, the name of the person to whom a referral was made.

(D) 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:

(1) visual acuity;
(2) distance vision and near vision;
(3) cover test;
(4) visual skills;
(5) tonometry; and
(6) biomicroscopy.

410.484: Vision Care Service Limitations: Visual Analysis

(A) The Division will not pay for a comprehensive eye examination or a visual analysis if either has been furnished:
(1) within the preceding 12 months, for a recipient under the age of 21; or
(2) within the preceding 24 months, for a recipient aged 21 or older.
However, these restrictions do not apply if there is a referral from the recipient's physician or if one of the following complaints or conditions is documented in the recipient's record: blurred vision, evidence of headaches, diabetes, or cataracts.

(B) The Division will pay for a consultation service only if it is provided independently of a comprehensive eye examination.

(C) The Division will not pay for a screening service if two screening services have been furnished to the recipient within the preceding 12 months.

(D) A comprehensive eye examination includes a screening service. If the provider performs both a screening service and a comprehensive eye examination for the same recipient, the Division will pay for only the latter.

(E) The Division will not pay for a tonometry as a separate service when it is performed as part of a comprehensive eye examination, a consultation, or a screening service. However, a tonometry is reimbursable when performed as a separate service to monitor a recipient who has glaucoma.

410.485: Vision Care Service Limitations: Dispensing Eyeglasses

(A) Time and Power Restrictions.
(1) The Division will pay for only one initial pair of eyeglasses and only if there is a corrective power of at least ±.75D sphere or ±.50D cylinder. (See 130 CMR 410.487(B) for an exception permitting two pairs of eyeglasses instead of bifocals.)
(2) The Division will pay for the replacement of a pair of lost or stolen eyeglasses only if there is a corrective power of at least ±.75D sphere or ±.50D cylinder, and only if the lost or stolen eyeglasses were not dispensed within the preceding 18 months.

(3) The Division will pay for a subsequent pair of eyeglasses only if there is a change from the current prescription of at least ±.50D sphere or cylinder; or an axis change of at least 3º for a ±1.00D cylinder or over, 5º for a ±.75D cylinder, or 10º for a ±.50D cylinder.

(B) Broken Eyeglasses. The Division will pay for the repair of broken eyeglasses, including the replacement of broken parts, subject to the following limitations.

(1) No serviceable parts of eyeglass frames supplied by the optical supplier shall be replaced.

(2) Except for recipients under the age of 21, the Division will not pay for the replacement of broken frames and lenses if a repair of either broken frames or lenses was furnished within the preceding 18 months.

(3) Dispensing practitioners must order replacement eyeglass frames, lenses, and repair parts from the optical supplier. Dispensing practitioners must use the order form to obtain replacement parts.

(4) When there is damage to eyeglass frames or lenses that were not fabricated by the optical supplier, dispensing practitioners must adhere to the following procedure:

(a) the recipient must be instructed to choose a new frame from the selection available through the Medical Assistance Program; and

(b) using the new frame that has been selected and the recipient's lens prescription, the dispensing practitioner shall order a completely new pair of eyeglasses from the optical supplier.

410.486: Vision Care Service Limitations: Lenses

(A) Tinted Lenses.

(1) The Division will pay for "pink 1" and "pink 2" colored lenses, up to 25 percent absorption or equal-density tint, if at least one of the following conditions applies:

(a) the recipient has a pathological or other abnormal condition such as aphakia; or

(b) the recipient has habitually worn tinted lenses of this nature, and the prescriber concludes that the recipient should continue to wear them. The Division will not pay for tinted lenses prescribed only because the recipient complains of photophobia.

(2) Any condition that warrants the use of tinted lenses must be fully documented in the recipient's health care record.

(3) In some situations, other tints (available for plastic lenses only) may be medically justified. Any condition that warrants the use of tinted lenses of this nature must be fully documented in the recipient's health care record, and may be ordered from the optical supplier only after the provider has received prior authorization from the Division.

(B) Coated Lenses. The Division will pay for coated lenses only when they are needed to give equal-density tint or, using clear coatings only, to prevent excessive reflective glare. Any condition that warrants the use of coated lenses must be fully documented in the recipient's health care record.

(C) Cataract Lenses. The Division will not pay for glass cataract lenses. All aphakic prescriptions for recipients requiring cataract lenses must specify plastic lenticular aspheric lenses only. Any condition that warrants the use of cataract lenses must be fully documented in the recipient's health care record.

(D) Contact Lenses.

(1) The Division will pay for hard, soft, or gas-permeable contact lenses if one or more of the following conditions exists:

(a) postoperative cataract extraction;
(b) kerataconus;
(c) anisomatropia of more than 3.00D; or
(d) more than 7.00D of myopia.

(2) Any condition that warrants the use of hard, soft, or gas-permeable contact lenses must be fully documented in the recipient's health care record.

410.487: Vision Care Service Limitations: Other Restrictions

(A) Extra or Spare Eyeglasses. The Division will pay for an extra or spare pair of eyeglasses on a prior authorization basis only. Any condition that warrants the use of an extra or spare pair of eyeglasses must be fully documented in the recipient's health care record. The Division will grant a prior authorization request for extra or spare eyeglasses only if one or more of the following conditions exists:

(1) aphakia;
(2) more than 7.00D of myopia; or
(3) more than 3.00D of astigma.

(B) Two Pairs of Eyeglasses Instead of Bifocals. The Division will pay for two pairs of eyeglasses instead of bifocals if one or more of the following conditions exists. Any condition listed below that warrants the use of two pairs of eyeglasses instead of bifocals must be fully documented in the recipient's health care record.

(1) The recipient's prescription cannot be satisfactorily made into bifocal lenses.
(2) The recipient has shown an inability to adjust to bifocals.
(3) The recipient has a physical disability (for example, severe arthritis) that would preclude or impede adjustment to bifocals.
(4) The recipient's advanced age would make adjustment to bifocals unduly difficult.
(5) The recipient's occupation would make bifocals hazardous.
(6) The recipient has a marked facial asymmetry.

410.488: Vision Care Service Exclusions

(A) The Division will not pay for any of the following services or materials:
(1) absorptive lenses of greater than 25 percent absorption;
(2) photochromatic lenses, sunglasses, or fashion tints;
(3) prisms obtained by decentration;
(4) treatment of congenital dyslexia (the Massachusetts Department of Education may offer resources for the treatment of this condition);
(5) routine adjustments or follow-up visits to check visual acuity and ocular comfort (payment for such visits is included in the dispensing fee for six months after the date on which the eyeglasses were dispensed);
(6) extended-wear contact lenses;
(7) invisible bifocals;
(8) the Welsh 4-Drop Lens; and
(9) substitutions.

(B) If a recipient desires a substitute for or a modification of a reimbursable item, such as photochromatic lenses or designer frames, the recipient must pay for the entire cost of the eyeglasses, including dispensing fees. The Division will not pay for a portion of the cost of the eyeglasses. In all such instances, the provider must inform the recipient of the availability of reimbursable items before dispensing nonreimbursable items.

(C) It is unlawful (M.G.L. c. 6A, s. 35) for a provider to accept any payment from a recipient for a service or item for which payment is available under the Medical Assistance Program. If a recipient claims that he was misinformed about the availability of reimbursable items, it will be the responsibility of the provider to prove that the recipient was offered a reimbursable item, refused it, and chose instead to accept and pay for a nonreimbursable item.

REGULATORY AUTHORITY

130 CMR 410.000: M.G.L. c. 118E, §§ 7 and 12.

PART 3. HOW TO SUBMIT CLAIMS

521 GENERAL INSTRUCTIONS FOR SUBMITTING CLAIMS

(A) UB-92 Claim Form

Acute hospitals, chronic disease and rehabilitation hospitals, psychiatric under 21 hospitals, and hospital-licensed health centers must use the UB-92 claim form to bill the Medical Assistance Program for most outpatient hospital services. (See Section 522 for exceptions.)

The UB-92 claim form is a standard form. Supplies of the UB-92 claim form are available from your forms vendor.

Up to 22 revenue codes and associated charges may be entered on each UB-92 claim form.

(B) Entering Information on the UB-92 Claim Form

(1) Enter information for one recipient and one provider only on each claim form.

(2) Type or print all required information on the claim form, using black ink only. Be sure that all entries are complete, accurate, and legible.

(3) For each claim line, enter all required information, repeating if necessary. Do not use ditto marks or words such as "same as above."

(4) Attach any necessary reports or required forms, facing forward, to the claim form.

(5) Unless otherwise specified, use only line "A" within a given item on the UB-92.

(6) Unless otherwise specified, when the required entry is a date (such as the date of service) enter a six-digit date in month/day/year order.

Example: For a service provided on January 10, 1995, the entry in Item 6 would be as follows.

01	10	95

521 GENERAL INSTRUCTIONS FOR SUBMITTING CLAIMS (cont.)

(C) Time Limitation on Submitting Claims

The period fixed by statute (M.G.L. c. 118E, s. 38) for the submission of claims is 90 days, measured from the date of service to the date on which the claim form is received. For regulations governing time limitations on the submission of claims, see the Billing Regulations in Subchapter 3.

(D) Payment Methodology for Ambulatory Surgical Center (ASC) Services

The Division of Medical Assistance adopted Ambulatory Surgical Center (ASC) pricing methodology effective 11/22/91 for in-state acute outpatient hospitals and hospital-licensed health centers. ASC claims are paid one global amount, which includes payment of related ancillary charges under a single episode of care. The surgical revenue code and HCPCS procedure code combination determines how the claim is paid. Refer to Section 530 to review the pricing methodology for revenue and HCPCS code combinations.

Out-of-state hospitals and nonacute in-state hospitals are reimbursed using a payment account factor (PAF).

(E) Professional Services Performed by Salaried Physicians

Professional services performed by salaried physicians at in-state acute outpatient hospitals and hospital-licensed health centers may be billed using Revenue Codes 961, 962, 981, 982, 983, 987, or 988, as appropriate. These charges are reimbursed at 50% of the Rate Setting Commission's Physician Fee Schedule.

Professional services for radiology Revenue Codes 972-974 and for surgery Revenue Codes 963 and 975 are reimbursed on a payment account factor.

Professional services provided by out-of-state outpatient hospitals and nonacute in-state outpatient hospitals are reimbursed on a payment account factor.

(F) Radiology and Laboratory Services

Radiology and laboratory services provided by in-state acute outpatient hospitals and hospital-licensed health centers are reimbursed according to the Medicare fee schedule, based on the HCPCS code entered on the UB-92.

Radiology services provided by out-of-state outpatient hospitals and nonacute in-state outpatient hospitals are reimbursed on a payment account factor. Laboratory services provided by out-of-state outpatient hospitals and nonacute in-state outpatient hospitals are reimbursed according to the Medicare fee schedule, based on the HCPCS code entered on the UB-92.

(G) Ancillary Services

Ancillary services provided by in-state acute outpatient hospitals and hospital-licensed health centers are reimbursed at a cost-to-charge ratio.

Ancillary services provided by out-of-state outpatient hospitals and nonacute in-state outpatient hospitals are reimbursed on a payment account factor.

(H) Copayment Requirements

A copayment of $3.00 is required from all recipients except those listed in 130 CMR 450.130(C) for nonemergency visits to the emergency department. When appropriate, the copayment will automatically be subtracted from the Medical Assistance payment of the facility charge. Providers should not subtract the copayment amount from the total facility charge, or indicate anywhere on the claim form the amount paid by the recipient. The decision to subtract a copayment is made by the Division based on the information on the claim form and in the recipient's file. Refer to the regulations at 130 CMR 450.130 for more information on copayments.

(I) Targeted Procedure Review Program

The Division of Medical Assistance has a Targeted Procedure Review Program (TPRP) to determine the medical necessity of certain non-emergency procedures. Refer to 130 CMR 450.209 for a list of these surgical procedures and for more information regarding the TPRP.

Emergency surgery is exempt from the TPRP. A claim for any targeted procedure that is performed on an emergency basis, however, must be accompanied by a report documenting the reason the procedure was performed on an emergency basis and the medical necessity of the procedure.

Claims for emergency procedures subject to the TPRP must be billed on paper with the appropriate attachment so that the claims can be reviewed.

521 GENERAL INSTRUCTIONS FOR SUBMITTING CLAIMS (cont.)

(J) Services Provided to Newborns

(1) RID Must Be Assigned to Newborn

All claims for Medical Assistance recipients, including newborns, must be submitted under the recipient's unique 10-character recipient identification number (RID). Claims for outpatient services provided to newborns must not be submitted until the newborn is assigned a RID. Any service provided to the mother must be submitted as a separate claim from any service provided to the newborn.

(2) Hospital Where Child Was Born Must Submit NOB-1 Form

(a) To expedite eligibility determination and RID assignment for the newborn child of a Medical Assistance recipient, the hospital in which the birth occurred must complete and submit a Notification of Birth form (NOB-1) to the following address.

Centralized Eligibility Programs: NOB Unit
Division of Medical Assistance
Schraffts Center
529 Main Street
Charlestown, MA 02129

(b) If a mother is enrolled in the Division's Managed Care Program under a Health Maintenance Organization (HMO) Plan, the hospital in which the child was born must complete the HMO section of the NOB-1 and submit it to the Division of Medical Assistance. The Division will then contact the HMO.

(3) Obtaining Newborn's RID After Eligibility Is Determined

Outpatient departments providing services to a newborn should ask the hospital in which the child was born to submit the NOB-1 form and, upon return of the form, inform the outpatient department of the eligibility determination and assigned RID. The eligibility determination should take no longer than 30 days. To inquire about a newborn's eligibility after 30 days, call MassHealth at 1-800-833-7582 or the mother's local office.

(K) Outpatient Hospitals as Primary Care Clinicians

Some outpatient hospitals are Primary Care Clinicians (PCCs) in the Division's PCC Plan. An enhanced payment is made on the outpatient hospital's facility charge when a recipient is treated by the hospital in accordance with the requirements outlined in their PCC Agreement. Outpatient hospital PCCs should refer to their PCC Agreement and subsequent amendments for information on how to bill for the PCC enhancement, and under what circumstances the provider may claim this enhancement.

521 GENERAL INSTRUCTIONS FOR SUBMITTING CLAIMS (cont.)

(L) Services Provided to Recipients Restricted to a Primary Care Clinician

Most recipients are (or will be) enrolled with a Primary Care Clinician, as part of the Division's Managed Care Program. All care, except for those services identified in 130 CMR 450.118(I), must be provided or authorized by the recipient's PCC. Refer to 130 CMR 450.118 for a full explanation of the Managed Care Program. Refer to Item 63 in Section 525 for specific instructions on completing the claim form for authorized services.

(M) Billing for Mental Health/Substance Abuse Services for Managed Care Recipients

(1) Most recipients who meet the Division's criteria for enrollment in Managed Care Plans are enrolled with the Division's Mental Health/Substance Abuse (MH/SA) Program for the purpose of managing the delivery of mental health or substance abuse treatment services the recipient may require. Mental health and substance abuse services for recipients with an MH/SA Program restriction must be authorized by the Division's MH/SA Program vendor, and resulting claims must be billed to the MH/SAP vendor. These services are identified as those billed with Revenue Codes 900-903, 909, 910-912, 914-916, 918, 919, 944, 945, and 961 regardless of the diagnosis; or Revenue Codes 450, 459, 510, and 519 with diagnosis codes in the mental health or substance abuse range (290.00-316.99).

(2) Medical services provided to recipients with a MH/SA Program restriction, except those services listed as excluded services in 130 CMR 450.118(I), and laboratory services as described below in Section 521(M)(3), must be authorized by the recipient's Primary Care Clinician (PCC). These services must be billed on a separate UB-92 from any mental health or substance abuse treatment charges, and sent to Unisys for processing.

(3) Laboratory services provided as part of a mental health or substance abuse treatment (diagnosis code range 290.00-316.99) must be billed directly to Unisys. Laboratory services, when provided as part of a mental health or substance abuse treatment, do not require authorization from the recipient's PCC. Network providers may leave Item 63 blank when billing for laboratory services provided as part of a MH/SA treatment or diagnosis. Non-network providers must enter the pay-to provider number of the mental health or substance abuse treatment provider requesting the laboratory work in Item 63.

521 GENERAL INSTRUCTIONS FOR SUBMITTING CLAIMS (cont.)

(N) Where to Send Claim Forms

(1) Claims for Services Provided to Recipients with a MH/SA Program Restriction

(a) Send all claims for medical, laboratory, and surgical services to Unisys at the following address.

Unisys
P.O. Box 9103
Somerville, MA 02145

(b) Send all claims for mental health or substance abuse treatment services as defined in Section 521(M)(1) to the Division's Mental Health/Substance Abuse (MH/SA) Program vendor.

(2) Claims for Services Provided to Recipients Who Do Not Have a MH/SA Program Restriction

Send all claims for medical, laboratory, surgical, mental health and substance abuse services to Unisys at the following address.

Unisys
P.O. Box 9103
Somerville, MA 02145

(O) Claims for Recipients with Other Health Insurance

Special instructions for submitting claims for services provided to recipients with other health insurance coverage begin in Section 581.

(P) Further Assistance

If, after reviewing the item-by-item instructions in Section 525, you need additional assistance to complete the UB-92 claim form, contact the Unisys Provider Services Department at the following telephone numbers and address.

(617) 628-4141 (Boston area and out of state)
1-800-325-5231 (toll free in state)

Unisys
ATTN: Provider Services
P.O. Box 9101
Somerville, MA 02145

(Q) Electronic Claims

To obtain specifications for submitting claims on tape, diskette, or other electronic media, contact the Unisys Automated Claims Unit at (617) 576-4483.

522 AVAILABILITY OF CLAIM FORMS AND OTHER PROGRAM MANUALS

The following chart specifies the provider manual and claim forms that in-state acute and nonacute hospitals and hospital-licensed health centers must use when billing for indicated services. Chronic, rehabilitation, psychiatric, and out-of-state outpatient facilities may bill for these services on the UB-92 with the appropriate revenue codes.

SERVICE TYPE	SERVICE CODES AND DESCRIPTIONS	CLAIM FORM
Legend Drugs & Insulin (for EAEDC Recipients)	Pharmacy Manual	No. 6
Adult Day Health	Adult Day Health Manual	No. 9
Adult Foster Care	"Adult Foster Care Guidelines"	No. 9
Dental	Dental Manual	No. 11
Early Intervention	Early Intervention Manual	No. 9
Home Health Agency	Home Health Agency Manual	No. 9
Psychiatric Day Treatment	Psychiatric Day Treatment Manual	No. 9
All Other Outpatient Services	Outpatient Hospital Manual	UB-92
Ambulance	Transportation Manual	No. 7

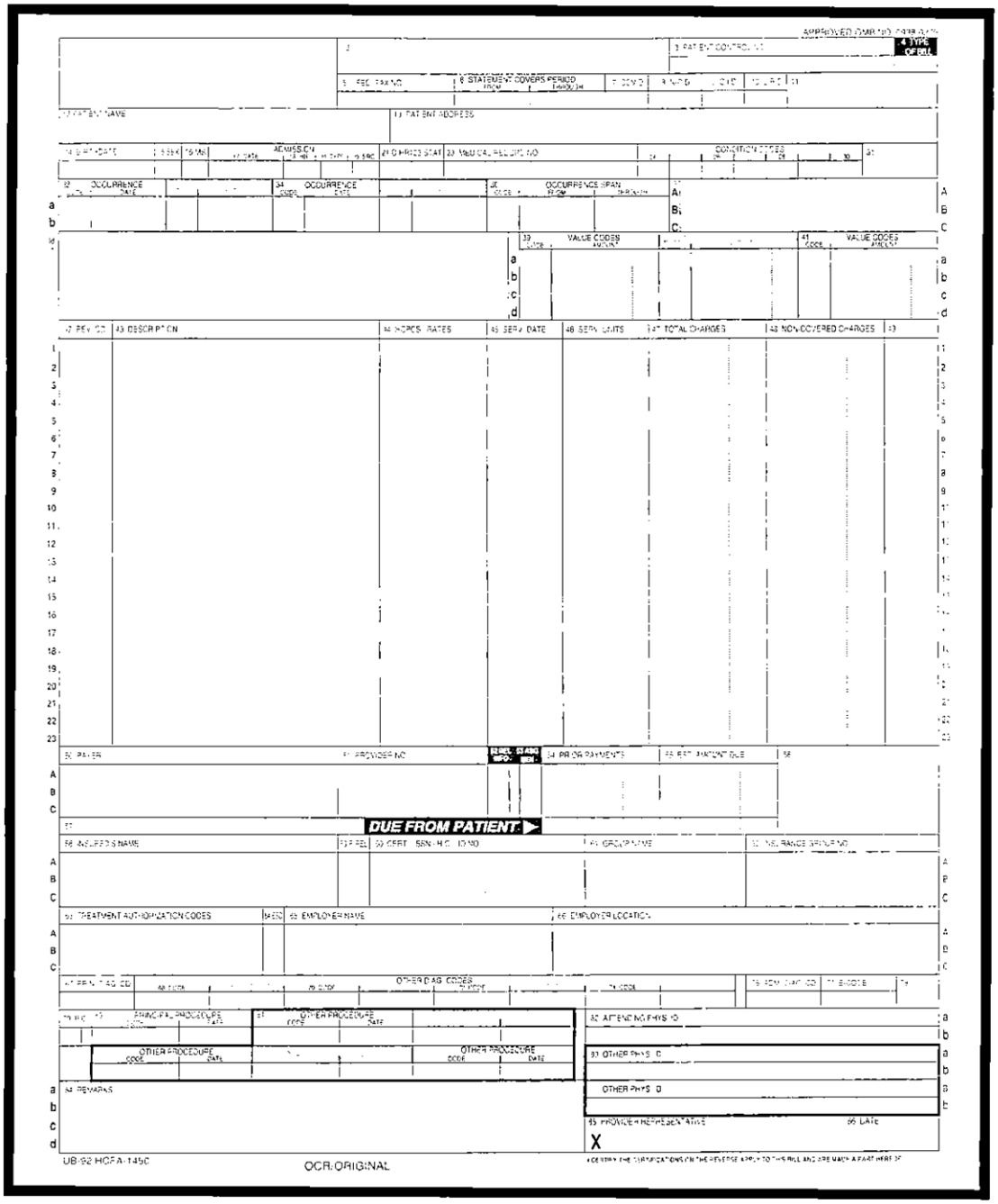
All manuals should be ordered from the Provider Enrollment Unit; Division of Medical Assistance; 600 Washington St., 5th floor; Boston, MA 02111.

All claim forms, with the exception of the UB-92, should be ordered from Unisys; ATTN: Forms Distribution; P.O. Box 9101; Somerville, MA 02145.

(523 and 524 Reserved)

525 ITEM-BY-ITEM INSTRUCTIONS FOR THE UB-92 CLAIM FORM

This section contains specific instructions for completing each item on the UB-92 claim form. A sample UB-92 claim form is printed below, and examples of properly completed UB-92 claim forms for specific billing situations are in Section 526.



525 ITEM-BY-ITEM INSTRUCTIONS FOR THE UB-92 CLAIM FORM (cont.)

Item 1	(Untitled)	Enter the name, mailing address, and telephone number of the hospital requesting payment for the services listed on the claim form.
Item 2	(Untitled)	Leave this item blank.
Item 3	PATIENT CONTROL NO.	Enter the patient control number assigned by the hospital for internal use. If an internal patient control number has not been assigned, enter the recipient's last name. (Up to 13 numbers/letters may be entered.) This patient control number or name will appear with other claim information on the Remittance Advice.
Item 4	TYPE OF BILL	Enter the appropriate three-digit code from the list in Subsection 527(A).
Item 5	FED. TAX NO.	Leave this item blank.
Item 6	STATEMENT COVERS PERIOD FROM/THROUGH	In both the "From" and "Through" fields, enter the date on which services were provided. Use a separate claim form for each date of service.
Item 7	COV D.	Leave this item blank.
Item 8	N-C D.	Leave this item blank.
Item 9	C-ID.	Leave this item blank.
Item 10	L-RD.	Leave this item blank.
Item 11	(Untitled)	If this form is being prepared by a billing intermediary with which the hospital has contracted for the submission of Medical Assistance claims, enter the seven-digit number assigned to the billing agency by the Division of Medical Assistance.
Item 12	PATIENT NAME	Enter the recipient's name in the following order: last name, first name, middle initial.
Item 13	PATIENT ADDRESS	Leave this item blank.
Item 14	BIRTHDATE	Enter the recipient's date of birth as an eight-digit entry in month/day/year order. Example: For a recipient born on November 7, 1982, the entry would be entered as 11071982.

525 ITEM-BY-ITEM INSTRUCTIONS FOR THE UB-92 CLAIM FORM (cont.)

Item 15	SEX	Enter either an "M" for male or an "F" for female.
Item 16	MS	Leave this item blank.
Item 17	ADMISSION DATE	Leave this item blank.
Item 18	ADMISSION HR	Enter the two-digit code from the following list that corresponds to the time of the recipient's visit for outpatient services. See Subsection 527(B) for codes.
Item 19	ADMISSION TYPE	Enter the code from the list in Subsection 527(C) that describes the priority of the visit. If billing for more than one visit on a single date of service, enter the code that describes the priority of the first visit.
Item 20	ADMISSION SRC	Leave this item blank.
Item 21	D HR	Leave this item blank.
Item 22	STAT	Leave this item blank.
Item 23	MEDICAL RECORD NO.	Enter the medical record number assigned by the hospital to the recipient's medical records.
Items 24-28	CONDITION CODES	If applicable, enter the code from the list in Subsection 527(D) that describes the recipient's special circumstances. If more than one code applies, enter the lower one first. If neither situation exists, leave these items blank.
Items 29-30	CONDITION CODES	Leave these items blank.
Item 31	(Untitled)	Leave this item blank.
Items 32-35	OCCURRENCE	If the service was necessary because the recipient was involved in an accident, enter in the "Code" field the code from the list in Subsection 527(E) that describes the type of accident. Enter in the "Date" field the date the accident occurred.
Item 36	OCCURRENCE SPAN	Leave this item blank.

525 ITEM-BY-ITEM INSTRUCTIONS FOR THE UB-92 CLAIM FORM (cont.)

Item 37	(Untitled)	Adjustment. When requesting an adjustment to a paid claim, enter an "A" followed by the 10-character transaction control number (TCN) assigned to the paid claim. This TCN appears on the Remittance Advice on which the original claim was paid. (See Section 570.) Resubmittal. When resubmitting a denied claim that will be received more than 90 days from the "Through" date of service, enter an "R" followed by the 10-character transaction control number (TCN) assigned to the original denied claim. This TCN appears on the Remittance Advice on which the original claim was denied. (See Section 568.)
Item 38	(Untitled)	Leave this item blank.
Item 39	VALUE CODES	Enter in the "Code" field the rate value "Y3." Enter in the "Amount" field the associated percentage of charge.
Item 40	VALUE CODES	Leave this item blank.
Item 41	VALUE CODES	Leave this item blank.
Item 42	REV. CD.	Enter the three-digit revenue code to identify the accommodations and services provided. See Section 527(F) for revenue codes. Revenue Code 001 (Total Charges) must be entered on the bottom line of this item.
Item 43	DESCRIPTION	No entry is required.
Item 44	HCPCS/RATES	For In-state Acute Outpatient Departments and Hospital-Licensed Health Centers: If the revenue code entered in Item 42 requires a HCPCS code, enter the appropriate 5-digit HCPCS code. Refer to Section 528 for a list of revenue codes that require HCPCS codes. For Out-of-state Outpatient Departments and for Nonacute In-state Outpatient Departments: If the revenue code entered in Item 42 indicates a laboratory service (Revenue Codes 300-319), enter the appropriate 5-digit HCPCS code.
Item 45	SERV. DATE	Leave this item blank.

525 Item-by-Item Instructions for the UB-92 Claim Form (cont.)

Item 57	DUE FROM PATIENT	Leave this item blank.
Item 58	INSURED'S NAME	Leave this item blank.
Item 59	P. REL	If this bill is submitted for care provided to a patient who is not a Medical Assistance Program recipient, but who is donating an organ to a Medical Assistance Program recipient, enter "11."
Item 60	CERT.-SSN-HIC.-ID NO.	Enter the complete 10-character recipient identification number (RID) exactly as it appears on the MassHealth card. These characters may be all numbers or a combination of numbers and letters. The 10th character of the RID on a temporary MassHealth card may include an asterisk, which is acceptable. For organ-donor claims in which the donor is not a Medical Assistance Program recipient, enter the RID of the recipient receiving the organ, and enter a patient control number in Item 3.
Item 61	GROUP NAME	Leave this item blank.
Item 62	INSURANCE GROUP NO.	Leave this item blank.

525 Item-by-Item Instructions for the UB-92 Claim Form (cont.)

Item 63	TREATMENT AUTHORIZATION CODES	Leave line "A" blank. When elective or urgent services are provided in an outpatient hospital to PCC Plan enrollees, use one of the following instructions to complete line "B." For care provided between 8:00 A.M. and 9:59 P.M., enter the PCC's seven-digit referral number. For care provided between 8:00 A.M. and 9:59 P.M., when the PCC did not return the outpatient hospital call requesting a referral within 30 minutes, enter "3093018." For care provided between 10:00 P.M. and 7:59 A.M., no PCC referral is necessary: enter "3093000." If the PCC Plan enrollee is a member of the outpatient hospital's panel, or if the service provided is exempt from PCC referral requirements (see 130 CMR 450.118(I)), leave this item blank. When services are provided to recipients not enrolled in the PCC Plan, leave line "B" blank.
Item 64	ESC	Leave this item blank.
Item 65	EMPLOYER NAME	Leave this item blank.
Item 66	EMPLOYER LOCATION	Leave this item blank.

525 ITEM-BY-ITEM INSTRUCTIONS FOR THE UB-92 CLAIM FORM (cont.)

Item 67	PRIN. DIAG. CD.	Enter the ICD-9-CM diagnosis code that describes the principal diagnosis (the condition established after study to have necessitated the outpatient services). Enter a pregnancy-related diagnosis code in this field or in Item 68 if the recipient is exempt from a copayment because of pregnancy or because she is within the allowable postpartum period. Enter the diagnosis code exactly as it appears in the ICD-9-CM code book. Use the most specific code; that is, use a three-digit or four-digit code only if it is not further subclassified. Do not use decimal points; do not delete leading zeros; do not add trailing zeros. "V" codes are acceptable. "E" and "M" codes are not acceptable.
Items 68-75	OTHER DIAG. CODES	If applicable, enter the ICD-9-CM diagnosis codes corresponding to conditions (other than the principal condition) that co-exist with, or develop subsequent to, the principal condition and affect the treatment. Use the most specific ICD-9-CM code available. "V," "E," and "M" codes are acceptable. Enter those diagnosis codes related to family planning and surgery services before any other diagnosis codes.
Item 76	ADM. DIAG. CD.	Leave this item blank.
Item 77	E-CODE	Leave this item blank.
Item 78	(Untitled)	Leave this item blank.
Item 79	P.C.	Leave this item blank.

525 ITEM-BY-ITEM INSTRUCTIONS FOR THE UB-92 CLAIM FORM (cont.)

Item 80	PRINCIPAL PROCEDURE CODE/DATE	If a surgical or obstetrical procedure was performed, enter in the "Code" field the most specific ICD-9-CM procedure code that identifies the procedure. In the "Date" field, enter in month/day order the date on which the procedure was performed. Also complete Item 83. If no surgical or obstetrical procedure was performed in this billing period, leave this item blank.
Item 81	OTHER PROCEDURE CODE/DATE	If applicable, enter the most specific ICD-9-CM procedure code that identifies any other surgical or obstetrical procedure and the date on which the procedure was performed. Include only procedures performed in this billing period. Enter those procedure codes related to family planning services before any other procedure code.
Item 82	ATTENDING PHYS. ID.	Enter the provider number of the assigned by the Division of Medical Assistance to the practitioner who referred the recipient to the hospital. If the referring source is not a Medical Assistance provider, enter the practitioner's name (last name/first name/middle initial). If there is no referring practitioner, leave this item blank. Practitioners who refer patients to other sources within the facility are not considered to be referring providers.
Item 83	OTHER PHYS. ID.	Complete this item if there is an entry in Item 80. If applicable, enter in line A only the provider number assigned by the Division of Medical Assistance to the practitioner who performed the principal procedure. If the practitioner does not have a Medical Assistance provider number, enter the name (last name/first name/middle initial).
Item 84	REMARKS	Leave this item blank.

525 ITEM-BY-ITEM INSTRUCTIONS FOR THE UB-92 CLAIM FORM (cont.)

Item 85	PROVIDER REPRESENTATIVE	The person designated by the hospital to certify that the information on the claim form is correct and conforms with the certifications on the back of the claim must sign the form. Signatures other than handwritten signatures (for example, those by stamp, typewriter, or data-processing equipment) are acceptable.
Item 86	DATE	Enter the date when the claim form was signed or submitted for reimbursement. The billing date must not be earlier than the service dates billed on the claim form.

526 EXAMPLES OF COMPLETED UB-92 CLAIM FORMS

This section contains examples of claims for the different billing situations listed below. For assistance with a billing situation not explained in these examples, contact the Unisys Provider Services Department. See Section 521 for the telephone numbers and address.

Example (A) - Emergency Room Services Provided by an In-State Acute Outpatient Department

This example shows a completed claim form for a recipient who received emergency room services from an in-state acute outpatient department. Refer to Section 528 to determine what revenue codes require HCPCS codes.

Example (B) - Ambulatory Surgery Services Provided by an In-State Acute Outpatient Department

This example shows a completed claim form for a recipient who received ambulatory surgery services from an in-state acute outpatient department. Refer to Section 528 to determine what revenue codes require HCPCS codes.

Example (C) - Ambulatory Surgery Services Provided by an Out-of-State Outpatient Department

This example shows a completed claim form for a recipient who received ambulatory surgery services from an out-of-state outpatient department that included a lab charge for Revenue Code 314. When using Revenue Codes 300 through 319, a HCPCS code must be entered in Item 44, as noted in this example.

Example (D) - Clinic Visit Referred by the Recipient's Primary Care Clinician

This example shows a completed claim for a recipient who was referred to the outpatient clinic by her Primary Care Clinician (PCC). Item 63 contains the PCC's authorization number.

526 EXAMPLES OF COMPLETED UB-92 CLAIM FORMS (cont.)

(A) Emergency Room Services Provided by an In-State Acute Outpatient Department

APPROVED OMB NO. 0938-0279

ABC HOSPITAL
123 MAIN STREET
BOSTON MA 02122
617-555-1200

3 PATIENT CONTROL NO: 432DOEP
4 TYPE OF BILL: 131
6 STATEMENT COVERS PERIOD: 010295 010295

PATIENT NAME: DOE PAUL

12 BIRTHDATE	13 SEX	14 MS	15 ADMISSION DATE	16 HR	17 TYPE	18 SRC	19 D-HR	20 STAT	21 MEDICAL RECORD NO	22 CONDITION CODES
11131963	M		10 2						432DOEP	

35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	36 OCCURRENCE DATE	37 OCCURRENCE SPAN CODE	37 OCCURRENCE SPAN FROM	37 OCCURRENCE SPAN THROUGH

39 VALUE CODES CODE	39 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
Y3	85 00		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	305	LAB/HEMATOLOGY	85023		1	15 00	
2	307	LAB/UROLOGY	81002		1	10 00	
3	450	EMERGENCY ROOM			1	85 00	
4	981	PRO FEE	99202		1	50 00	
23	001	TOTAL CHARGES				160 00	

50 PAYER
51 PROVIDER NO: 1200011
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56

DUE FROM PATIENT

58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID / SSN / HIC ID NO: 0123456789
61 GROUP NAME
62 INSURANCE GROUP NO

63 TREATMENT AUTHORIZATION CODES
64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION

67 PRIN. DIAG. CD: 075
68 CODE
69 CODE
OTHER DIAG. CODES 72 CODE
74 CODE
76 ADM. DIAG. CD
77 E CODE
78

79 E.C.	80 PRINCIPAL PROCEDURE CODE	80 PRINCIPAL PROCEDURE DATE	81 OTHER PROCEDURE CODE	81 OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE

82 ATTENDING PHYS. ID: 0123456
83 OTHER PHYS. ID
OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X ROBERT JONES
86 DATE: 020195

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 OCR/ORIGINAL

526 EXAMPLES OF COMPLETED UB-92 CLAIM FORMS (cont.)

(B) Ambulatory Surgery Services Provided by an In-State Acute Outpatient Department

APPROVED OMB NO. 0938-0279

ABC HOSPITAL
123 MAIN STREET
BOSTON MA 02122
617-555-1200

1 PATIENT CONTROL NO: PATIENT123
4 TYPE OF BILL: 831
6 STATEMENT COVERS PERIOD: FROM 010295 THROUGH 010295

12 PATIENT NAME: PATIENT ELIZABETH M
14 BIRTHDATE: 07111956
15 SEX: F
ADMISSION 18 HR: 08
19 TYPE: 3
23 MEDICAL RECORD NO: PATIENT123

39 VALUE CODES: a. Y3 — 85 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	46 SERV. UNITS	47 TOTAL CHARGES
314	PATHOLOGY	88305	1	50 00
329	DX XRAY/PRE ADM	71010	1	25 00
360	OR SERVICES	57520	1	400 00
360	OR SERVICES	57061	1	200 00
370	ANESTHESIA		1	100 00
710	RECOVERY ROOM		1	50 00
001	TOTAL CHARGES			825 00

51 PROVIDER NO: 1230001

DUE FROM PATIENT ▶

60 CERT. - SSN - HIC. - ID NO: 0234567899

67 PRIN. DIAG. CD.: 2360
68 CODE: 0781

80 PRINCIPAL PROCEDURE: CODE 672, DATE 0102

82 ATTENDING PHYS. ID: 0123456
83 OTHER PHYS. ID: 0512345

85 PROVIDER REPRESENTATIVE: X ROBERT JONES
86 DATE: 020195

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 OCR/ORIGINAL

526 EXAMPLES OF COMPLETED UB-92 CLAIM FORMS (cont.)

(C) Ambulatory Surgery Services Provided by an Out-of-State Outpatient Department

APPROVED OMB NO. 0938-0279

ABC HOSPITAL
123 MAIN STREET
BOSTON MA 02122
617-555-1200

3 PATIENT CONTROL NO.: ABCD123456
4 TYPE OF BILL: 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD: FROM 010295 THROUGH 010295
7 COV D. | 8 N-C D | 9 O-I D | 10 L-R D | 11

12 PATIENT NAME: DOE CHERYL D
13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 25	26	27	28	29	30	31
03181951	F			08	3				ABCD123456								

32 OCCURRENCE CODE / DATE | 34 OCCURRENCE CODE / DATE | 36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37

38

39 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a Y3	92 00		
b			
c			
d			

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	314	PATHOLOGY/BIOPSY	88304		1	50 00		
2	329	DX/XRAY/PRE ADM			1	25 00		
3	360	OR SERVICES			1	400 00		
4	370	ANESTHESIA			1	50 00		
5	710	RECOVERY ROOM			1	50 00		
23	001	TOTAL CHARGES				575 00		

50 PAYER | 51 PROVIDER NO: 7200012 | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57: DUE FROM PATIENT

58 INSURED'S NAME | 59 P REL | 60 CERT. - SSN - HIC - ID NO: 0123456789 | 61 GROUP NAME | 62 INSURANCE GROUP NO

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD: 2360 | 68 CODE | 70 CODE | OTHER DIAG. CODES 72 CODE | 74 CODE | 76 ADM. DIAG. CD | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE: 672 0102 | 81 OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID: 4345678
83 OTHER PHYS. ID: DOCTOR, DAN M. MD
OTHER PHYS. ID

84 REMARKS

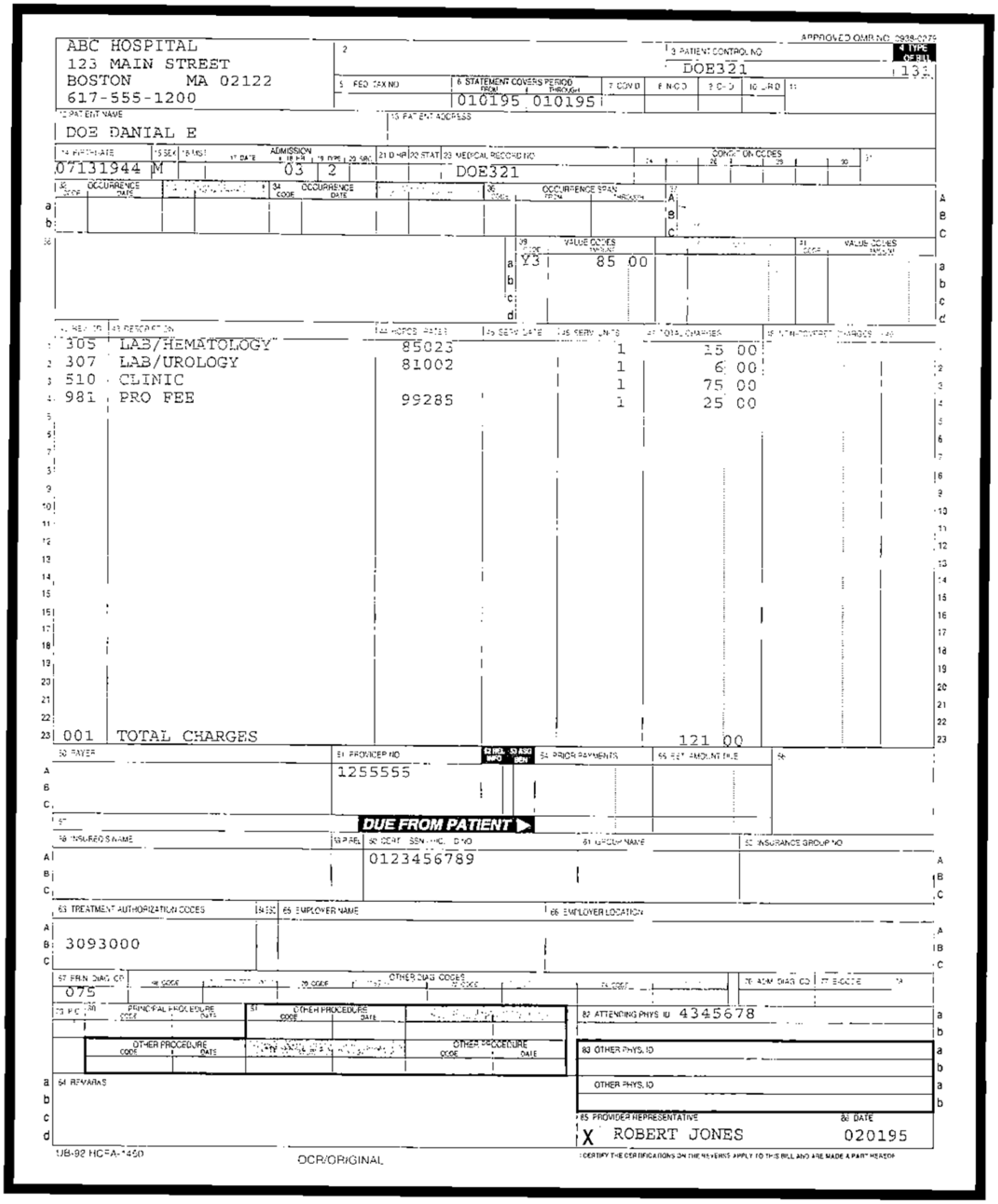
85 PROVIDER REPRESENTATIVE: X ROBERT JONES | 86 DATE: 020195

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

526 EXAMPLES OF COMPLETED UB-92 CLAIM FORMS (cont.)

(D) Clinic Visit Referred by the Recipient's Primary Care Clinician



ABC HOSPITAL
123 MAIN STREET
BOSTON MA 02122
617-555-1200

3 PATIENT CONTROL NO: DOE321
4 TYPE OF BILL: 131
6 STATEMENT COVERS PERIOD: FROM 010195 THROUGH 010195
12 PATIENT NAME: DOE DANIAL E
14 BIRTHDATE: 07131944
15 SEX: M
19 TYPE: 03
20 SRC: 2
23 MEDICAL RECORD NO: DOE321
39 VALUE CODES: a Y3 85 00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	46 SERV. UNITS	47 TOTAL CHARGES
305	LAB/HEMATOLOGY	85023	1	15 00
307	LAB/UROLOGY	81002	1	6 00
510	CLINIC		1	75 00
981	PRO FEE	99285	1	25 00
001	TOTAL CHARGES			121 00

51 PROVIDER NO: 1255555
DUE FROM PATIENT ▶
60 CERT. - SSN - HIC. - ID NO: 0123456789
63 TREATMENT AUTHORIZATION CODES: 3093000
67 PRIN. DIAG. CD.: 075
82 ATTENDING PHYS. ID: 4345678
83 OTHER PHYS. ID
85 PROVIDER REPRESENTATIVE: X ROBERT JONES
86 DATE: 020195
UB-92 HCFA-1450
OCR/ORIGINAL
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

527 Codes to be Used on the UB-92 Claim Form

(A) Item 4: TYPE OF BILL

131 - All outpatient claims (except late charges)
135 - Late charges (not allowed for ambulatory surgery charges)
831 - Ambulatory surgical center (ASC) claims.

(B) Item 18: ADMISSION HR

00 - Midnight to 12:59 A.M.
01 - 1:00 to 1:59 A.M.
02 - 2:00 to 2:59 A.M.
03 - 3:00 to 3:59 A.M.
04 - 4:00 to 4:59 A.M.
05 - 5:00 to 5:59 A.M.
06 - 6:00 to 6:59 A.M.
07 - 7:00 to 7:59 A.M.
08 - 8:00 to 8:59 A.M.
09 - 9:00 to 9:59 A.M.
10 - 10:00 to 10:59 A.M.
11 - 11:00 to 11:59 A.M.
12 - Noon to 12:59 P.M.
13 - 1:00 to 1:59 P.M.
14 - 2:00 to 2:59 P.M.
15 - 3:00 to 3:59 P.M.
16 - 4:00 to 4:59 P.M.
17 - 5:00 to 5:59 P.M.
18 - 6:00 to 6:59 P.M.
19 - 7:00 to 7:59 P.M.
20 - 8:00 to 8:59 P.M.
21 - 9:00 to 9:59 P.M.
22 - 10:00 to 10:59 P.M.
23 - 11:00 to 11:59 P.M.

(C) Item 19: ADMISSION TYPE

1 - Emergency
The recipient required immediate medical intervention for the treatment of a severe, life-threatening, or potentially disabling condition or symptoms.

2 - Urgent
The recipient required immediate attention for the care and treatment of a physical or mental disorder.

3 - Elective
The recipient's condition permitted adequate time to schedule necessary services.

4 - Newborn
The recipient is a baby born in the facility on the date of service.

527 Codes to be Used on the UB-92 Claim Form (cont.)

(D) Items 24-30: CONDITION CODES

A1 - EPSDT/PGH
Physical and mental health assessments provided to recipients under age 21 to carry out the screening provisions of Project Good Health/Early and Periodic Screening, Diagnosis and Treatment.

A4 - Family planning
Claim includes medically approved services provided to an individual of childbearing age for the purpose of enabling that individual to determine freely the number and spacing of her or his children.

A7 - Induced abortion; danger to life
Claim includes charges for an abortion performed because the life of the recipient would have been endangered if her pregnancy had been carried to term.

Z1 - Induced abortion; other medically necessary
Claim includes charges for an abortion performed for medically necessary reasons other than danger to the recipient's life.

Z2 - Sterilization primary reason for hospitalization
Claim includes charges for sterilization when sterilization was the primary reason for this hospitalization.

Z3 - Sterilization not primary reason for hospitalization
Claim includes charges for sterilization when sterilization was not the primary reason for this hospitalization.

Z5 - School-based health center
Claim includes services provided at a school-based health center site that is operated by the outpatient hospital provider.

02 - Condition is employment related
The recipient alleges that her or his medical condition is due to environment/events resulting from his or her employment.

05 - Lien has been filed
The provider has filed a legal claim for the recovery of funds that may be due the recipient as the result of legal action initiated by or on behalf of the recipient.

(E) Items 32-35: OCCURRENCE CODE/DATE

01 - Auto accident
02 - Auto accident/no-fault
03 - Accident/tort liability
04 - Employment-related accident
05 - Other accident
06 - Crime victim

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) Item 42: REVENUE CODES

This section contains the revenue codes to be used to complete Item 42 of the UB-92 claim form. Each code identifies a specific accommodation, ancillary service or billing calculation.

General categories of service are listed below in alphabetical order, with the first two digits of the corresponding revenue codes. Subsection 527(G) lists all revenue codes in numeric order. Be sure to enter in Item 42 of the UB-92 claim form the complete three-digit code from Subsection 527(G) that identifies the service provided. Use only the revenue codes listed in Subsection 527(G).

Section	Category
Ambulance	54x
Ambulatory surgical care	49x
Anesthesia	37x
Audiology	47x
Blood	38x
Blood storage and processing	39x
Cardiology	48x
Cast-room services	70x
Clinic services	51x
CT scans	35x
Diagnostic services (other)	92x
Donor Bank	89x
Drugs requiring identification	63x
Durable medical equipment	29x
EEG (electroencephalogram)	74x
EKG/ECG (electrocardiogram)	73x
Emergency-room services	45x
Gastrointestinal services	75x
Home health services	57x
Home health visits (other)	58x
Imaging services (other)	40x
IV therapy	26x
Laboratory services	30x
Lithotripsy	79x
Labor- and delivery-room services	72x
Magnetic resonance imaging	61x
Medical/surgical supplies and devices	27x
Nuclear medicine	34x
Occupational therapy	43x
Oncology	28x
Operating room services	36x
Osteopathic services	53x
Pathology (laboratory) services	31x
Peritoneal dialysis	83x
Pharmacy	25x
Physical therapy	42x
Professional fees	96x
Professional fees	97x
Professional fees	98x
Pulmonary function tests	46x
Psychiatric/psychological services	91x
Psychiatric/psychological treatments	90x
Radiology (diagnostic)	32x
Radiology (supplies)	62x
Radiology (therapeutic)	33x
Recovery-room services	71x
Renal dialysis services:	87x
Continuous ambulatory peritoneal dialysis (CAPD) (outpatient or home)	84x
Continuous cycling peritoneal dialysis (CCPD) (outpatient or home)	85x
Hemodialysis (outpatient or home)	82x
Other dialysis services	88x
Respiratory services	41x
Speech/language pathology	44x
Therapeutic services (other)	94x
Total charge	001
Treatment room or observation	76x

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) REVENUE CODES (cont.)

001 Total Charge. The sum of all charges.

001 Total charge

25x Pharmacy. Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist.

250 General classification
251 Generic drugs
252 Nongeneric drugs
253 Take-home drugs
255 Drugs incident to radiology
257 Nonprescription drugs
258 IV solutions
259 Injection/immunization

26x IV Therapy. Charges for the administration of intravenous solution by specially trained personnel to individuals requiring such treatment.

260 General classification
261 Infusion pump
262 IV therapy/pharmacy services
263 IV therapy/drug/supply delivery
264 IV therapy/supplies
269 Other IV therapy

27x Medical/Surgical Supplies and Devices. Charges for supply items required for patient care.

270 General classification
271 Nonsterile supply
272 Sterile supply
273 Take-home supplies
274 Prosthetic/Orthotic Devices
275 Pacemaker
276 Intraocular lens
277 Oxygen (take home)
278 Other implants
279 Other supplies/devices

28x Oncology. Charges for the treatment of tumors and related diseases.

280 General classification
289 Other oncology services

29x Durable Medical Equipment (Other than Renal). Charges for medical equipment that can withstand repeated use, excluding renal equipment.

290 General classification
291 Rental
292 Purchase of new DME
293 Purchase of used DME
299 Other medical equipment

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) REVENUE CODES (cont.)

30x Laboratory Services. Charges for the performance of diagnostic and routine clinical laboratory test.

300 General classification
301 Chemistry
302 Immunology
303 Renal patient (home)
304 Nonroutine dialysis
305 Hematology
306 Bacteriology and microbiology
307 Urology
309 Other lab

31x (Laboratory) Pathological Services. Charges for diagnostic and routine laboratory tests on tissues and culture.

310 General classification
311 Cytology
312 Histology
314 Biopsy
319 Other pathology

32x Radiology Diagnostic. Charges for diagnostic radiology services provided for the examination and care of patients, including taking, processing, examining, and interpreting radiographs and fluorographs.

320 General classification
321 Angiocardiography
322 Arthrography
323 Arteriography
324 Chest X-ray
329 Other X-ray

33x Radiology: Therapeutic. Charges for therapeutic radiology services and chemotherapy that are required for the care and treatment of patients, including therapy by injection or ingestion of radioactive substances.

330 General classification
331 Chemotherapy: injected
332 Chemotherapy: oral
333 Radiation therapy
335 Chemotherapy: intravenous
339 Other therapeutic radiology

34x Nuclear Medicine. Charges for procedures and tests performed by a radioisotope laboratory using radioactive materials as required for diagnosis and treatment of patients.

340 General classification
341 Diagnostic
342 Therapeutic
349 Other

35x CT Scan. Charges for computed tomographic scans of the head and other parts of the body.

350 General classification
351 Head scan
352 Body scan
359 Other CT scans

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) REVENUE CODES (cont.)

36x Operating Room Services. Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical-related procedures during and immediately following surgery.

- 360 General classification
- 361 Minor surgery
- 369 Other operating room services

37x Anesthesia. Charges for anesthesia services in the hospital.

- 370 General classification
- 371 Anesthesia incident to radiology
- 374 Acupuncture
- 379 Other anesthesia

38x Blood.

- 380 Blood general
- 381 Packed red blood cells
- 383 Blood plasma
- 384 Platelets
- 385 Leucocytes
- 386 Blood other components
- 387 Derivatives Other (cryoprecipitates)
- 389 Other blood

39x Blood Storage and Processing. Charges for the storage and processing of whole blood. See Subsection 405(A)(8).

- 390 General classification
- 391 Blood administration
- 399 Other blood storage and processing

40x Imaging Services (other).

- 400 General classification
- 401 Mammography
- 402 Ultrasound
- 403 Screening mammography
- 404 Positron emission tomography PET SCN
- 409 Other imaging services

41x Respiratory Services. Charges for the administration of oxygen and certain potent drugs through inhalation or positive pressure, and other forms of rehabilitation therapy, through measurement of inhaled and exhaled gases, analysis of blood, and evaluation of the patient's ability to exchange gases.

- 410 General classification
- 412 Inhalation services
- 413 Hyperbaric oxygen therapy
- 419 Other respiratory services

42x Physical Therapy. Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities. See Sections 451 through 453.

- 420 General classification
- 421 Visit charge
- 422 Hourly charge
- 423 Group rate
- 424 Evaluation or reevaluation
- 429 Other physical therapy

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) REVENUE CODES (cont.)

43x Occupational Therapy. Charges for teaching manual skills and independence in personal care to stimulate patient's mental and emotional activity. See Sections 451 through 453.

- 430 General classification
- 431 Visit charge
- 432 Hourly charge
- 433 Group rate
- 434 Evaluation or reevaluation
- 439 Other occupational therapy

44x Speech/Language Pathology. Charges for services provided to persons with impaired functional communication skills. See Sections 451 through 453.

- 440 General classification
- 441 Visit charge
- 442 Hourly charge
- 443 Group rate
- 444 Evaluation or reevaluation
- 449 Other speech/language pathology

45x Emergency-Room/Trauma Services. Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care. See Section 411.

- 450 General classification
- 459 Other emergency room

46x Pulmonary Function Tests. Charges for tests that measure inhaled and exhaled gases and analysis of blood, and for tests that evaluate the patient's ability to exchange oxygen and other gases.

- 460 General classification
- 469 Other pulmonary function

47x Audiology. Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

- 470 General classification
- 471 Diagnostic
- 472 Treatment
- 479 Other audiology

48x Cardiology. Charges for cardiac procedures rendered in a separate unit within the hospital, such as heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

- 480 General classification
- 481 Cardiac catheterization lab
- 482 Stress test
- 489 Other cardiology

49x Ambulatory Surgical Care. Only charges for ambulatory surgery that are not covered by other categories.

- 490 General classification
- 499 Other ambulatory surgical care

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) REVENUE CODES (cont.)

51x Clinic Services. Clinic (nonemergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and educational services on a scheduled basis to ambulatory patients.

510 General classification
511 Chronic pain center
*512 Dental clinic
519 Other clinic

53x Osteopathic Services. Charges for a structural evaluation of the cranium, and the entire cervical, dorsal, and lumbar spine by a doctor of osteopathy.

530 General classification
531 Osteopathic therapy
539 Other osteopathic services

54x Ambulance

*540 General classification
*541 Supplies
*542 Medical transport
*543 Heart mobile
*544 Oxygen
*545 Air ambulance
*546 Neonatal ambulance services
*547 Pharmacy
*548 Telephone Transmission EKG
*549 Other ambulance

57x Home Health Services. Charges by a hospital-based home health agency for personnel that are primarily responsible for the personal care of the patient.

*570 General classification
*571 Visit charge
*572 Hourly home health aide
*579 Other home health aide

58x Other Home Health Visits. Charges by a hospital-based home health agency for visits other than home health aide, physical therapy, occupational therapy, or speech/language therapy, which must be specifically identified.

*580 General classification
*581 Visit charge
*582 Hourly charge
*589 Other home health visits

61x MRI. Charges for Magnetic Resonance Imaging of the brain and other parts of the body.

610 Magnetic resonance imaging
611 Brain (including brainstem)
612 Spinal cord (including spine)
619 MRI other

62x Radiology Supplies. Charges for supply items required for patient care. The category is an extension of 27x for recording additional breakdowns, when necessary.

*621 Supplies incident to radiology

* *These revenue codes may be billed only by chronic, rehabilitation, psychiatric and out-of-state outpatient facilities.*

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) REVENUE CODES (cont.)

63x Drugs Requiring ID. Charges for drugs and biologicals requiring specific identification as required by the payer.

630 EPO, Dialysis
634 Erythropoietin (EPO) less than 10,000 units
635 Erythropoietin (EPO) 10,000 units or more
636 Drugs Require Detail Codes
639 Other Drugs Requiring ID

70x Cast-Room Services. Charges for services related to the application, maintenance, and removal of casts.

700 General classification
709 Other cast-room services

71x Recovery-Room Services.

710 General classification
719 Other recovery room

72x Labor and Delivery-Room Services. Charges for labor and delivery-room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance and during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

720 General classification
721 Labor-room services
722 Delivery-room services
723 Circumcision
724 Birthing-center services
729 Other labor-room/delivery-room services

73x EKG/ECG (Electrocardiogram). Charges for operation of specialized equipment that records electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

730 General classification
731 Holter monitor
732 Telemetry
739 Other EKG/ECG

74x EEG (Electroencephalogram). Charges for the operation of specialized equipment that measures impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

740 General classification
749 Other

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) REVENUE CODES (cont.)

75x Gastrointestinal Services. Procedure room charges for endoscopic procedures not performed in the operating room.

750 General classification
759 Other gastrointestinal

76x Treatment Room or Observation. Charges for minor procedures performed in the observation room or other room.

761 Treatment room
762 Observation room

79x Lithotripsy. Charges for the use of lithotripsy in the treatment of kidney stones.

790 General classification
799 Other lithotripsy

82x Hemodialysis: Outpatient or Home. Hemodialysis is a waste-removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

*820 General classification
821 Hemodialysis (composite or other rate)
*822 Home supplies
*823 Home equipment
*824 Maintenance (100%)
*825 Support services
*826 Home dialysis supplies
*827 Home dialysis support services
*829 Hemodialysis drugs

83x Peritoneal Dialysis: Outpatient or Home. Peritoneal dialysis is a waste-removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed between the abdominal covering and the tissue.

*830 General classification
831 Peritoneal (composite or other rate)
*832 Home supplies
*833 Home equipment
*834 Maintenance (100%)
*835 Support services
839 Other outpatient peritoneal dialysis

84x Continuous Ambulatory Peritoneal Dialysis (CAPD): Outpatient or Home. CAPD is a continuous dialysis process in an outpatient or home setting that uses the patient's peritoneal membrane as a dialyzer.

*840 General classification
841 CAPD: composite or other rate
*842 Home supplies
*843 Home equipment
*844 Maintenance: 100%
*845 Support services
*849 Other outpatient CAPD

* *These revenue codes may be billed only by chronic, rehabilitation, psychiatric and out-of-state outpatient facilities.*

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) REVENUE CODES (cont.)

85x Continuous Cycling Peritoneal Dialysis (CCPD): Outpatient or Home. CCPD is a continuous dialysis process performed in an outpatient or home setting that uses a machine to make automatic exchanges at night.

*850 General classification
851 CCPD (composite or other rate)
*852 Home supplies
*853 Home Equipment
*854 Maintenance (100%)
*855 Support services
*859 Other outpatient CCPD

87x Home Dialysis.

*870 Home dialysis CAPD
*875 Home dialysis CAPD delivery
*876 Home dialysis CAPD supplies
*877 Home dialysis CAPD support
*878 Home dialysis CAPD target

88x Miscellaneous Dialysis Services. Charges for dialysis services not identified elsewhere.

*880 General classification
*881 Ultrafiltration
*882 Home dialysis aid visit
*889 Miscellaneous dialysis service/other

89x Other Donor Bank. Charges for the acquisition, storage and preservation of all human organs, excluding kidneys.

890 General Classification
891 Bone
892 Organ (other than kidney)
893 Skin
899 Other Donor Bank

90x Psychiatric/Psychological Treatment. See 130 CMR 410.471 through 410.479.

900 General classification
901 Electroshock therapy
*902 Milieu therapy (psychiatric day treatment)
903 Play therapy
909 Other psychiatric/psychological treatments

91x Psychiatric/Psychological Services. Charges for providing nursing-care, employee, and professional services for emotionally disturbed patients. See 130 CMR 410.471 through 410.479.

910 General classification
911 Rehabilitation
914 Individual therapy
915 Group therapy
916 Family therapy
*917 Biofeedback
918 Testing
919 Other psychiatric psychological services

* *These revenue codes may be billed only by chronic, rehabilitation, psychiatric and out-of-state outpatient facilities.*

527 CODES TO BE USED ON THE UB-92 CLAIM FORM (cont.)

(F) REVENUE CODES (cont.)

92x Diagnostic Services (Other). Charges for other diagnostic services not otherwise categorized.

- 920 General classification
- 921 Peripheral vascular lab
- 922 Electromyelogram
- 923 Pap smear
- 924 Allergy test
- 925 Pregnancy test
- 929 Other diagnostic services

94x Therapeutic Services (Other). Charges for other therapeutic services not otherwise categorized.

- *940 General classification
- *941 Recreational therapy
- *942 Education/training
- 943 Cardiac rehabilitation
- 944 Drug rehabilitation
- 945 Alcohol rehabilitation
- 946 Complex medical equipment routine
- 947 Complex medical equipment ancillary
- *949 Other therapeutic services

96x Professional Fees. Charges for medical professionals that the hospitals or third-party payers require to be separately identified on the billing form.

- 960 General classification
- 961 Psychiatric
- 962 Ophthalmology
- 963 Anesthesiologist
- *964 Nurse/anesthetist
- 969 Other professional fees

97x Professional Fees.

- *971 Laboratory
- 972 Radiology (diagnostic)
- 973 Radiology (therapeutic)
- 974 Radiology (nuclear medicine)
- 975 Operating room
- *976 Respiratory therapy
- *977 Physical therapy
- *978 Occupational therapy
- *979 Speech pathology

98x Professional Fees.

- 981 Emergency room
- 982 Outpatient services
- 983 Clinic
- *985 EKG
- *986 EEG
- 987 Hospital visit
- 988 Consultation

* *These revenue codes may be billed only by chronic, rehabilitation, psychiatric and out-of-state outpatient facilities.*

528 REVENUE CODES THAT REQUIRE HCPCS CODES

The following chart lists the services by narrative and revenue code that require entry of HCPCS codes in Item 44 of the UB-92.

Service	Revenue Code	HCPCS Code	Payment
Laboratory	300-319, 923, 925	P2028-P9615 80002-89399 36415	Medicare Fee Schedule
Radiology	320-329, 330, 333, 339-349, 350-359, 400-409, 610-612, 619	70010-79999	Medicare Fee Schedule
Surgery	360, 361, 369, 490, 499	10000-69999	If ASC, Medicare ASC Fee Schedule. If non-ASC, PAF.
	450, 459, 510, 511, 519, 700, 709, 710, 719, 720-724, 729, 750, 759-762, 769	10000-69999 if applicable	If ASC procedure, zero payment as part of ASC group rate. If non-ASC procedure, PAF. If non-surgery related, see appropriate section below.
	250-253, 255, 257-259, 270, 272, 276, 370, 371, 374, 379, 380, 381, 383-387, 389-391, 399, 920	Not required	If ASC related, zero payment as part of ASC group rate. If non-ASC cost-to-charge ratio, see Ancillary Services.

528 REVENUE CODES THAT REQUIRE HCPCS CODES (cont.)

Service	Revenue Code	HCPCS Code	Payment
ER/Trauma	450, 459	N/A	Division-approved provider-specific rate
Clinic	510, 511, 519, 910, 911, 914-916 918, 919	N/A	Division-approved provider-specific rate
Dialysis	821, 831, 841, 851	N/A	Provider-specific composite rate
Professional Services			
ER/Trauma	981	99202-99205 99212-99215 99281-99285 99291-99292	50% RSC Physician Fee Schedule
ER/Screening	981	X5911	Division-approved provider-specific rate
Clinic	961, 962, 982, 983, 987, 988	99201-99205 99212-99215 99241-99244	50% RSC Physician Fee Schedule
Radiology	972-974	N/A	PAF
Surgery	963, 975	N/A	PAF

528 REVENUE CODES THAT REQUIRE HCPCS CODES (cont.)

Service	Revenue Code	HCPCS Code	Payment
Ancillary Services	250-253, 255, 257-259, 260-264, 269, 270-279, 280-289, 290-293, 299, 331, 332, 335, 370, 371, 374, 379-381, 383-387, 389-391, 399, 410-413, 419, 420-424, 429-434, 439-444, 449, 460, 469-472, 479-482, 489, 530-531, 539, 621, 630, 634-636, 639, 700, 709-710, 719, 720-724, 729, 730-732, 739, 740, 749, 750, 759, 760-762, 769, 790, 799, 890-893, 899, 900, 901, 903, 909, 920-922, 924, 929, 943-947	N/A	Cost-to-charge ratio

528 REVENUE CODES THAT REQUIRE HCPCS CODES (cont.)

Service	Revenue Code	HCPCS Code	Payment
Other Ancillary Services			
* Ambulance	N/A	See appropriate Provider Manual	RSC Fee Schedule
Home Health	N/A	See appropriate Provider Manual	RSC Fee Schedule
Psych Day Treatment	N/A	See appropriate Provider Manual	RSC Fee Schedule
Adult Day Health	N/A	See appropriate Provider Manual	RSC Fee Schedule
Adult Foster Care	N/A	See appropriate Provider Manual	RSC Fee Schedule
Early Intervention	N/A	See appropriate Provider Manual	RSC Fee Schedule
Dental	N/A	See appropriate Provider Manual	RSC Fee Schedule

* *If a hospital had incorporated the cost of its hospital-owned ambulance in its clinic or ER/Trauma cost center as submitted in the FY '90 RSC 403, the hospital may not bill for ambulance services, since the cost of this service has been included in the development of the clinic/ER rate.*

(529 through 530 Reserved)

This page is reserved.

PART 5. HOW TO READ THE REMITTANCE ADVICE

556 GENERAL EXPLANATION OF REMITTANCE ADVICE

(A) The Remittance Advice is sent to providers to explain the disposition of Medicaid claims. It lists paid, denied, suspended, and pended claims. Three-digit error codes for denied and suspended claims, amounts paid, and claim identification information are also listed. The Remittance Advice will list claims in three groupings in the following order: (1) paid claims, (2) denied claims, and (3) suspended claims. Entries within each grouping of claims on the Remittance Advice are sorted first by earliest date of service, second by patient account number, and third by recipient last name. Remittance Advices are mailed with payment checks.

The first page of each Remittance Advice will be available as a "Message Page." The Message Page will provide timely information from the Department of Public Welfare and Unisys regarding the Medicaid Program. The messages can be provider-type specific and can be helpful to providers in furnishing weekly updates.

(B) Sections 557 through 561 contain the following information about the Remittance Advice:

(1) a sample Remittance Advice;

(2) an item-by-item key identifying the location and type of information on the Remittance Advice;

(3) an explanation of the information on the Remittance Advice relating to the status of each claim, including examples of paid, denied, suspended, and pended claims;

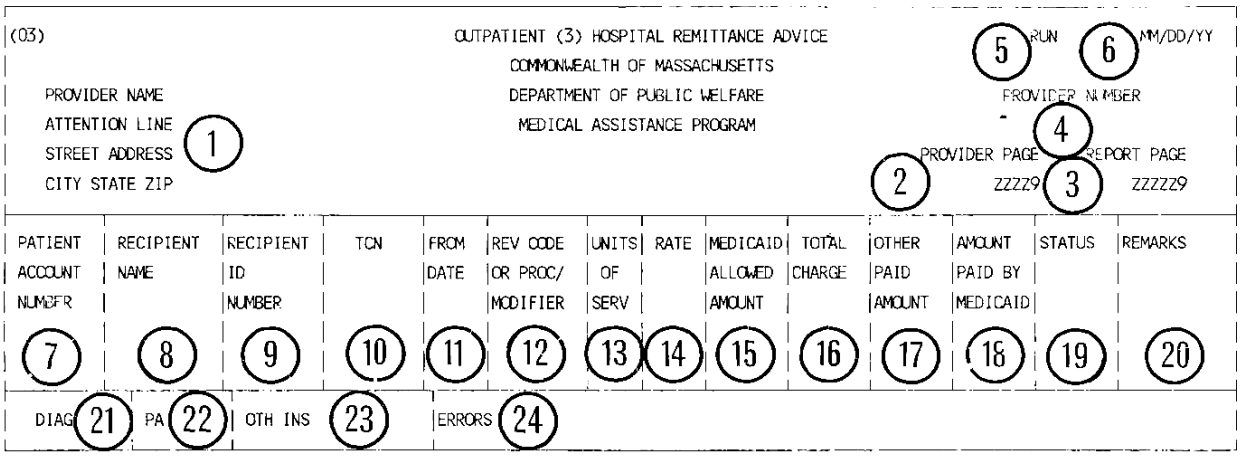
(4) an explanation of the information on the Remittance Advice relating to the different kinds of claims-processing requests, including requests for payment, adjustments, voids, and returned monies; and

(5) examples of Remittance Advices.

(C) The error codes and messages are listed and explained in Part 9 of the billing instructions.

557 SAMPLE REMITTANCE ADVICE

Pictured below is a standard Outpatient Hospital (3) Remittance Advice, used to report the disposition of all claims. An item-by-item explanation is given in Section 558.



558 ITEM-BY-ITEM EXPLANATION OF THE REMITTANCE ADVICE

The following list explains the items found on the standard Remittance Advice as depicted in the sample on the previous page.

Top of Advice

1	TO	This is the legal entity's name and the check mailing address.
2	PROVIDER PAGE	This is the sequential page number of the Remittance Advice.
3	REPORT PAGE	This is the page number of the total computer printout.
4	PROVIDER NUMBER	This is the Pay to Provider Number.
5	RUN	This is the number identifying the specific processing cycle.
6	DATE	This is the date (month/day/year) the Remittance Advice was printed.

Claim Lines

7	PATIENT ACCOUNT NUMBER	If a patient account number was entered on the claim form, then that number is listed to the left of the recipient's last name.
8	RECIPIENT NAME	Recipients' names are listed by month of service within each claim status and alphabetically by recipient's last name. If the recipient identification number is not on the Medicaid Recipient Eligibility File, or if the number is incorrect, "NM NOT AVAIL" appears in this field.
9	RECIPIENT ID	This is the recipient identification number that was entered on the claim form.
10	TCN	This is a unique 10-digit number assigned to each claim line. The TCN is assigned when a claim is received. It is used to identify a claim for adjustments, resubmittals, and records research.

558 ITEM-BY-ITEM EXPLANATION OF THE REMITTANCE ADVICE (cont.)

Explanation of Each Digit of a Transaction Control Number: Example: 019002744A

Last Digit of Current Calendar Year	Julian Date Claim is Received	MMIS Batch Number	Claim Number Within Batch	Line on Claim Form
0	190	027	44	A
(1990)	(July 9)	(Batch #27)	(Claim #44)	(Claim Line A)

11	FROM DATE	This is the date the service was provided.
12	REV CODE OR PROC/MODIFIER	This is the revenue code or the HCPCS procedure code (and modifier if applicable) that was entered on the claim form.
13	UNITS OF SERV	This is the number of items or number of times performed.
14	RATE	This is the rate (either percentage of charge or per diem) established by the Massachusetts Rate Setting Commission, or other appropriate agency.
15	MEDICAID ALLOWED AMOUNT	This is the calculated amount based on the rate ID and the rate, or the amount established by the Massachusettts Rate Setting Commission or other appropriate agency if the claim is paid by HCPCS code.
16	TOTAL CHARGE	This is the amount entered in Item 53 on the claim form.
17	OTHER PAID AMOUNT	This is the amount entered on the claim form that was paid by other health insurance.
18	AMOUNT PAID BY MEDICAID	This appears for paid and pended claims only and is the amount paid by Medicaid. Positive amounts are amounts paid by Medicaid. A positive payment results from the submission of a claim approved for payment or from an accepted adjustment of a previously paid or pended claim.

558 ITEM-BY-ITEM EXPLANATION OF THE REMITTANCE ADVICE (cont.)

Negative amounts are amounts owed by the provider to Medicaid. A negative amount is generated by an adjustment to or a void of a previously paid or pended claim that resulted in an overpayment.

19 STATUS

This reports the status of the claim, adjustment, resubmittal, void, or returned monies:

PAID - claim is paid
DENIED - claim is not paid
SUSPEND - claim must be reviewed to determine status
ACCEPTED - void claim is accepted
RETURN CHECK AMOUNT - a returned money void

20 REMARKS

This contains additional claim information about the claim being processed and returned monies description:

ORIG - original claim
RESUB - resubmittal of a previously denied claim
VOID - void to a previously paid claim
DBADJ - due to an adjustment, the amount previously paid is debited
CRADJ - due to an adjustment, the amount previously paid is recalculated
FISCPEND - claim is pending payment for fiscal reasons
RELFISC - claim released from fiscal pend
PPRU - PPRU Pend (indicates the Sanction Log Number)
REL - released from PPRU pend (indicates the Sanction Log Number)
TAPE - claim was submitted on electronic media
TPL-18-A - collection from Title XVIII (Medicare Part A)
TPL-18-B - collection from Title XVIII (Medicare Part B)

558 ITEM-BY-ITEM EXPLANATION OF THE REMITTANCE ADVICE (cont.)

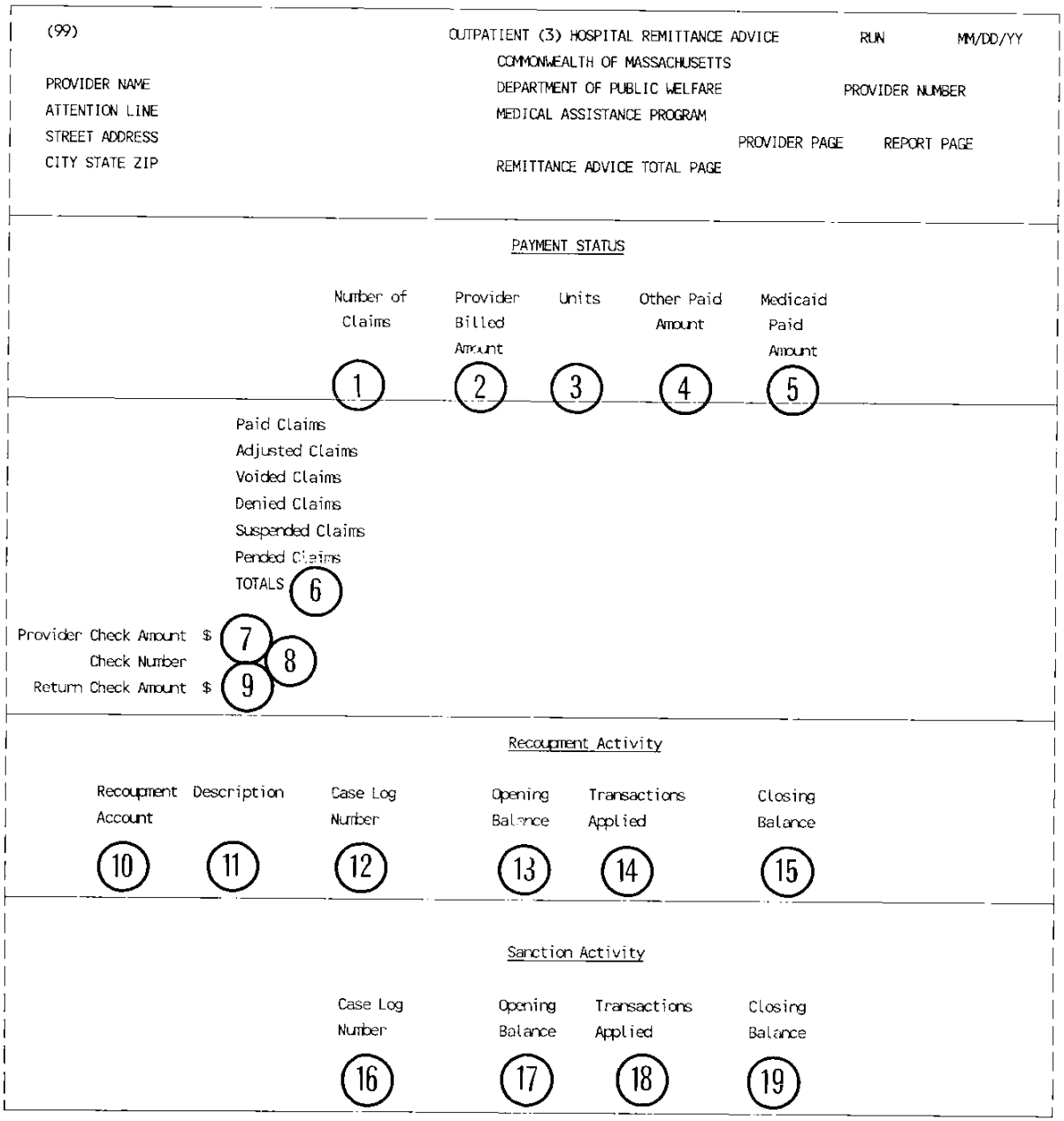
20	REMARKS (cont.)	TPL-INS - collection from health insurance TPL-ACC - collection from casualty insurance, Worker's Compensation, auto accident, etc. TPL-EST - collection from estate of deceased recipient RET-PROV - money returned because paid to wrong provider RET-RECP - money returned because paid for wrong recipient RET-ERR - provider billed service prior to service date/service not delivered RET-DUPA - money returned because of duplicate payment RET-DUPB - provider billed twice RET-CRADJ - collection from credit balance on recipient accounts RET-OVER - provider paid more than billed RET-PART - provider only performed component of service billed RET-OTH - money returned for other reason RTN-CHK - if the transaction is a returned money adjustment, the amount of the returned check applied appears here RCOUP-AMT - a recoupment amount
20	REMARKS (last character)	The last character of the remarks code indicates the following conditions. M - claim was manually reviewed P - claim was pended R - claim was for returned money S - claim was suspended
21	DIAG	This is the principal ICD-9-CM diagnosis code that was entered on the claim form.
22	PA	This is the prior authorization number that was entered on the claim form.

558 ITEM-BY-ITEM EXPLANATION OF THE REMITTANCE ADVICE (cont.)

23	OTH INS	The TPL carrier code representing the Explanation of Benefits (EOB) from another insurance will appear in this field if an EOB from the other insurance was attached to the claim form.
24	ERRORS	The error codes that caused the claim to suspend or deny will be shown here. See Part 9 of these billing instructions for a complete listing of error codes and their explanations.

559 SAMPLE REMITTANCE ADVICE TOTAL PAGE

Pictured below is a sample Remittance Advice Total Page. An item-by-item explanation is given in Section 560.



560 ITEM-BY-ITEM EXPLANATION OF THE REMITTANCE ADVICE TOTAL PAGE

The following list explains the items found on the Remittance Advice Total Page as depicted in the sample on the previous page.

Payment Status

1	NUMBER OF CLAIMS	These are the totals of the number of claims within each of the six categories of claim status: PAID CLAIMS ADJUSTED CLAIMS VOIDED CLAIMS DENIED CLAIMS SUSPENDED CLAIMS PENDED CLAIMS
2	PROVIDER BILLED AMOUNT	These are the totals of the amounts billed by the provider for each of the six categories of claim status.
3	UNITS	These are the totals of the number of reimbursable days or units for each of the six categories of claim status.
4	OTHER PAID AMOUNT	These are the totals of the amounts paid by other health insurance for each of the six categories of claim status.
5	MEDICAID PAID AMOUNT	These are the totals of the amounts paid by Medicaid within each of the six categories of claim status.
6	TOTALS	These are the totals for Items 1 through 5 listed above.
7	PROVIDER CHECK AMOUNT	This is the amount of the payment check.
8	CHECK NUMBER	This is the serial number of the payment check issued to the provider.
9	RETURNED CHECK AMOUNT	This is the total amount of payment the provider returned to Medicaid.

560 ITEM-BY-ITEM EXPLANATION OF THE REMITTANCE ADVICE TOTAL PAGE (cont.)

Recoupment Activity

10	RECOUPMENT ACCOUNT	This is the code for the recoupment account with activity this processing cycle. If the recoupment account code G, H, or I appears in this field, a separate check for the recouped amount has been issued to the appropriate government agency. When checks are issued as part of recoupment activity, the check numbers are printed in the lower right margin.
11	DESCRIPTION	This is a description of the recoupment account with activity this processing cycle.
12	CASE LOG NUMBER	This is the case log number assigned to the recoupment account with activity this processing cycle.
13	OPENING BALANCE	This is the balance of the recoupment account at the beginning of this processing cycle.
14	TRANSACTIONS APPLIED	This is the amount of claims activity applied to the recoupment account this processing cycle.
15	CLOSING BALANCE	This is the balance of the recoupment account at the end of this processing cycle.

Sanction Activity

16	CASE LOG NUMBER	This is the case log number assigned to the sanction activity during this processing cycle.
17	OPENING BALANCE	This is the balance of the sanction account at the beginning of this processing cycle.
18	TRANSACTIONS APPLIED	This is the amount of claims activity applied to the sanction account this processing cycle.
19	CLOSING BALANCE	This is the balance of the sanction account at the end of this processing cycle.

561 EXAMPLES OF CLAIM LINES ON THE REMITTANCE ADVICE

(A) Example of a PAID Claim

In this example, outpatient hospital care was furnished to eligible Medicaid recipient John Smith on July 1, 1990. The provider reported a $50.00 payment from another insurance source. The amount paid by Medicaid is $44.24.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID NUMBER	TCN	FROM DATE	REV CODE OR PROC/ MODIFIER	UNITS OF SERV	RATE	MEDICAID ALLOWED AMOUNT	TOTAL CHARGE	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
ABC0123456789	SMITH JOH	0123456789	019634162A	070190	270	1	.6200	9424	15200	5000	4424	PAID	(ORIG)
DIAG 7542	PA	OTH INS 027	ERRORS										

(B) Example of a DENIED Claim

In this example, outpatient hospital care was furnished to eligible Medicaid recipient John Smith on July 1, 1990. Two claims for the same stay were mistakenly submitted. The second submission was denied with error code 103, meaning "Duplicate Claim." The previously paid claim appears on the following line as a "Conflicting Claim" with the run number of the Remittance Advice on which it appears.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID NUMBER	TCN	FROM DATE	REV CODE OR PROC/ MODIFIER	UNITS OF SERV	RATE	MEDICAID ALLOWED AMOUNT	TOTAL CHARGE	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
ABC0123456789	SMITH JOH	0123456789	019634163A	070190	270	1	.6200	9424	15200	5000	4424	DENIED	(ORIG)
DIAG 7542	PA	OTH INS 027	ERRORS 103										
ABC0123456789	SMITH JOH	0123456789	019134111A	070190	270	1	.6200	9424	15200	5000	4424	PAID	(ORIG)
DIAG 7542	PA	OTH INS 027	ERRORS CONFLICTING CLAIM RUN 462										

561 EXAMPLES OF CLAIM LINES ON THE REMITTANCE ADVICE (cont.)

(C) Example of a SUSPENDED Claim

In this example, outpatient hospital care was furnished to Medicaid recipient John Smith on July 1, 1990. When the provider billed Medicaid for the service, the claim was suspended with error code 246 because John Smith was not eligible for Medicaid on the date of service according to the Medicaid Recipient Eligibility File. The claim will be recycled for a period of 60 days to allow for updates to the Medicaid Recipient Eligibility File.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID NUMBER	TCN	FROM DATE	REV CODE OR PROC/ MODIFIER	UNITS OF SERV	RATE	MEDICAID ALLOWED AMOUNT	TOTAL CHARGE	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
ABC0123456789	SMITH JOH	0123456789	019632704A	070190	85027	1	.0000	1026	1900			SUSPEND	(ORIG)
DIAG 075	PA	OTH INS		ERRORS 246									

(D) Example of a Postpayment Review Unit (PPRU) Pended Claim

In this example, it was determined that $45.75 was payable for this claim; however, payment is being withheld as a result of a sanction initiated by the Department's Postpayment Review Unit (PPRU). A sanction inhibits the release of current payments to a provider. This claim may be released for payment when a resolution is reached between the provider and the PPRU.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID NUMBER	TCN	FROM DATE	REV CODE OR PROC/ MODIFIER	UNITS OF SERV	RATE	MEDICAID ALLOWED AMOUNT	TOTAL CHARGE	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
ABC0123456789	SMITH JOH	0123456789	019642397A	070190	320	1	.6100	4575	7500		4575	PAID	(PPRU1234)
DIAG 83969	PA	OTH INS		ERRORS									

561 EXAMPLES OF CLAIM LINES ON THE REMITTANCE ADVICE (cont.)

(E) Examples of Adjustments

An adjustment is indicated on a Remittance Advice by a debit-credit transaction. The debit (DBADJ) line reflects the original claim, and the corresponding status field contains the amount originally paid that has been reversed (subtracted). The credit (CRADJ) line reflects the adjustment to the original claim, and the corresponding status field contains the amount that should have been paid. The amount in the "Amount Paid by Medicaid" column represents the difference between these two amounts. This amount will be zero if the adjustment did not change the original payment. If the amount is negative, it will be deducted from the payment. If the amount is positive, it will result in an additional payment for the claim.

The following examples illustrate situations when adjustments result in (1) a negative amount and (2) a positive amount.

(1) Example of a Negative Amount Adjustment

In this example, a change in the HCPCS procedure code resulted in an overpayment of $6.00 ($11.63 - $5.63) to the provider. This change established an overpayment for the original claim. The $6.00 overpayment will be deducted from the total amount of paid claims on the Remittance Advice.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID NUMBER	TCN	FROM DATE	REV CODE OR PROC/ MODIFIER	UNITS OF SERV	RATE	MEDICAID ALLOWED AMOUNT	TOTAL CHARGE	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
ABC0123456789	SMITH JOH	0123456789	023157211A	070190	85651	1	.0000	563	1150		600 -	563	(CRADJ)
DIAG 83969	PA	OTH INS		ERRORS									
ABC0123456789	SMITH JOH	0123456789	019657403A	070190	85025	1	.0000	1163	1500			1163 -	(DBADJ)
DIAG 83969	PA	OTH INS		ERRORS									

561 EXAMPLES OF CLAIM LINES ON THE REMITTANCE ADVICE (cont.)

(2) Example of a Positive Amount Adjustment

In this example, a change in the reimbursement rate (from 62% to 67%) established an underpayment of $.75 for the original claim. As a result, Medicaid pays $.75 to the provider.

Note: Rate change adjustments are automatically generated by the system (not by the provider).

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID NUMBER	TCN	FROM DATE	REV CODE OR PROC/ MODIFIER	UNITS OF SERV	RATE	MEDICAID ALLOWED AMOUNT	TOTAL CHARGE	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
ABC0123456789	SMITH JOH	0123456789	019632791A	070190	510	1	.6700	1005	1500		75	1005 -	(CRADJ)
DIAG 3469	PA	OTH INS	ERRORS										
ABC0123456789	SMITH JOH	0123456789	023505797A	070190	510	1	.6200	930	1500			930 -	(DBADJ)
DIAG 3469	PA	OTH INS	ERRORS										

561 EXAMPLES OF CLAIM LINES ON THE REMITTANCE ADVICE (cont.)

(F) Example of a VOID

A void transaction is reported on a Remittance Advice to correct and report any one of the following situations:

(1) duplicate claim erroneously paid;

(2) payment to wrong provider;

(3) payment for wrong recipient;

(4) payment in excess of the maximum allowable Medicaid rate;

(5) payment for overstated services; and

(6) payment for services for which reimbursement has been received from third-party payers.

A void transaction always results in a negative amount to reverse the original claim. These voids do not represent the return of owed monies. Therefore, they are treated as an overpayment and are deducted from current payments. See Section 572 for information on how to request a void to paid or pended claims.

In this example, a payment of $16.25 was issued to the wrong provider for a claim for Mary Smith. This claim is voided and this provider's payments are deducted until the total amount of $16.25 is recovered.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID NUMBER	TCN	FROM DATE	REV CODE OR PROC/ MODIFIER	UNITS OF SERV	RATE	MEDICAID ALLOWED AMOUNT	TOTAL CHARGE	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
ABC0123456789	SMITH MAR	0123456789	019633127A	070190	510	1	.6500	1625	2500		1625	ACCEPTED	(VOID)
DIAG 3460	PA	OTH INS		ERRORS									

561 EXAMPLES OF CLAIM LINES ON THE REMITTANCE ADVICE (cont.)

(G) Example of Returned Monies

A provider may return money for a previously paid claim. The Remittance Advice reports returned monies and the source of returned money.

In this example, a provider returned a check for a claim paid to the wrong Medicaid provider number. With the check, the provider enclosed a copy of the Remittance Advice with the error circled and a letter of explanation. The return payment from the provider is recorded. Since the amount of returned monies equals the amount of original payment, no monies are owed by the provider.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID NUMBER	TCN	FROM DATE	REV CODE OR PROC/ MODIFIER	UNITS OF SERV	RATE	MEDICAID ALLOWED AMOUNT	TOTAL CHARGE	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
ABC0123456789	SMITH JOH	0123456789	019622795A	070190	510	1	.6500	1625	2500		1625		RET-PROV
DIAG 3460	PA	OTH INS	ERRORS										

562 RECOUPMENT/RECOVERY INFORMATION

(A) When a claim adjustment or a payment error results in an overpayment, a negative amount appears in the "Amount Paid by Medicaid" column on the Remittance Advice. These negative amounts are subtracted from the provider's current payment. If a negative balance is still outstanding, it is carried forward as an outstanding recoupment account. This activity is reported on the Remittance Advice and will appear under "Remarks."

(B) Monies owed by a provider are deducted from future claim payments, or the provider may send a check to be applied to an outstanding account. The provider must clearly identify the recoupment account to which the money is to be applied by submitting a photocopy of the Remittance Advice with the payment check.

(C) The Department may be required to make payment to federal or state authorities when served with a levy upon payments due to a Medicaid provider. In these instances, a recoupment account for the amount of the levy is established for one processing cycle. Levy amounts are recouped from current payments. This activity is reported on the Remittance Advice. Checks are sent to the lienholder.

(563 through 565 Reserved)

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