



Guidelines for Medical Necessity Determination for Home Health Services

These Guidelines for Medical Necessity Determination (Guidelines) identify the clinical information that MassHealth uses to determine medical necessity for home health agency services. These Guidelines are based on generally accepted standards of practice, review of medical literature, and federal and state policies and laws applicable to Medicaid programs.

MassHealth Home Health Agency Services providers (“Providers”) should consult MassHealth regulations at [130 CMR 403.000: Home Health Agency](#) and [101 CMR 350.00: Rates for Home Health Services](#) for information about coverage, limitations, service conditions, and prior-authorization (PA) requirements. Providers serving members enrolled in a MassHealth-contracted accountable care partnership plan (ACPP), managed care organization (MCO), One Care organization, Senior Care Options (SCO) plan, or Program of All-inclusive Care for the Elderly (PACE) should refer to the ACPP’s, MCO’s, One Care organization’s, SCO’s, or PACE’s medical policies, respectively, for covered services.

MassHealth requires PA after a certain number of visits (see Section III) for the following home health services provided in the member’s home: intermittent skilled nursing visits, medication administration visits, physical therapy, occupational therapy, speech/language therapy, and home health aide services. MassHealth reviews requests for PA on the basis of medical necessity. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, and program restrictions.

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SECTION I. GENERAL INFORMATION

Home health services are skilled and supportive care services provided in the member’s home to meet skilled care needs and assist with activities of daily living to allow the member to safely stay in their home. Home health services incorporate a wide variety of skilled healthcare and supportive services provided by licensed and unlicensed professionals that assist people with health conditions or disabilities to carry out everyday activities safely. These services are designed to meet the needs of people with acute, chronic, and terminal healthcare conditions who, without this support, might otherwise require services in an acute care or residential facility.

PA determinations are made on an individual, case-by-case basis and in accordance with 130 CMR 403.000 and 101 CMR 350.00.

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SECTION II. CLINICAL GUIDELINES

A. CLINICAL COVERAGE

MassHealth bases its determination of medical necessity for home health services on clinical data including, but not limited to, indicators that would affect the relative risks and benefits of the provision of these services in the member’s home.

1. Home health services must meet the following.
 - a. Determination by the member's physician, podiatrist, or ordering non-physician practitioner as defined at 130 CMR 403.402 ("prescribing practitioner") that the member has a medical condition including, but not limited to, recovering from an acute illness, injury, or surgical procedure; a chronic health condition; an acute and chronic behavioral health illness; a terminal illness; or a disability that requires
 - i. skilled intervention or treatment from a licensed nurse, physical therapist/physical therapy assistant, occupational therapist/occupational therapy assistant, or speech/language therapist in the home;
 - ii. home health aide services under the direction of nursing or rehab services for hands-on assistance for the performance of activities of daily living (ADLs), specifically bathing, grooming, dressing, toileting/continence, transferring, ambulation, and eating, under the direction of nursing or rehab services; or
 - iii. for ADL Supports Only, hands-on assistance throughout the task or until completion with at least two ADLs, specifically bathing, grooming, dressing, toileting/continence, transferring/ambulation, and eating.
 - b. Completion of a comprehensive evaluation of the member by the home health agency's relevant service professional. This evaluation will determine the member's current medical status, disability, level of functioning, health, and psychosocial status and confirm the presence of a condition requiring the need for specific services as designated under the criteria for the specific home health service as described at (3), below;
 - c. Establishment of the prescribing practitioner's plan of care, in consultation with the home health clinician, following the evaluation and initial order of home health services for the member's medical and behavioral condition(s) for home health treatment and services;
 - d. Confirmation that the designated home health provider is certified by DPH and enrolled with MassHealth as a provider of home health services.
2. Coverage of home health services will be based on the following.
 - a. The type of professional services covered will be based on the degree of skill required for the tasks related to the member's medical and behavioral health needs.
 - b. The plan of care demonstrates that the services will
 - i. improve/stabilize the member's condition within a reasonable period of time; and/or
 - ii. maintain, prevent, or slow the worsening of function as a result of the condition.
 - c. The amount, frequency, and duration of services are appropriate based on professionally recognized standards of practice and the length of time required to perform the needed tasks related to the member's condition in 2.b.i.
 - d. Demonstration that services are provided under the care of a licensed practitioner with a written treatment plan that has been developed in consultation with the relevant professional(s).

3. Home Health Service Criteria

a. **TEACHING REQUIREMENTS FOR ALL HOME HEALTH SERVICES**

Teaching must be provided to the member, member's family, or caregiver at every nurse or therapist visit in order to foster independence. Teaching may include how to manage the member's treatment regimen; any ongoing teaching required due to a change in the procedure or the member's condition; and the response to the teaching.

- i. If continued teaching is not reasonable, the member's record must contain sufficient documentation demonstrating that continued efforts to teach the member and/or caregiver were made; that teaching was unsuccessful; and why further teaching is not reasonable.
- ii. For members who had teaching discontinued as a part of their home health care plan, teaching must be resumed if the following occurs.
 - a) There is a break in service of at least 60 days.
 - b) A new service is added to the care plan.
 - c) Teaching is requested by the member or member's caregiver when there is a change that requires new instructions.

b. **INTERMITTENT SKILLED NURSING VISITS**

Intermittent skilled nursing refers to direct skilled nursing services that are needed to provide a targeted skilled nursing assessment and intervention for a specific medical or mental health need, and/or discrete procedures and/or treatments to treat the medical/mental health need. Intermittent skilled nursing visits are typically less than two consecutive hours; are limited to the time required to perform the designated procedures/treatments; and are based on the member's needs, whether the illness or injury is acute, chronic, terminal, or expected to extend over a period of time.

Intermittent skilled nursing services may be considered medically necessary when the member's medical/mental health condition requires one or more of the following.

- i. Evaluation of nursing care needs
- ii. Development and implementation of a nursing care plan and provision of services that require the following specialized skills of a nurse.
 - a) Making a skilled assessment, including observing signs and symptoms
 - b) Performing skilled nursing interventions, including administering skilled treatments ordered by the prescribing practitioner
 - c) Assessing member response to treatment and medications
 - d) Communicating changes in medical status to the prescribing practitioner
 - e) Administering intravenous medications or other infusions due to the complexity of care and the time required to complete the infusion
 - f) Educating the member and caregiver

Intermittent skilled nursing services can be provided when the member requires treatment at a level of complexity and sophistication that can only be safely and effectively performed by a professional licensed registered nurse or a licensed practical nurse working under the supervision of a registered nurse.

In addition to the regularly ordered skilled nursing services, as needed or *pro re nata* (PRN) visits can be requested. PRN visits are approved, modified, or simply not authorized, depending on the clinical documentation submitted.

Medication administration may occur as part of an intermittent skilled nursing visit for the purpose of the administration of medications ordered by the prescribing practitioner that generally require the skills of a licensed nurse to perform or teach a member or caregiver to perform independently. Again, visits solely for intravenous medication and/or infusion administrations could be an appropriate intermittent skilled nursing visit due to the time required to complete the task(s) and the skilled nature of the task(s).

c. MEDICATION ADMINISTRATION NURSING VISITS

A medication administration visit (MAV) is a nursing visit that is: 1) ordered by the prescribing practitioner; and 2) where the primary purpose of the visit is the nursing intervention of administering medications and assessing the member's response to those administered medications. MAVs do not include intravenous medication or infusion administrations that, in accordance with b. above, are properly categorized as an intermittent skilled nursing visit.

- i. Medication administration services may be considered medically necessary when
 - a) medication administration is prescribed to treat a medical or behavioral health condition;
 - b) a member has no able caregiver present;
 - c) the task requires the skills of a licensed nurse; and
 - d) at least one of the following conditions apply.
 - 1) The member is unable to perform the task due to impaired physical or cognitive issues, or behavioral and/or emotional issues.
 - 2) The member has a history of failed medication compliance resulting in a documented exacerbation of the member's condition.
- ii. An MAV visit includes administration of the medication; documentation of that administration; observing for medication effects, both therapeutic and adverse; reporting adverse effects to the ordering practitioner; and soliciting and addressing whatever questions or concerns the member may have.
- iii. Intramuscular, subcutaneous, or other injectable medication administrations can be categorized on their own as medication administration visits, except for anti-psychotic injectables that require an intermittent skilled visit due to the complexity of the member's diagnosis and the effects of these types of medications.
- iv. Medication administration routes other than intravenous, intramuscular, and/or subcutaneous, including enteral, intranasal, or topical, will be considered as a medication administration visit only when the conditions in 3.c.v are met.
- v. Certain medication administration tasks do not require the skills of a licensed nurse, unless the complexity of the member's condition or medication regimen requires the observation and assessment of a licensed nurse to safely perform. Such conditions include the following.
 - a) Administration of oral, aerosolized, eye, ear, and topical medication, which requires the skills of a licensed nurse only when the complexity of the condition(s) and/or nature of the medication(s) require the skilled observation and assessment of a licensed nurse and/or the member/caregiver is unable to perform the task.

- b) Filling of weekly/monthly medication box organizers, which requires the skills of a licensed nurse only when the member/caregiver is unable to perform the task.
- vi. Members receiving medication administration visits must be provided, at a minimum, one skilled nursing visit (separate from the MAV) every 60 days to assess the plan of care and the member's ongoing need for medication administration visits. Home health providers must request any additional skilled nursing visits along with their request for medication administration visits. The authorized number of skilled nursing visits will be determined by medical necessity and submitted supporting documentation.
- vii. Documentation of Medication Administration Documentation requirements include, at a minimum,
 - a) the time of the visit;
 - b) drug identification, dose, and route/or reference to the member's medication profile, as ordered by the prescribing practitioner;
 - c) teaching, as applicable;
 - d) the member's response to the medication(s); and
 - e) the signature of the licensed nurse administering the medication, along with printed name, date, and time.

d. PHYSICAL THERAPY

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 or maintain functional levels. Physical therapy services may be considered medically necessary when

- i. the member presents signs and symptoms of physical deterioration, impairment, or illness and requires treatment from a physical therapist, including evaluation; therapeutic intervention; member and caregiver training in a home program; and communicating changes in functional status to the prescribing practitioner; or
- ii. the member's condition requires treatment of a level of complexity and sophistication that can only be safely and effectively performed by a licensed physical therapist (PT) or a physical therapy assistant (PTA) under the supervision of a PT.

A PT may also supervise the work of home health aides (HHAs) following an established plan of care if the member needs a skilled physical therapist.

e. OCCUPATIONAL THERAPY

Occupational therapy programs are designed to improve quality of life by recovering competence and preventing further injury or disability, and to improve or maintain the member's ability to perform tasks required for independent functioning, so the member can engage in activities of daily living.

Occupational therapy services may be considered medically necessary when the following occurs.

- i. The member presents signs and symptoms of functional impairment/injury and requires treatment from an occupational therapist, including evaluation; therapeutic intervention; member and caregiver training in a home program; and communicating changes in functional status to the prescribing physician.

- ii. The member's condition requires treatment of a level of complexity and sophistication that can only be safely and effectively performed by a licensed occupational therapist (OT) or a licensed occupational therapy assistant (OTA) supervised by an OT.

An OT may also supervise the work of home health aides (HHAs) following an established plan of care if the member has a skilled OT need.

f. SPEECH-LANGUAGE THERAPY

Speech-language therapy programs are designed to treat disorders that affect articulation of speech, impaired comprehension, communication, and/or swallowing. Speech-language therapy may be considered medically necessary when the following occurs.

- i. The member presents with a communication disorder with functional difficulty and/or swallowing disorder and requires treatment from a speech-language therapist, including diagnostic evaluation; therapeutic intervention; member and caregiver training in a home program; and communicating changes in functional status to the prescribing physician.
- ii. The member's condition requires treatment of a level of complexity and sophistication that can only be safely and effectively performed by a licensed speech-language pathologist (SLP).

An SLP may also supervise the work of HHAs following an established plan of care if the member has a skilled speech-language need.

g. HOME HEALTH AIDE SERVICES

HHAs are trained personnel who provide personal care and/or assist members following an established plan of care ordered by the prescribing practitioner and member-specific home health aide care instructions created by the RN or therapist supervising the HHA.

h. HHA SERVICES PROVIDED CONCURRENTLY WITH SKILLED NURSING SERVICES OR HOME HEALTH THERAPY SERVICES

HHA services may be considered medically necessary when the member's medical condition or cognitive and/or psychological limitations prevent them from performing one or more of the following.

- i. Activities of daily living and/or personal care services
- ii. Activities that are directly supportive of skilled nursing, physical, occupational, or speech-language therapy, as identified in the plan of care
- iii. Verbal medication reminders for medications that are ordinarily self-administered and do not require the skills of a registered or licensed nurse
- iv. Simple dressing changes that do not require the skills of a nurse
- v. Routine care of prosthetic and orthotic devices
- vi. Instrumental activities of daily living (IADL) support services provided incidental to hands-on ADL assistance

The tasks performed by a home health aide for the member must not require treatment of a level of complexity and sophistication that can only be safely and effectively performed by a licensed professional.

i. **HOME HEALTH AIDE SERVICES FOR ADL SUPPORTS ONLY**

HHA services provided for ADL support require a skilled nursing/therapy visit for assessment of the member and assessment and supervision of the home health aide care plan only once every 60 days. These HHA services may be considered medically necessary when the member's medical or behavioral health condition requires any form of hands-on assistance for successful task completion, with at least two ADLs. Qualifying ADLs for this requirement are bathing, grooming, dressing, toileting/continence, transferring/ambulation, and eating.

A home health agency may request authorization for additional personal care services if 1) the member meets medical necessity for HHA services provided for ADL support only, and 2) the services are medically necessary to maintain the member's health or to facilitate treatment of the member's injury or illness; or the services are provided incidental to the member's ADL supports.

B. NONCOVERAGE

MassHealth does not consider home health services to be medically necessary under certain circumstances. Examples of such circumstances include, but are not limited to, the following.

1. The service replicates concurrent services provided in a different setting with similar treatment goals, plans, and therapeutic modalities.
2. The service replicates concurrent services provided by a different provider in the same setting with similar treatment goals, plans, and therapeutic modalities.
3. The services are primarily educational, emotional, or psychological in nature and provided in a school or behavioral health setting.
4. The services are more appropriately provided in a setting other than the member's home, or the member's need is such that home-based services will not meet the need.
5. The condition(s) do(es) not require the level of professional care requested, or the need can be met with a lower level of service.
6. The treatment is for a dysfunction that is self-correcting or developmental in nature and could reasonably be expected to improve without treatment.
7. The services of a licensed nurse are limited to filling or assisting the member in filling daily medication box organizers on a daily basis, except as covered under Section II.A.3.c.v.b).
8. Maintenance of functional skills that do not require the level of sophistication and training of a licensed PT, OT, or SLP.
9. The purpose of the treatment is educationally, vocationally, or recreationally based.
10. There is no clinical documentation or treatment plan to support the need for the service or continuing the service.
11. Services are considered research or experimental in nature.

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SECTION III. PRIOR AUTHORIZATION FOR HOME HEALTH SERVICES

Prior authorization (PA) is required for home health services for all members after a certain number of visits within a specific period of time. Requests for PA for home health services must be submitted by an enrolled MassHealth home health agency provider.

Agencies should not wait until the service thresholds are met before submitting a PA request. The MassHealth agency may take up to 21 days to act on a request for PA for home health services. See 130 CMR 450.303(A). If there is an urgent need for PA, the provider may submit a PA through the LTSS Provider Portal at www.MassHealthLTSS.com; indicate that the PA needs to be expedited; and explain the medical necessity for expediting the PA request in the Provider Online Service Center (POSC).

The guidelines for requesting PA for home health services are as follows.

- A.** For skilled nursing visits, MAVs, therapy services, and home health aide services provided concurrently to any skilled nursing or therapy services must include the following attachments.
 - 1. Completed PA request in the LTSS Provider Portal
Urgent PA requests may also be submitted by calling or e-mailing the provider support center;
 - 2. Signed Plan of Care or unsigned Plan of Care with documentation of the verbal order;
 - 3. For initial PA requests, an initial assessment note;
 - 4. For PA requests, at least three visit notes per home health service being requested. Submitted visit notes may not be dated more than 30 calendar days from the requested start date for the PA.
- B.** Home health agencies must submit PAs for new home health admissions in a timely way and no less than 21 days before the PA gets triggered, in order to avoid claim denials. See 130 CMR 403.410. Below are the specific PA criteria for each home health service.
 - 1. For skilled nursing and MAVs, PA is required whenever the services provided exceed more than 30 intermittent skilled nursing and/or MAVs in aggregate in a calendar year.
 - 2. For all home health aide services, PA is required whenever services provided exceed 240 units in a calendar year. HHA PA must also be submitted whenever one of the following services exceed PA requirements: skilled nursing, medication administration, or any therapy service.
 - 3. A provider may request a combination of skilled nursing visits, medication administration, or home health aide visits on one PA request.
 - 4. For therapy services, PA is required as follows.
 - a) Physical therapy after 20 visits in a calendar year
 - b) Occupational therapy after 20 visits in a calendar year
 - c) Speech-language therapy after 35 visits in a calendar yearAll PA requests for physical therapy, occupational therapy, and speech-language therapy must be submitted by the therapist/designee. For further guidance, please refer to the MassHealth Guidelines for Medical Necessity Determination for the specific therapy service.

- C.** For members with existing PAs, the following guidelines apply to home health agencies.
1. Submit new requests 21 days before the authorized end date. Services will not be approved retroactively if requests are submitted after the PA expires. This guideline does not apply in the following circumstances.
 - a. For transfers from another agency, the accepting agency needs to submit a new PA that complies with the requirements of Section III.A. within one week from the start of care, unless otherwise authorized by MassHealth.
 - b. Agencies serving members who require PA to begin a new episode of home health services must submit a new PA request that complies with the requirements of Section III.A. within one week from the start of care, unless otherwise authorized by MassHealth.
 2. If a member receiving skilled nursing visits is discharged from a hospital or other inpatient facility and meets the conditions described in 130 CMR 403.423 (G), the home health provider may submit the member's discharge details to MassHealth or its designee in order to return to the higher rate applied to services provided within the first 30 days of skilled nursing home health services. Requests to return to the higher rate for skilled nursing services must be submitted within four weeks of the member's discharge for review on a case-by-case basis.
- D.** If authorized services need to be adjusted because the member's condition has changed, the home health agency needs to submit a new PA in the LTSS Provider Portal, explaining the medical necessity for adjusted services.
- E.** MassHealth reserves the right to exercise its clinical discretion to waive certain PA requirements, including, but not limited to, the documentation needed to start or resume services.

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SECTION IV. CLINICAL DOCUMENTATION GUIDELINES AND SUBMISSION

Requests for PA for home health services must be accompanied by clinical documentation, including the individual plan of care certifying the medical necessity of the service from the designated provider. Note that the provider signing off on the plan of care must not be on the staff of or under contract with the requesting home health agency.

The following are guidelines for submitting clinical documentation.

- A.** Documentation of medical necessity for all home health services must include the applicable PA type, completed in its entirety, in the LTSS Provider Portal, including the following.
1. The primary diagnosis name and ICD-CM code for which service is being requested.
 2. The secondary diagnosis name and ICD-CM code specific to the medical or mental health condition if different from above.
 3. The severity of the signs and symptoms pertinent to the primary diagnosis.
 4. A written comprehensive assessment of the member's condition containing the following.
 - a. Medical history, including underlying medical diagnosis; description of the medical

condition, including date of onset or exacerbation; medical status; disability; previous functional level (if relevant); and psychosocial status.

- b. Treatment history and documented progress with past treatment, if applicable.
- c. Results of standardized assessment and/or an objective and subjective description of the member's current level of functioning.
- d. Identified need for treatment/intervention and plan of care, including need for further assessment or referral, prognosis, and expectation for change in level of functioning with and without intervention.
- e. The member's rehabilitation potential, including any risk factors or comorbid conditions affecting the treatment plan.

B. The following clinical documentation is required for the home health services specified below, in addition to the information required in Section IV(A).

- 1. If requesting MAVs, provide rationale to support the member/caregiver's inability to administer medications independently. In addition, include the number of intermittent skilled nursing visits anticipated, supported by documentation of the member's medical history and complexity of care, history of re-hospitalizations, history of frequent medication changes, and need for extensive observation and assessment.
- 2. If requesting therapy services, provide a written treatment plan with recommendations for intervention, including all of the following.
 - a. Specific measurable functional treatment goals
 - b. Treatment types, techniques, and interventions to be used to achieve goals
 - c. Amount, frequency, and duration of treatment that is consistent with the member's current medical and functional needs and required to achieve goals
 - d. The types of services, supplies, and equipment ordered
 - e. Safety measures to prevent injury
 - f. Education of the member and caregivers to promote awareness and understanding of diagnosis, prognosis, and treatment
 - g. A summary of all treatment provided and results achieved (response to treatment, changes in the member's condition, documentation of measurable progress toward previously defined goals, problems encountered, and goals met) during previous periods of therapy
 - h. Discharge plans
 - i. For members receiving therapy services in another setting, requests for additional services must be for substantially different treatment from that currently being received. Justification for additional services must include not only the medical basis for the services, but also the goals for the additional therapy.
- 3. If requesting intermittent skilled nursing services, provide a licensed practitioner plan of care with recommendations for intervention, including all of the following.
 - a. All pertinent diagnoses, including the member's mental status

- b. Types of services, supplies, and equipment ordered
 - c. The amount, frequency, and duration of the visits to be made
 - d. The prognosis, rehabilitation potential, functional limitations, and permitted activities
 - e. Nutritional requirements, medications, and treatments
 - f. Safety measures to prevent injury
 - g. Teaching activities to be conducted by the nurse to teach the member and caregivers how to manage the member's treatment regimen or, if teaching is not reasonable, supporting documentation
 - h. Discharge plans
 - i. Additional items that the home health agency or licensed practitioner chooses to include
4. For home health aide services for ADL supports, the following attachments must be included.
- a. Members new to home health services
 - 1. Completed LTSS Provider Portal PA request
 - 2. Signed plan of care or unsigned plan of care with a documented verbal order
 - 3. The initial assessment visit note conducted by an RN or therapist, including a list of home health aide tasks that the member needs
 - 4. For members 21 and older and all members enrolled in an HCBS waiver, a [Completed Member Connection Form](#) (MCF) with proof of delivery
 - 5. Member-specific discharge plans (may be included in the initial assessment visit note)
 - b. Members receiving HHA services with nursing/therapy who are switching to only HHA services for hands-on assistance with ADLs
 - 1. Completed LTSS Provider Portal PA request
 - 2. Signed plan of care or unsigned plan of care with a documented verbal order
 - 3. For members 21 and older and all members enrolled in an HCBS waiver, a completed MCF with proof of delivery
 - 4. Member-specific discharge plans reviewed and updated as applicable
 - 5. Three recent home health aide visit notes and, if applicable, three recent nursing/therapy visit notes
 - 6. Plan of care for HHA services created by the aide's supervising RN
 - c. Members requiring a renewed authorization of HHA services for hands-on assistance with ADLs
 - 1. Completed LTSS Provider Portal PA request
 - 2. Signed plan of care or unsigned plan of care with a documented verbal order
 - 3. Member-specific discharge plans reviewed and updated as applicable
 - 4. One week of home health aide notes
 - 5. The most recent RN visit note
 - 6. Plan of care for HHA services created by the aide's supervising RN

5. If requesting an HHA service where the HHA is a legally responsible relative for the member who is to receive the HHA services, documentation of the aide's completion of a home health aide training and competency evaluation program that meets the requirements in 42 CFR 484.80 must be entered in the LTSS Provider Portal and submitted with the PA request.
- C. Clinical information submission: Clinical information must be submitted by a MassHealth home health provider. Providers are strongly encouraged to submit PA requests electronically. Providers must submit all information pertinent to the diagnosis using the appropriate PA Request Type in the LTSS Provider Portal, or by completing a MassHealth Prior Authorization Request (PA-1) form and attaching pertinent documentation. The PA-1 form can be found at mass.gov/how-to/request-prior-authorization-for-nonpharmacy-services. If submitting a non-electronic request, the PA-1 form and the Request and Justification form are required; mail these forms and any supporting documentation to the address on the back of the PA-1 form. Call the LTSS Provider Service Center toll-free at (844) 368-5184 with any questions about portal access.

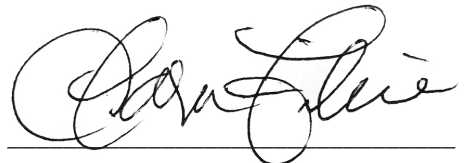
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These Guidelines are based on review of the medical literature and current practice in home health services. MassHealth reserves the right to review and update the contents of these Guidelines and cited references as new clinical evidence and medical technology emerge. This document may also be updated from time to time to reflect MassHealth administrative updates.

This document was prepared for medical professionals to assist them in submitting documentation supporting the medical necessity of the proposed treatment, products, or services. Some language used in this communication may be unfamiliar to other readers; in this case, those readers should contact their healthcare provider for guidance or explanation.

Revised Policy Effective: March 26, 2024

Approved by: _____



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Supersedes policy dated October 2, 2024