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Executive Office of Health and Human Services
Office of Medicaid
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MassHealth
Transmittal Letter COH-14
June 2022

TO: Chronic Disease and Rehabilitation Outpatient Hospitals Participating in MassHealth

FROM: Amanda Cassel Kraft, Assistant Secretary for MassHealth

RE: *Chronic Disease and Rehabilitation Outpatient Hospital Manual* (Revisions to 130 CMR 410.000 to Clarify Coverage of Abortion Services)

This letter transmits amendments to the chronic disease and rehabilitation outpatient hospital regulation at 130 CMR 410.000. These amendments clarify MassHealth coverage of abortion services for consistency with M.G.L. c. 112, §§ 12K through 12R, and make certain other technical edits.

These amendments are effective as of June 10, 2022.

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Questions

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NEW MATERIAL

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

Chronic Disease and Rehabilitation Outpatient Hospital Manual

Pages iv, 4-1, 4-2, and 4-17 through 4-22

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Chronic Disease and Rehabilitation Outpatient Hospital Manual

Pages iv, 4-1, 4-2, 4-17, and 4-18 — transmitted by Transmittal Letter COH-13

Pages 4-19 through 4-22 — transmitted by Transmittal Letter COH-12

4. Program Regulations

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410.401: Introduction

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

410.402: Definitions

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

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

340B Drug Pricing Program – a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992.

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

Acute Hospital – a facility that (i) is licensed as a hospital by the Massachusetts Department of Public Health (DPH) under M.G.L. c. 111, §51 (if in-state) or by the governing or licensing agency in its state (if out-of-state); (ii) is Medicare-certified and participates in the Medicare program; (iii) has more than 50% of its beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (obstetrics), or neonatal intensive care beds (Level III) as determined by DPH (or if out-of-state, the governing or licensing agency in its state, and as determined by MassHealth) and; (iv) utilizes more than 50% of its beds exclusively as either medical / surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (obstetrics), or neonatal intensive care beds (Level III), as determined by MassHealth. An acute hospital is not a chronic disease and rehabilitation hospital or a hospital licensed primarily to provide mental health services, or any unit of a facility that is licensed as a nursing facility, chronic disease unit, or rehabilitation unit.

Acute Inpatient Hospital – an acute hospital that provides diagnosis and treatment on an inpatient basis 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 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, chronic disease unit, or a rehabilitation unit.

Chronic Disease and Rehabilitation Hospital (CDR) – a hospital licensed by the Massachusetts Department of Public Health (DPH) under M.G.L. c.111, §51 (or by the governing or licensing agency in its state (if out-of-state)), with a majority of its beds licensed to provide chronic care services, or comprehensive rehabilitation services, or both, to patients with appropriate medical needs, or that is operated by DPH's Bureau of Public Health Facilities. This definition includes such a hospital licensed with a pediatric specialty. Hospitals with 50% or more of their beds licensed as medical/surgical, intensive care, coronary care, burn, maternal (obstetrics) and neonatal intensive care beds (Level III) possess acute hospital licensure and do not meet the definition of a chronic disease and rehabilitation hospital.

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

Drug – a substance as defined by the Food, Drug, and Cosmetic Act, containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

Emergency Medical Condition – a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant individual, as further defined in §1867(e)(1)(B) of the Social Security Act, 42 U.S.C. §1395dd(e)(1)(B).

Emergency Services – medical services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.

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.

Gross Cost Per Utilizer Per Year – Annual cost per utilizer projected by EOHHS based on factors including actual or expected utilization, dosing information, duration of therapy, and the National Average Drug Acquisition Cost (NADAC) or Wholesale Acquisition Cost (WAC) (when NADAC is not available) of the covered drug prior to any federal or supplemental rebate.

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.

CMR 410.432(A)(1) are effectively communicated to any member who is blind, deaf, or otherwise handicapped;

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

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

(B) When Informed Consent Must Be Obtained.

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

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

(a) in labor or childbirth;

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

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

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

410.433: Sterilization Services: Consent Form Requirements

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

(A) Required Consent Form.

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

(a) CS-18 – for members 18 through 20 years of age; or

(b) CS-21 – for members 21 years of age or older.

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

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

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

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

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

(D) Provider Billing and Required Submissions.

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

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

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

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

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

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

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

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

410.434: Abortion Services: Reimbursable Services

The MassHealth agency pays for abortion services performed by a licensed physician, physician assistant, cerified nurse practitioner, or certified nurse midwife in a hospital outpatient department only when all of the following conditions are met:

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

(B) the abortion is medically necessary—that is, according to the medical judgment of a licensed physician, or, consistent with c. 112, s. 12M and the time limitations established therein a physician assistant, certified nurse practitioner, or certified nurse midwife, necessary in light of all factors affecting the pregnant individual'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 providers (i.e., physicians, physician assistants, nurse practitioners, or nurse midwives and hospital outpatient departments) must complete a Certification for Payable Abortion (CPA-2) form and retain the form in the member's record. (Instructions for obtaining the Certification for Payable Abortion form are in Subchapter 5 of the *Outpatient Hospital Manual*.) To identify those abortions that meet federal reimbursement standards, the MassHealth agency must secure on the CPA-2 form the certifications described in 130 CMR 410.435(A) through (C), when applicable. For all medically necessary abortions not included in 130 CMR 410.435(A) through (C), the certification described in 130 CMR 410.435(D) is required on the CPA-2 form. The provider 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 Pregnant Individual Would Be Endangered. The attending provider must certify that, in their professional judgment, the life of the pregnant individual would be endangered if the pregnancy were carried to term.

(B) Severe and Long-lasting Damage to the Pregnant Individual's Physical Health. The attending provider and another provider must each certify that, in their professional judgment, severe and long-lasting damage to the pregnant individual's physical health would result if the pregnancy were carried to term. At least one of the providers must also certify that they are not an "interested provider," 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 provider whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(C) Victim of Rape or Incest. The provider is responsible for retaining signed documentation from a law enforcement agency or public health service certifying that the person 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 provider must certify that, in their medical judgment, for reasons other than those described in 130 CMR 410.435(A) through (C), the abortion performed was necessary in light of all factors affecting the pregnant individual's health.

410.436: Abortion Services: Out-of-state Abortions

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

(A) The member, the referring provider, or a referral agency may request prior authorization from the MassHealth agency 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 MassHealth agency authorizes the abortion, it will issue a prior authorization number directly to the out-of-state facility. The facility must enter the prior authorization number on the claim form when requesting payment from the MassHealth agency.

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

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

410.437: Family Planning Services

The MassHealth agency will pay for outpatient hospital services related to family planning. These services may include but are not limited to the following:

(A) nonpermanent contraceptive care;

(B) comprehensive medical examination;

(C) diagnosis and treatment of medical problems specific to reproduction as well as diagnosis of and appropriate referral for other medical problems;

(D) sexually transmitted infection (STI) testing and treatment;

(E) cervical cancer screening (Pap smear);

(F) breast examination;

(G) laboratory services related to family planning (for example, Pap smear, gonorrhea culture, vaginal culture and smear, blood test for sexually transmitted infection (STI), hematocrit, complete blood count, urinalysis, and pregnancy testing); and

(H) family planning counseling, including discussions about family planning, human reproduction, and methods of contraception.

410.438: Acupuncture

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

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

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

(D) Provider Qualifications for Acupuncture.

(1) Qualified Providers. MassHealth pays a hospital for acupuncture services only when the provider rendering the service is:

(a) a physician; or

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

(2) Acupuncture Providers in Hospitals. Hospitals must ensure that acupuncture providers for whom the hospital will submit claims possess the appropriate training, credentials, and licensure.

(E) Conditions of Payment. The MassHealth agency pays the hospital for services of an acupuncturist qualified to render such services in accordance with 130 CMR 410.438(D) only when:

(1) the services are limited to the scope of practice authorized by state law or regulation (such as 243 CMR 5.00: *The Practice of Acupuncture*); and

(2) the provider has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine.

(F) Acupuncture Claims Submissions.

(1) Hospitals may submit claims for on-site acupuncture services when a provider qualified to render such services in accordance with 130 CMR 410.438(D) provides those services directly to MassHealth members. *See* Subchapter 6 of the *Acute Outpatient Manual* for service code descriptions and billing requirements.

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

(130 CMR 410.439 through 410.440 Reserved)

410.441: Early Intervention Program Services

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

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

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

410.442: Home Health Agency Services

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

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

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

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

410.443: Adult Day Health Program Services

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

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

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