



MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE

One Federal Street, Suite 700 • Boston, MA 02110
(617) 521-7794 • (877) 563-4467 • www.mass.gov/doi

ERIC PALEY
SECRETARY

LAYLA R. D'EMILIA
UNDERSECRETARY

MICHAEL T. CALJOUW
COMMISSIONER

HEALTH COVERAGE
Filing Guidance Notice: 2026-L

TO: Insurance Carriers Subject to M.G.L. c. 176O

FROM: Kevin Patrick Beagan, Deputy Commissioner, Health Care Access Bureau

DATE: September 17, 2026

RE: Filings to Implement Amendments to 211 CMR 52.07(5)

Filing Guidance Notice 2026-L provides additional clarification to insurance carriers (“Carriers”) about materials required to be submitted to the Division of Insurance (“Division”) in order to implement prospective review (i.e., prior authorization) changes identified in the recent amendments to 211 CMR 52.00, and specifically, 211 CMR 52.07(5) (“Prospective Review for Certain Health Services, Supplies and Pharmaceuticals”). The recent amendments apply to prospective review; Carriers are reminded that they are expected to follow the requirements of M.G.L. c. 176O and 211 CMR 52.02 et seq. with regard to utilization review processes.¹ The Division also notes that self-insured accounts are not subject to this guidance but encourages Carriers to seek aligned approaches whenever practicable.

Implementation Plans

As noted in Filing Guidance Notice 2026-I, the Division is developing further guidance concerning elements of the amended regulation in furtherance of orderly and consistent implementation. The Division expects that Carrier to submit a detailed plan for the Division’s review and approval within 45 days of the issuance of guidance documents explaining how the Carrier will implement the prospective review changes.

¹ In 211 CMR 52.02, "Utilization Review" is defined as a “[s]et of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures or settings. Such techniques may include, but are not limited to, Ambulatory Review, Prospective Review, Second Opinion, certification, Concurrent Review, Case Management, Discharge Planning or Retrospective Review.” When employing utilization review techniques other than prospective review, Carriers are expected to follow all applicable statutory and regulatory requirements. The Division reminds Carriers that nothing in this filing guidance is meant to limit Carriers’ employment of utilization review techniques under M.G.L. c. 176O and 211 CMR 52.00 when investigating or managing waste or fraud in health insurance markets. The Division also notes that step therapy is separately addressed in section 12A of M.G.L. c. 176O, 211 CMR 52.07(10), and Bulletin 2024-03. Therefore, this filing guidance does not address Carriers’ use of step therapy.

The implementation plan is expected to include an explanation of the steps that the Carrier will follow to modify its internal systems, whenever and wherever necessary, to fully operationalize the changes to the prospective review process. The plan should provide details about how the Carrier will explain to providers and insureds how the changes will go into effect. Once approved, the Carriers must implement the prospective review changes according to the timelines identified in the approved plans.

Limitations on Use of Prospective Review for Emergency Services

As noted in 211 CMR 52.07(5)(a)(1), a Carrier shall not require prospective review for emergency services that are provided to an insured to address emergency medical conditions, whether provided in or out of network. The Division reminds Carriers that emergency services include those services that are medically necessary to treat an emergency medical condition defined in 211 CMR 52.02 as “[a] medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, [such] 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 an Insured 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 woman, as further defined in § 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).”

Regarding behavioral health care, the Division reminds Carriers that emergency services include the provision of community-based emergency psychiatric services, including, but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention services for adults; (iii) emergency service provider community based locations; and (iv) adult community crisis stabilization services. The Division expects emergency services to include those provided within an emergency department of an inpatient facility, as well as those provided within other facilities, or on an outpatient basis provided that the insured’s health needs meet the definition of an emergency medical condition.

The Division notes that this provision applies only to emergency services provided to evaluate and treat an emergency medical condition and does not include services provided after the emergency medical condition has been stabilized. This provision does not extend to subsequent reviews, including those related to post-stabilization services, observation status determinations, or inpatient admission decisions following an emergency department encounter.

Limitations on Use of Prospective Review for Certain Inpatient Acute Care Services

As noted in 211 CMR 52.07(5)(a)(2), a Carrier shall not require prospective review for inpatient acute care services that are provided to an insured in network. For purposes of this provision, inpatient acute care services do not include scheduled or elective procedures or services for which prospective review may reasonably be completed prior to the scheduled admission. The Division expects inpatient acute care services to include medically necessary services furnished following a formal inpatient admission to a licensed acute care hospital. The Division expects that inpatient acute care services include those services defined by the Centers for Medicare and Medicaid Services as short-term, time-sensitive medical treatment to prevent complications or deterioration of an insured’s health and well-being.

Limitations on Use of Prospective Review for Post-Acute Care Services

As noted in 211 CMR 52.07(5)(a)(3), a Carrier shall not require prospective review for in-network post-acute care services that are provided to an insured on weekends or legal holidays. The Division expects this provision to apply to post-acute services initiated following discharge from an acute inpatient admission to an in-network post-acute care setting on a weekend or legal holiday.

The Division expects that post-acute care services include services defined by the Centers for Medicare and Medicaid Services as short-term, medically necessary services for patients recovering from an acute illness, injury, or medical procedure. Post-acute care services are expected to include those that occur after an inpatient acute hospital stay and help patients heal, regain function, and return to everyday life.. This includes medically necessary care provided at any facility licensed under M.G.L. c. 111 to provide inpatient post-acute care services, and includes, but is not limited to, skilled nursing facilities, long-term care hospitals, intermediate care facilities, and rehabilitation facilities, or a home health agency certified by the Centers for Medicare and Medicaid Services.

Limitations on Use of Prospective Review for Certain Urgent Care Services

As noted in 211 CMR 52.07(5)(a)(4), a Carrier shall not require prospective review for in-network urgent care services provided to an insured. The Division expects urgent care services to include episodic care for the diagnosis, treatment, management or monitoring of acute and chronic disease or injury that is for the treatment of illness or injury that is immediate in nature but does not require emergency services. Such urgent care is not to be used for preventative or routine services. This includes urgent behavioral health care, which is characterized by changes in behavior or thinking, role dysfunction, emerging intent of self-injury, or threats to others, but does not include immediate risk of harm to self or others. Urgent behavioral health care includes urgent care services provided by a behavioral health urgent care provider. This also includes services defined by the Centers for Medicare and Medicaid Services as medical services that are not life-threatening but which are needed within 12 hours to treat a sudden illness or injury.

The Division expects urgent care services to include evaluation and treatment services and does not include advanced diagnostic imaging, laboratory testing, infusions, procedures, or other ancillary services performed or ordered by a provider. The Division expects this provision to apply to urgent care services provided at a location separate from a hospital emergency room, such as urgent care clinics, licensed clinics, and community behavioral health centers.

Limitations on Use of Prospective Review for Certain Primary Care Services

As noted in 211 CMR 52.07(5)(a)(5), a Carrier shall not require prospective review for in-network primary care services that are provided to an insured.

The Division expects that primary care services include services defined in 211 CMR 52.02 as those provided by a primary care provider who is a “health care professional qualified to provide general medical care for common health care problems who: (i) supervises, coordinates, prescribes, or otherwise provides or proposes Health Care Services; (ii) initiates referrals for Specialty Care; and (iii) maintains continuity of care within the scope of his or her practice.” For purposes of 211 CMR 52.07(5)(a)(5), primary care services are those delivered by or under the direct supervision of a primary care provider.

The Division expects primary care services to include routine services provided by a primary care practitioner within the scope of the in-network provider’s primary care practice, including primary care

evaluation and management, preventive services, routine management of chronic conditions, administration of routine immunizations and injections furnished as part of primary care, routine screening and assessments, routine behavioral health care screening and brief intervention furnished as part of primary care, routine laboratory testing, diagnostic testing and imaging, and care coordination. Primary care services may include services furnished in an outpatient primary care setting by an in-network primary care provider or by an in-network primary care provider in an insured's home or while an insured is in an in-network nursing facility.

Limitations on Use of Prospective Review for Certain Pharmaceuticals for Chronic Conditions

As noted in 211 CMR 52.07(5)(a)(6), a Carrier shall not require prospective review for in-network pharmaceuticals for chronic conditions as identified pursuant to M.G.L. section 47CCC of c. 175, section 8DDD of c. 176A, section 4DDD of c. 176B, and section 4VV of c. 176G.

For the purpose of 211 CMR 52.07(5)(a)(6), the Division considers the pharmaceuticals for chronic conditions to be those drugs identified by Carriers to be the generic pharmaceuticals available without cost-sharing and the brand-name pharmaceuticals available at a \$25 copayment to treat the chronic conditions that are identified in M.G.L. section 47CCC of c. 175, section 8DDD of c. 176A, section 4DDD of c. 176B, and section 4VV of c. 176G, and otherwise set forth in the Division's applicable annual filing guidance to Carriers.

Limitations on Use of Prospective Review for Certain Preventive Health Services

As noted in 211 CMR 52.07(5)(a)(7), a Carrier shall not require prospective review for in-network preventive health services. The Division expects preventive health services to include any periodic, routine, screening or other services designed for the prevention and early detection of illness provided according to certain timelines or at certain ages based upon recommendations from the Massachusetts Department of Public Health or United States Preventive Services Taskforce, and those preventive health services that Carriers are required to provide under Massachusetts or federal law. The Division considers preventive health services to include the following as defined by the Centers for Medicare and Medicaid Services:

- Annual Wellness Visits and Physical Exams, for instance with a primary care doctor
- Health Screenings for blood pressure, cholesterol, blood sugar for diabetes, and various cancer screenings such as colonoscopies and mammograms
- Vaccinations and Immunizations for flu and pneumococcal disease
- Mental Health Screenings for conditions like depression and anxiety
- Risk Factor Assessments to identify lifestyle or genetic factors that may contribute to chronic diseases
- Counseling or lifestyle guidance on diet, exercise, managing stress, and other ways to improve overall health and well-being

Limitations on Use of Prospective Review for Certain Vaccinations

As noted in 211 CMR 52.07(5)(a)(8), a Carrier shall not require Prospective Review for vaccinations that are provided to an insured in network. The Division expects that vaccinations include those immunizations provided according to certain timelines or at certain ages based upon recommendations from the Massachusetts Department of Public Health or the United States Preventive Services Taskforce. The

Division understands this provision to include vaccinations that are required to be covered by Carriers under Massachusetts or federal law.

Limitations on Use of Prospective Review for Abortion and Abortion-Related Care

As noted in 211 CMR 52.07(5)(a)(9), a Carrier shall not require prospective review for abortion and abortion-related care that is provided to an insured in network. The Division expects that abortion and abortion-related care include services provided as described in chapter 127 of the Acts of 2022, chapter 188 of the Acts of 2026, and Bulletin 2023-01.

The Division expects abortion-related care to include services defined under 130 CMR 484.005 that are “provided in conjunction with a payable abortion procedure: (1) pre-operative evaluation and examination; (2) pre-operative counseling; (3) laboratory services, including pregnancy testing, blood type, and Rh factor; (4) Rh (D) immune globulin (human); (5) anesthesia (general or local); (6) post-operative care; (7) follow-up; and (8) advice on contraception or referral to family planning services.” The Division expects ultrasounds, pre-abortion evaluation and examination, and post-abortion care provided in conjunction with a covered surgical or medication-based abortion to be “abortion-related care.”

Limitations on Use of Prospective Review for Certain Maternity Care

As noted in 211 CMR 52.07(5)(a)(10), a Carrier shall not require prospective review for maternity services that are provided to an insured in network. The Division expects that maternity services include pre-maternity treatment, maternity services provided in a hospital or other facility for the mother and newborn, and post-maternity care. Among the services that are considered maternity care are those identified in M.G.L. section 47F of c. 175, section 8H of c. 176A, section 4H of c. 176B, and sections 4 and 4I of c. 176G, as well as hearing screening for newborns, identified in section 47C of c. 175, section 8B of c. 176A, section 4C of c. 176B, and section 4K of c. 176G, and those services addressed in other Division guidance such as Bulletins 1997-01 and Filing Guidance Notice 2025-I. The Division understands maternity services to include routine obstetrical care associated with an uncomplicated pregnancy, including routine prenatal office visits, standard labor and delivery admission, and routine post-maternity follow-up care.²

Limitations on Use of Prospective Review for Insureds with Confirmed Cancer Diagnosis

As noted in 211 CMR 52.07(5)(a)(11), a Carrier shall not require prospective review for those insureds with an already confirmed cancer diagnosis, limited to plain radiography, ultrasound, computed tomography, magnetic resonance imaging, scintigraphy and echocardiogram, used to stage or determine treatment efficacy, that is provided to an insured in network.

The Division expects that cancer is a defined medical condition, as identified in the most recent edition of the International Classification of Diseases or succeeding document. The Division expects that, for the purposes of determining whether imaging meets the requirements of 211 CMR 52.07(5)(a)(11): (1) the

² Prospective review may still be appropriate for non-routine, non-urgent maternity care, e.g., high-risk pregnancies or pregnancy complications, advanced diagnostic or genetic testing beyond routine screening, post-delivery inpatient hospitalization, extended or non-routine inpatient hospitalization, fertility treatment or assisted reproductive technology, durable medical equipment, or neonatal services.

imaging is ordered by a treating physician or authorized non-physician practitioner (e.g., Nurse Practitioner, Physician Assistant); (2) the order and medical records detail the insured's confirmed cancer diagnosis and the clinical purpose for which the imaging is being ordered; and; and (3) claims for the noted imaging are submitted with ICD-10 codes that directly link the confirmed cancer diagnosis to the imaging service.

The Division expects that a confirmed diagnosis exists when the insured has already been tested and has a confirmed diagnosis. This provision does not apply to imaging performed to establish an initial diagnosis. For an insured with a confirmed cancer diagnosis, the exemption from prospective review applies only to the imaging services specified in 211 CMR 52.07(5)(a)(11) when such imaging is used to stage the confirmed cancer or determine treatment efficacy. The existence of a confirmed cancer diagnosis does not independently exempt imaging performed for other clinical purposes from otherwise applicable prospective review requirements.

Limitations on Use of Prospective Review for Certain Physical, Occupational or Speech Therapy

As noted in 211 CMR 52.07(5)(a)(12), a Carrier shall not require prospective review for physical therapy, occupational therapy, and speech therapy that are provided to an insured in network. The Division expects that physical, occupational, or speech therapy includes those services provided by appropriately licensed therapists according to those services identified in the Current Procedural Terminology for health services for rehabilitative therapy services permitted under a practitioner's license. The Division expects that the therapy is ordered by a treating physician or authorized non-physician practitioner (e.g., Nurse Practitioner, Physician Assistant); (2) the order and medical records detail the patient's current symptoms, preliminary diagnosis, or the suspected condition(s) that is being treated; and (3) claims are submitted with exact ICD-10 codes that directly link the symptoms or condition to the therapy. The Division understands speech therapy to include swallow therapy in relation to this provision.

Limitations on Use of Prospective Review for Pharmaceuticals for Serious Persistent Mental Illness

211 CMR 52.07(5)(a)(13) prohibits a Carrier from requiring prospective review for pharmaceuticals for serious persistent mental illness that are provided to an insured in network.

The Division, in consultation with the Massachusetts Department of Mental Health, defines serious, persistent mental illness, for the purposes of 211 CMR 52.07(5)(a)(13), as a diagnosis of schizophrenia, schizoaffective disorder, severe major depressive disorder, or bipolar disorder in adults ages 18 or older. This limitation on the use of prospective review does not apply to the MassHealth Pediatric Behavioral Health Medication Initiative designed to promote safety of children prescribed psychotropic drugs. The Division and Department of Mental Health expect Carriers to continue to operate consistently with the requirements of MGL c. 176O, s. 12A.

The Division expects that this provision applies only to pharmaceuticals approved by the U.S. Food and Drug Administration for the treatment of, or prescribed for the treatment of, a serious persistent mental illness, and the provision does not extend to all medications prescribed to an insured with such a diagnosis.

The Division expressly recognizes Carriers may need to conduct prospective review necessary for the sole purpose of compliance with U.S. Food and Drug Administration safety actions, risk evaluation and mitigation strategy requirements, product withdrawals, significant new clinical evidence, and other patient

safety considerations that would necessitate changes in coverage. Additionally, it is the Division's expectation that Carriers may still apply prospective review for Schedule II and Schedule III pharmaceuticals as described by the U.S. Drug Enforcement Agency.

Limitations on Use of Prospective Review for Certain Substance Use Disorder Services

As noted in 211 CMR 52.07(5)(a)(13), a Carrier shall not require prospective review for outpatient substance use disorder services that are provided to an insured in network.

The Division expects that substance use disorder services include those services provided by appropriately licensed substance use disorder treatment providers for those services identified in the Current Procedural Terminology for substance use treatment services permitted under a practitioner's license. This includes those services identified in Bulletin 2015-05.

The Division expects that the substance use disorder services are those ordered by a treating physician or authorized non-physician practitioner (e.g., Nurse Practitioner, Physician Assistant); (2) the order and medical records detail the patient's current symptoms, preliminary diagnosis, or the suspected condition; and (3) claims are submitted with exact ICD-10 codes that directly link the symptoms or condition to the substance use disorder treatment.

It is the Division's expectation that Carriers comply with prospective review requirements as outlined in the Division's bulletins, including 2015-05, and M.G.L. sections 47GG of c. 175, 8HH of c. 176A, 4HH of c. 176B, and 4Z of c. 176G. These sections prohibit prospective review for:

- Medically necessary acute treatment services and medically necessary clinical stabilization services for up to a total of 14 days, provided the facility notifies the Carrier of the admission and the initial treatment within 48 hours of admission; and
- Substance abuse treatment, including early intervention services for substance use disorder treatment, outpatient services, including medically assisted therapies,³ intensive outpatient and partial hospitalization service, residential or inpatient services, and medically intensive inpatient services, if the provider is certified or licensed by the Department of Public Health.

Filing Requirement

As set forth above, Carriers shall be expected to file their implementation plans pursuant to this Guidance, which must also include certification of compliance with the amended regulatory requirements and the information set forth in Filing Guidance Notices 2026-J, K, and L. If you have any questions about any of the information in this guidance, please contact Kevin.Beagan@mass.gov or Niels.Puetthoff@mass.gov.

³ For pharmaceuticals used in medically assisted treatment, Carriers may continue to designate preferred products and apply clinically appropriate formulary management consistent with applicable law.