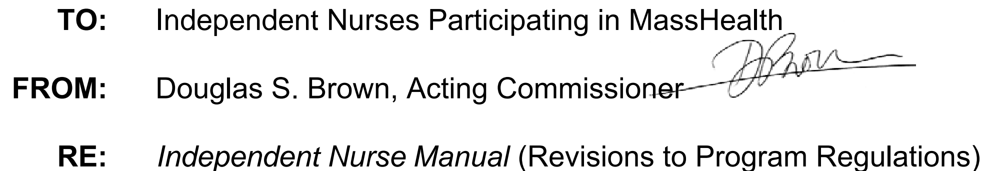
Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER IN-23
July 2003



TO: Independent Nurses Participating in MassHealth

FROM: Douglas S. Brown, Acting Commissioner

RE: *Independent Nurse Manual* (Revisions to Program Regulations)

This letter transmits revisions to the private duty nurse program regulations in Subchapter 4 and service codes and descriptions in Subchapter 6. These revisions are effective for dates of service on or after August 1, 2003.

Revisions to Regulations

The Division has made several changes to program regulations. The title of the *Private Duty Nurse* M*anual* has been changed to the *Independent Nurse* M*anual*. The private duty nurse service is now referred to as "nursing."

A. Case Management for Complex-Care Members

Revisions to the regulations include case management of MassHealth members under the age of 22, whom the Division refers to as complex-care members.

Beginning August 1, 2003, the Division or its designee will enroll these members in case management and assign each member a case manager who will perform a comprehensive needs assessment and authorize all medically necessary nursing services for the complex-care member. You will be able to identify these members through the Recipient Eligibility Verification System (REVS).

For new referrals for nursing services for MassHealth members under age 22 or questions about complex-care members, you must call the Division's designee on or after August 1, 2003, at 1-800-863-6068 for case management and authorization.

There are no changes to the assessment or authorization process for nursing services for members aged 22 or older.

B. Multiple Providers

A revision to the PA section of these regulations addresses the situation where more than one provider is authorized to provide nursing services to an individual MassHealth member. Please refer to 130 CMR 414.412(A)(4) for more detailed instructions.

C. Unused Hours

If there are unused hours of nursing services in a calendar week, they may be used at any time during the current authorization period.

D. Limit of Nursing Hours

An individual nurse will not be approved for a total of more than 60 hours of nursing care provided during any consecutive seven-day period.

Revisions to the Service Codes and Descriptions

The Centers for Medicare and Medicaid Services (CMS) have revised the Healthcare Common Procedure Coding System (HCPCS) for 2003. New national service codes have been added and MassHealth local service codes have been deleted from Subchapter 6 of the *Independent Nurse Manual*. You must use a modifier with some codes to accurately reflect the service provided. The attached Subchapter 6 contains codes with modifiers, where applicable. Please note that the new national service codes are in units of 15-minute increments. These revisions are effective for dates of service on or after August 1, 2003.

Billing for nursing services has been simplified. All applicable MassHealth local service codes have been replaced with new national service codes.

A. Weekend and Holiday Nursing Services

Providers will no longer need to bill distinct service codes for weekend or holiday nursing services. Providers will bill the applicable service code without specific reference to "weekend" or "holiday." Payment for nursing services provided on weekends and holidays will be made automatically in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP). Providers must use a service code that accurately reflects the nursing service that was provided.

Providers must use a separate line when billing for weekend or holiday nursing services. If you are billing for weekday nursing services on the same claim form as weekend nursing services, weekday nursing services must be on a separate claim line than weekend nursing services. Holiday nursing services must also be on a separate claim line.

- Holiday — all official Commonwealth of Massachusetts holidays: New Year's Day, Martin Luther King Day, Washington's Birthday, Patriots' Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, and Christmas Day.
- Weekend — Saturday and Sunday.

B. New and Current Prior Authorizations

Effective for dates of service on or after August 1, 2003, all new requests for PA must be submitted using the new national service codes from the revised Subchapter 6. For dates of service from August 1, 2003, through October 15, 2003, providers who have received approval for nursing services under the old local code system may continue to bill, during the approval period of their PA, using the old local service codes. For dates of service beginning October 16, 2003, providers must use the new national service codes from the revised Subchapter 6 that correspond to the old local service codes on the approved PA.

Providers are not required to do anything to convert their approved PA numbers due to the MassHealth transition to national service codes. Previously approved PAs with expiration dates on or after October 16, 2003, will be adjusted by the Division to reflect the appropriate new national service codes.

Modifiers are not required on a PA form. However, you must use the applicable modifier with claims submission.

C. Attachments

Please see the attached crosswalk of the new national service codes and modifiers, which can be found in Subchapter 6, and the obsolete MassHealth local service codes.

Please see the attached claim form examples using new national service codes and modifiers for nursing services.

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

Independent Nurse Manual

Pages iv, vi, vii, 4-1 through 4-12, and 6-1 and 6-2

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

Private Duty Nurse Manual

Pages iv, 4-3, and 4-4 — transmitted by Transmittal Letter PDN-22

Pages vi, 4-1, 4-2, 4-5 through 4-10, and 6-1 and 6-2 — transmitted by Transmittal Letter PDN-21

Pages vii and vii-a — transmitted by Transmittal Letter PDN-1

Billing Guidelines for Independent Nurses

Each line in the table below must be billed on a separate claim line in order to receive appropriate reimbursement. You may span dates of service (bill From-Through) for all similar services that were provided within one line of this table.

Regular services (non-overtime):

- Day services provided Monday-Friday (weekday)
- Day services provided Saturday-Sunday (weekend)
- Night services (all days of the week)
- Holiday services

Overtime services:

- Overtime day services (non-holiday) provided Monday-Friday (weekday)
- Overtime day services (non-holiday) provided Saturday-Sunday (weekend)
- Overtime night services (non-holiday) (all days of the week)
- Overtime holiday services

Type of Nurse	# Patients seen	When service was provided *If properly billed on separate claim lines, holiday and weekend services will be automatically recognized.*						New service code – modifier to be billed	Comments *Please note the change in units: effective 09/01/2003, bill in 15-minute increments for the new service code/modifier.*	Obsolete DMA service code
		Day	Night	Mon-Fri	Sat-Sun	Holiday	Overtime			
RN	1	X		X				T1002	Mon-Fri, day	X9570
RN	1		X	X				T1002-UJ	Mon-Fri nights and/or weekends (any time of day)	X9572
RN	1		X		X			T1002-UJ		
RN	1	X			X			T1002		
RN	1		X	X			X	T1002-U4	Nights OT and/or weekend OT	X9596
RN	1		X		X		X	T1002-U4		
RN	1	X			X		X	T1002-TU		
RN	1	X		X			X	T1002-TU	Mon-Fri, day, OT	X9594
RN	1					X	X	T1002-TU	Holiday OT	X9598
RN	1					X		T1002	Holiday	X9574
RN	2	X		X				T1002-TT	Mon-Fri, day, 2:1 Bill per member.	X9578
RN	2		X	X				T1002-U1	Mon-Fri nights and/or weekends (any time of day), 2:1 Bill per member.	X9580
RN	2		X		X			T1002-U1		
RN	2	X			X			T1002-U1		
RN	2					X		T1002-TT	Holiday, 2:1 Bill per member.	X9582
RN	3	X		X				T1002-U2	Mon-Fri, day, 3:1 Bill per member.	X9560

Type of Nurse	# Patients seen	When service was provided *If properly billed on separate claim lines, holiday and weekend services will be automatically recognized.*						New service code – modifier to be billed	Comments *Please note the change in units: effective 09/01/2003, bill in 15-minute increments for the new service code/modifier.*	Obsolete DMA service code
		Day	Night	Mon-Fri	Sat-Sun	Holiday	Overtime			
RN	3		X	X				T1002-U3	Mon-Fri nights and/or weekends (any time of day), 3:1 Bill per member.	X9561
RN	3		X		X			T1002-U3		
RN	3	X			X			T1002-U3		
RN	3					X		T1002-U2	Holiday, 3:1 Bill per member.	X9562
LPN	1	X		X				T1003	Mon-Fri, day	X9571
LPN	1		X	X				T1003-UJ	Mon-Fri nights and/or weekends (any time of day) Please note: bill using new 15-minute units	X9573
LPN	1		X		X			T1003-UJ		
LPN	1	X			X			T1003		
LPN	1		X	X			X	T1003-U4	Nights OT and/or weekend OT	X9597
LPN	1		X		X		X	T1003-U4		
LPN	1	X			X		X	T1003-TU		
LPN	1	X		X			X	T1003-TU	Mon-Fri, day, OT	X9595
LPN	1					X	X	T1003-TU	Holiday OT	X9599
LPN	1					X		T1003	Holiday	X9575
LPN	2	X		X				T1003-TT	Mon-Fri, day, 2:1 Bill per member.	X9579
LPN	2		X	X				T1003-U1	Mon-Fri nights and/or weekends (any time of day), 2:1 Bill per member.	X9581
LPN	2		X		X			T1003-U1		
LPN	2	X			X			T1003-U1		
LPN	2					X		T1003-TT	Holiday, 2:1 Bill per member.	X9583
LPN	3	X		X				T1003-U2	Mon-Fri, day, 3:1 Bill per member.	X9563
LPN	3		X	X				T1003-U3	Mon-Fri nights and/or weekends (any time of day), 3:1 Bill per member.	X9564
LPN	3		X		X			T1003-U3		
LPN	3	X			X			T1003-U3		
LPN	3					X		T1003-U2	Holiday, 3:1 Bill per member.	X9565

Examples of Completed Paper Claim Forms (claim form no. 9)

This attachment has examples of completed paper claims using the new national service codes for MassHealth nursing services, which were formerly known as private duty nursing services.

For assistance with a billing situation not explained in these examples, contact MassHealth Provider Services at 1-800-325-5231 or 617-628-4141.

REMINDERS:

- The new national service codes for nursing are effective for dates of service on or after August 1, 2003. Please refer to Subchapter 6 of your provider manual for a listing of the new national service codes for nursing.
- The new national service codes are units of 15-minute increments (1 unit = 15 minutes).
- You must use the applicable modifier with claims submission. Please refer to Subchapter 6 for a listing of the modifiers and definitions.
- Payment for nursing services provided on the “weekend” and “holiday” will be made automatically in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP). However, you must use a separate line on the claim form when billing for weekend or holiday nursing services.
- When you are billing multiple patient nursing services, you must bill a separate claim for each member.
- If you have received a PA for nursing services under the old local code system, you may continue to bill during the approval period of your PA using the old local service codes for dates of service on or before October 15, 2003. For dates of service beginning October 16, 2003, you must use the new national service codes. If you have a PA with an expiration date on or after October 16, 2003, it will be adjusted by the Division to reflect the appropriate new national service codes.

Example (A) – consecutive billing for day

In this example, a registered nurse requests payment for four and a half hours per day of nursing services provided Monday through Thursday (8A.M. to 12:30P.M.).

Four and a half hours per each date of service equals 18 units per day.
Monday through Thursday (four days) equals 72 units.

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	26. DATE OF SERVICE TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO DIAG.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	08 04 03	08 07 03	Registered Nurse Services	T1002			72	$	$
B									
C									
D									
E									

New national code: T1002 – RN services, up to 15 minutes (day)

Example (B) – consecutive billing for night

In this example, a licensed practical nurse requests payment for eight hours per night of nursing services provided Tuesday through Thursday (3P.M. to 11P.M).

Eight hours per each date of service equals 32 units per night.
Tuesday through Thursday (three days) equals 96 units.

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	26. DATE OF SERVICE TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO DIAG.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	08 05 03	08 07 03	Licensed Practical Nurse Services	T1003UJ			96	$	$
B									

New national code: T1003-UJ – LPN/LVN services, up to 15 minutes (night)

Example (C) – billing for weekend

In this example, a licensed practical nurse requests payment for six hours per day of nursing services provided Saturday and Sunday. On Saturday the nurse provides six hours (7 A.M. to 1 P.M.). On Sunday the nurse provides eight hours (12 P.M. to 8 P.M.).

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	26. DATE OF SERVICE TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO EMPL.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	080203	080303	Licensed Practical nurses Services	T1003			36	$	$
B	080303		Licensed Practical Nurses Services	T1003 UJ			20		
C									

New national code: T1003 – LPN/LVN services, up to 15 minutes (day)
T1003-UJ – LPN/LVN services, up to 15 minutes (night)

Line (A) on the claim form: day nursing services on the weekend
Saturday is six hours of day nursing and Sunday is three hours of day nursing (total of nine hours of day nursing), which equals 36 units

Line (B) on the claim form: night nursing service on the weekend
Sunday equals five hours of night nursing, which equals 20 units

Please Note: Payment for weekend rate is automated to reimburse in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP).

Example (D) – billing for holiday

In this example, a registered nurse requests payment for four hours and 15 minutes, which equals 17 units of nursing services (8 A.M. to 12:15 P.M.) for the December 25, 2003, holiday.

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	26. DATE OF SERVICE TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO EMPL.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	122503		Registered Nurse Services	T1002			17	$	$
B									

New national code: T1002 – RN services, up to 15 minutes (day)

Please Note: Payment for holiday rate is automated to reimburse in accordance with applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP).

Example (E) – billing for weekday and nights and weekend

In this example, a registered nurse requests payment for six hours of nursing services per day (9 A.M. to 3 P.M.) and two hours per night (3 P.M. to 5 P.M.) for Monday, Wednesday, and Thursday. The registered nurse also request payment for six hours per day (8 A.M. to 2 P.M.) for Saturday and Sunday.

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	26. DATE OF SERVICE TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO DIAG.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	08 11 03	08 15 03	Registered Nurse Services	T1002			72	$	$
B	08 11 03	08 15 03	Registered Nurse Services	T1002 UJ			24		
C	08 16 03	08 17 03	Registered Nurse Services	T1002			48		

New national code: T1002 – RN services, up to 15 minutes (day)
T1002-UJ – RN services, up to 15 minutes (night)

Line (A) on the claim form: day nursing services during the week
Six hours for each day equals 24 units per day.
Day hours for Monday, Wednesday, and Thursday (three days) equal 72 units.

Line (B) on the claim form: night nursing services during the week
Two hours for each date of service equals 16 units per night.
Night hours for Monday, Wednesday, and Thursday (three days) equal 48 units.

Line (C) on the claim form: day nursing service on the weekend
Six weekend hours per date of service equals 24 units per day.
Day hours for Saturday and Sunday (two days) equal 48 units.

Please Note: Billing for nursing services provided on the weekend must be on a separate claim line from weekday nursing services.

Example (F) - billing for multiple-patient (nursing care provided simultaneously to two patients)

In this example, a registered nurse requests payment for four hours per day Monday through Saturday. The registered nurse also requests payment for five hours at night on Sunday.

Patient One:

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO INDIV.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	08 04 03	08 08 03	Registered nurse Services	T1002TT			80	$	$
B	08 09 03		Registered nurse Services	T1002TT			16		
C	08 10 03		Registered nurse Services	T1002U1			20		

Patient Two:

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO INDIV.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	08 04 03	08 08 03	Registered nurse Services	T1002 TT			80	$	$
B	08 09 03		Registered nurse Services	T1002TT			16		
C	08 10 03		Registered nurse Services	T1002U1			20		

New national code: T1002-TT – RN services, up to 15 minutes (day) (one nurse to two patients)
T1002-U1 – RN services, up to 15 minutes (night) (one nurse to two patients)

Line (A) on the claim form: day nursing services during the week
Four hour per day equals 16 units per day.
Monday through Friday (five days) equals 80 units.

Line (B) on the claim form: day nursing services on the weekend (Saturday)
Four hours per day equals 16 units per day.
Saturday (one day) equals 16 units.

Line (C) on the claim form: night nursing services on the weekend (Sunday)
Five hours per day equals 20 units per day.
Sunday (one day) equals 20 units total.

Please note: when billing for multiple-patient nursing services, you must bill a separate claim form for each member. Also in this example, billing for Saturday and Sunday are on separate lines because of night and day billing modifiers.

Example (G) – billing for day and night nursing service on the same day

In this example, a licensed practical nurse requests payment for three and a half hour of nursing services for a Monday (1:30 P.M. to 5 P.M.).

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25. LIN	26. DATE OF SERVICE FROM	26. DATE OF SERVICE TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO DIAG.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT
A	0 8 2 5 0 3		Licensed Practical Nurse Services	T1003		6		$	$
B	0 8 2 5 0 3		Licensed Practical Nurse Services	T1003 UJ		8			
C									

New national code: T1003 – LPN/LVN services, up to 15 minutes (day)
T1003-UJ – LPN/LVN services, up to 15 minutes (night)

Line (A) on the claim form: day nursing service during the week
One and a half hours for Monday during the day (1:30 P.M. to 3 P.M.) equals 6 units.

Line (B) on the claim form: night nursing service during the week
Two hours for Monday during the night (3 P.M. to 5 P.M.) equals 8 units.

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

Each manual in the series contains administrative regulations, billing regulations, program regulations, service codes and descriptions, billing instructions, and general information. The Division's 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. Regulations promulgated by the Division of Medical Assistance 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 independent nurses, those matters are covered in 130 CMR Chapter 414.000, reproduced as Subchapter 4 in the *Independent Nurse 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 the Division's effort to give each provider a single convenient source for the essential information providers need in their routine interaction with the Division and with MassHealth members.

414.401: Introduction

The regulations in 130 CMR 414.000 state the requirements for the reimbursement of nursing services provided by an independent nurse participating in MassHealth. These regulations apply to nurses who contract independently with MassHealth.

414.402: Definitions

The following definitions used in 130 CMR 414.000 have the meanings given in this section unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 414.402 is not determined by these definitions, but by the application of regulations elsewhere in 130 CMR 414.000 and in 130 CMR 450.000.

Calendar Week — seven consecutive days.

Case Manager — a registered nurse employed by the Division or its designee to provide case management to complex-care members, to work cooperatively with that member, his or her family and primary caregiver(s), and all relevant providers.

Clinical Criteria — professionally recognized health-care need standards by which the Division or its designee determines the medical necessity for nursing services.

Clinical Outcome — the consequence of nursing intervention.

Community Long-Term-Care (CLTC) Services — certain MassHealth-covered services intended to enable a complex-care member to remain in the community which include, but are not limited to, home health, durable medical equipment, oxygen and respiratory equipment, personal-care attendant, and other health-related services as determined by the Division or its designee.

Complex-Care Member — a MassHealth member, under the age of 22 at enrollment, whose medical needs, as determined by the Division or its designee, are such that he or she requires a nurse encounter of more than two continuous hours of nursing services to remain in the community.

Data Base — a component of the health-care record, the data base is the sum total of all health-related information about the member (for example, the data base includes medical and nursing-care histories as well as physician physical examination and nursing-assessment results).

Emergency — the unexpected onset of symptoms or a condition requiring immediate medical or surgical care, including, but not limited to, heart attack, stroke, poisoning, convulsions, loss of consciousness, and cessation of breathing.

Health-Care Record — a collection of data that includes biographical information and the data base related to the member.

Health-Care Team — a group of individuals with various professional skills who work together, with the member, toward a common health-care goal.

Household Members — individuals who dwell as a single family under the same roof.

Independent Nurse — a nurse who independently enrolls as a provider in MassHealth to provide specialized nursing services, the administration of which require an encounter with a member for more than two continuous hours.

Medical Standards — professionally recognized standards of health care.

Member — an individual determined by the Division to be eligible for MassHealth.

Member Teaching Needs — health-care information required by a MassHealth member or household members, or both, necessary for the promotion, restoration, and maintenance of a member's optimal health status.

Nurse — a person licensed as a registered nurse, a licensed practical nurse, or a licensed vocational nurse by a state's board of registration in nursing.

Nursing-Care Plan — a component of the health-care record, a plan for nursing intervention designed to meet the needs of the member identified in the nursing-care problem list.

Nursing-Care Problem List — a component of the health-care record, obtained from the data base and consisting of the member's clinical needs for intervention by a nurse.

Nursing Progress Notes — a component of the health-care record, the dated notes coincide with the nursing-care problem list and indicate the outcome of nursing intervention.

Nursing Services — the planning, provision, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse.

Primary Caregiver — the individual, other than the nurse, home health aide, or personal-care worker, who is primarily responsible for providing ongoing care to the member.

Recordkeeping Requirement — member health-care record documentation required by the Division or its designee.

Request and Justification Form — the form (paper, electronic, or other) authorized by the Division or its designee, on which the nursing-care needs of the member, other than a complex-care member, as identified in the screening are described by the provider. This form is submitted to the Division or its designee with the request for prior authorization for nursing services.

414.403: Eligible Members

(A) (1) MassHealth Members. The Division covers nursing services provided by independent nurses only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.
(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

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

414.404: Provider Eligibility

The Division pays for nursing services furnished by an independent nurse who:

(A) is licensed as a nurse by the board of registration in nursing for the state in which the nursing services are provided; and

(B) signs a MassHealth provider agreement and is assigned a MassHealth provider number. The Division does not reimburse an independent nurse for nursing services provided before the nurse signs a MassHealth provider agreement and obtains a MassHealth provider number.

(130 CMR 414.405 through 414.407 Reserved)

414.408: Clinical Criteria for Services

(A) The Division pays for nursing services based only on the nursing care needs of the member and not on the availability or unavailability of the member's family or primary caregiver, except under the circumstances described at 130 CMR 414.409(L)(2) and 414.416.

(B) For nursing services to be authorized, there must be a clearly identifiable, specific medical need for nursing services that requires a nursing encounter of more than two continuous hours in duration. The Division or its designee approves the amount of nursing services based on the level of skilled nursing care determined by the Division or its designee to be medically necessary for the member. Nursing services are reimbursable only if all of the following conditions are met:
(1) the services are ordered by the physician;
(2) the services are medically necessary to treat an illness or injury in accordance with 130 CMR 414.409(D); and
(3) prior authorization is obtained where required in compliance with 130 CMR 414.412.

414.409: Conditions of Coverage

(A) Place of Service. The Division does not pay for nursing services when provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or any other institutional health-care or custodial-care facility. Only those members who require and who are authorized to receive nursing services in the home may receive those services outside the home during those hours when the member's normal life activities take him or her outside the home.

(B) Service Limitation. The Division does not pay an independent nurse for a nursing encounter of less than two continuous hours in duration.

(C) Limit of Hours. The Division does not pay an independent nurse for more than 60 hours of nursing in a calendar week.

(D) Medical Necessity Requirement. In accordance with 130 CMR 450.204, the Division pays for only those nursing services that are medically necessary.

(E) Continuous Nursing. The member must have a medical condition requiring continuous skilled nursing care that includes documentation of assessment, intervention, the teaching of the member and/or family members or other caregivers who are caring for the member, and evaluation of clinical outcomes.

(F) Members for Whom Services Are Approved. The Division does not pay for nursing services provided to any individual other than the member who is eligible to receive such services and for whom such services have been approved by the Division or its designee.

(G) Caregivers Who Are Relatives. The Division does not pay for nursing services when such services are provided by the member's immediate relative defined as: spouse, natural parent, foster parent, child, foster child, sibling, adopted child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandparent, or grandchild.

(H) Availability of Other Caregivers. When a family member or other caregiver is providing services that adequately meet the member's needs, it is not medically necessary for an independent nurse to furnish such services.

(I) Least Costly Form of Care. The Division pays for nursing services only when services are no more costly than medically comparable care in an appropriate institution and the least costly form of comparable care available in the community.

(J) Maintained Safely in the Community. The member's physician and independent nurse must determine that the member can be maintained safely in the community.

(K) Prior Authorization. Nursing services provided by an independent nurse require prior authorization. See 130 CMR 414.412 for requirements.

(L) Maximum Nursing Hours.

(1) A member may be eligible for up to a maximum of 112 hours of nursing services per calendar week if he or she meets the criteria for nursing services as stated in 130 CMR 414.408.

(2) Members may be eligible on a short-term basis, not to exceed three months, for nursing services over the maximum amount if such additional services are determined to be medically necessary by the Division or its designee, and at least one of the following criteria is met:

(a) the member's physician has submitted a determination in writing that the death of the member will likely occur within three months and a request has been made that the member be permitted to die at home;

(b) the member has repeated, acute exacerbations of, or develops acute complications in addition to, a chronic medical condition that would result in an acute hospitalization;

(c) the member has been discharged following a lengthy acute hospitalization and may be clinically unstable in the community. Before providing such services, the independent nurse must telephone the Division or its designee with information about the need for such additional services on a weekly basis; or

(d) the member meets the clinical criteria for nursing services and the primary caregiver is temporarily unavailable because he or she:

(i) has an acute illness or has been hospitalized;

(ii) has abandoned the member or has died within the past 30 days;

(iii) has a high-risk pregnancy that requires significant restrictions; or

(iv) has given birth within the four weeks prior to a request for additional services.

414.410: Multiple-Patient Care

(A) The Division pays for one nurse to provide nursing services simultaneously to more than one but not more than three members if:

(1) the members have been determined by the Division or its designee to meet the criteria listed at 130 CMR 414.408;

(2) the members will receive services in the same physical location and during the same time period;

(3) the independent nurse has determined that its safe and appropriate for one nurse to provide nursing services to the members simultaneously; and

(4) the independent nurse has received a separate prior-authorization approval for each member as described in 130 CMR 414.412.

(B) Services provided pursuant to 130 CMR 414.410(A) must be billed by using the multiple-patient service code that reflects the number of members receiving the services.

414.411: Case Management

The Division or its designee provides case management for complex-care members that includes service coordination with independent nurses as appropriate. The purpose of case management is to ensure that complex-care members are provided with a coordinated CLTC service package that meets such members' individual needs and to ensure that the Division pays for nursing and other CLTC services only if they are medically necessary in accordance with 130 CMR 450.204.

(A) DMA – Case Management Activities.
(1) Enrollment. The Division or its designee automatically enrolls members under the age of 22 who require a nurse encounter of more than two continuous hours of nursing, assigns such members a case manager, and informs the member of the name, telephone number, and role of the assigned case manager.
(2) Comprehensive Needs Assessment. The case manager may perform an in-person visit with the member, to evaluate whether the member meets the criteria to be a complex-care member as described in 130 CMR 414.402 and to complete a comprehensive needs assessment. The comprehensive needs assessment will identify, but may not be limited to identifying:
(a) services that are medically necessary, covered by MassHealth, and required by the member to remain safely in the community;
(b) services the member is currently receiving; and
(c) any other case management activities in which the member participates.
(3) Service Plan. The case manager:
(a) develops a service plan, in consultation with the member, the member's physician, the primary caregiver and, where appropriate, the home health agency that
(i) lists those MassHealth-covered services to be authorized by the case manager;
(ii) describes the scope and duration of each service;
(iii) lists service arrangements approved by the member or the member's primary caregiver; and
(iv) informs the member of his or her right to a hearing, as described in 130 CMR 414.413.
(b) provides to the member copies of the service plan, one copy of which the member or the member's primary caregiver must sign and return to the case manager. On the copy being returned, the member must indicate whether he or she accepts or rejects each service as offered and that he or she has been notified of the right to appeal and provided an appeal form;
(c) provides to the independent nurse information from the service plan that is applicable to the independent nurse.
(4) Service Authorizations. The case manager authorizes those CLTC services in the service plan, including nursing, that require prior authorization (PA) and that are medically necessary, as provided in 130 CMR 414.412, and coordinates all nursing services and any subsequent changes with the independent nurse.
(5) Discharge Planning. The case manager may participate in member hospital discharge planning meetings as necessary to ensure that medically-necessary CLTC services necessary to discharge the member from the hospital to the community are authorized and to provide all other identified third-party payers.

(6) Service Coordination. The case manager works with any other identified case managers for the member assigned to the member as may be identified during the comprehensive needs assessment other means.
(7) Case Manager Follow-up and Reassessment. The case manager provides ongoing case management for members and in coordination with the independent nurse to:
(a) determine whether the member continues to be a complex-care member; and
(b) reassess whether services in the service plan are appropriate to meet the member's needs.

(B) Independent Nurse — Case Management Activities.
(1) Service Plan. The independent nurse participates in the development of the service plan for each complex-care member, as described in 130 CMR 414.411(A)(3), in consultation with the case manager, the member, and/or the primary caregiver that:
(a) includes the appropriate assignment of nursing services; and
(b) incorporates full consideration of the member’s and the caregiver’s preferences for service arrangements.
(2) Coordination and Communication. The independent nurse closely communicates and coordinates with the Division’s or its designee’s case manager concerning the status of the member’s nursing needs.

414.412: Prior Authorization

(A) General Terms.
(1) Prior authorization must be obtained from the Division as a prerequisite to payment for all nursing services. The Division bases its decision on the criteria set forth in 130 CMR 414.408. Prior authorization must be obtained from the Division before services are provided to the member. Without such prior authorization, services will not be reimbursed by the Division.
(2) 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.
(3) Approvals for prior authorization specify the number of hours for each service that are reimbursable each calendar week and the duration of the prior-authorization period. The authorization is issued in the member’s name and specifies frequency and duration of care for each service approved per calendar week.
(4) Prior authorization for nursing services may be approved for more than one home health provider and/or independent nurse, provided that:
(a) each provider is authorized only for a specified portion of the member’s total hours; and
(b) the sum total of the hours approved over the duration of the approved period do not exceed what the Division or its designee has determined to be medically necessary for the member.
(5) The independent nurse must complete the Request and Justification form for all non-complex-care members who require more than two continuous hours of nursing. The Request and Justification form must be signed and dated by the member’s physician and submitted to the Division or its designee for review.

(6) The independent nurse may initiate the prior-authorization process by telephone or by submitting a completed prior-authorization request form to the Division or its designee. The independent nurse must submit all prior-authorization requests in accordance with the Division's billing instructions.
(7) If nursing services in excess of the authorized weekly amount are necessary, the independent nurse must contact the Division or its designee by telephone to request additional hours. The verbal request for additional hours must be followed up in writing within two calendar weeks of the verbal request.
(8) If there are unused hours of nursing services in a calendar week, they may be used at any time during the current authorized period.

(B) Complex Care Members.
(1) The independent nurse must obtain from the Division or its designee, as a prerequisite for payment, prior authorization for all nursing services provided to complex-care members.
(2) The independent nurse must refer potential complex-care members to the Division or its designee for a comprehensive needs assessment.
(3) If authorized services need to be adjusted because the complex-care member's medical needs have changed, the independent nurse must contact the Division or its designee by telephone to request an adjustment to the prior authorization.
(4) Any verbal request for changes in service authorization must be followed up in writing to the Division or its designee within two weeks of the date of the verbal request.

(C) Screening. The independent nurse must perform a screening of any member aged 22 or over who requires more than two continuous hours of nursing services and refer members under the age of 22 to the Division or its designee for case management.

414.413: Notification of Approval or Denial of Prior Authorization

(A) Notification of Approval. For all approved prior-authorization requests for nursing services, the Division or its designee sends written notice to the member and the independent nurse regarding the frequency, duration, and intensity of care authorized, and the effective date of the authorization.

(B) Notification of Denial or Modification and Right of Appeal.
(1) For all denied or modified prior-authorization requests, the Division or its designee notifies both the member and the independent nurse of the denial or modification, reason, right to appeal, and appeal procedure.
(2) A member may request a fair hearing from the Division if the Division or its designee denies or modifies a prior-authorization request. The member must request a fair hearing in writing within 30 days after the date of the denial or modification. The Division's Board of Hearings conducts the hearing in accordance with 130 CMR 610.000.

(130 CMR 414.414 and 414.415 Reserved)

414.416: Overtime

(A) The Division pays an overtime rate for nursing services provided by an independent nurse only in the case of a documented emergency and for a short-term basis, not to exceed 30 consecutive calendar days, and when all of the following conditions are met:

(1) prior authorization for overtime has been obtained from the Division or its designee;

(2) nursing services are provided by the same independent nurse and exceed 40 hours in a given calendar week for the MassHealth member;

(3) documentation from a minimum of two home health agencies has been provided that demonstrates, to the satisfaction of the Division or its designee, that the independent nurse has attempted to find other nurses to fill the nursing hours that exceed 40 hours for the member; and

(4) the member meets any of the criteria listed in 130 CMR 414.409(L)(2).

(B) The Division or its designee does not approve requests for overtime as part of a routine submission for authorization for nursing services.

(C) In no event will any individual nurse be approved for a total of more than 60 hours of nursing care provided during any consecutive seven-day period.

414.417: Recordkeeping Requirements

(A) The record maintained by an independent nurse for each member must conform to the Division's administrative and billing regulations at 130 CMR 450.000. Payment for any service listed in 130 CMR 414.000 requires full and complete documentation in the member's health-care record. The independent nurse must maintain records for each member to whom nursing services are provided. Records must be maintained for at least six years after the date of service.

(B) In order for a health-care record to completely document a service to a member, the record must disclose fully the nature, extent, quality, and necessity of the care furnished to the member. When the information contained in a member's record does not provide sufficient documentation for the service, the Division may disallow payment (see the Division's administrative and billing regulations at 130 CMR 450.000).

(C) The independent nurse must maintain the health-care record using the problem-oriented system for recordkeeping. The health-care record must be reviewed and updated at least monthly by the independent nurse. The problem-oriented system for recordkeeping must contain at least the following:

(1) the member's name;
(2) a copy of the approved prior-authorization form;
(3) a data base, as defined at 130 CMR 414.402;
(4) a current nursing-care problem list, as defined at 130 CMR 414.402;
(5) a current nursing-care plan, as defined at 130 CMR 414.402; and
(6) nursing progress notes for each encounter, signed by the independent nurse, that includes the following information:

(a) the full date of service;
(b) a notation of the specific time that each shift both began and ended;
(c) a current medication-administration sheet that includes the time of administration, drug identification and strength, route of administration, the member's response to the medication, and the signature of the person administering the medication;
(d) a current treatment list or description of treatments administered, the time of administration, the member's response to the treatment, and the signature of the person administering the treatment;
(e) the member's vital signs;
(f) if the member's condition warrants, an intake and output record; and
(g) any clinical tests and their results.

(D) The Division or its designee may request, and the independent nurse must furnish, copies of any and all health-care records of members corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, s. 38 and 130 CMR 450.000.

(E) For members who are not complex-care members, the Request and Justification form, as defined at 130 CMR 414.402, must be signed by the member's physician, and submitted to the Division or its designee for prior authorization.

414.418: Maximum Allowable Fees

(A) The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for nursing services. The maximum allowable payment for a service is the lower of the following:

(1) the independent nurse's usual and customary fee; or
(2) the rate that DHCFP had established for that service.

(B) The payments made by the Division to the independent nurse constitute payment in full for nursing services as well as for all administrative duties relating to such services.

414.419 Denial of Services and Administrative Review

(A) A failure or refusal by an independent nurse to furnish services that have been ordered by the member's attending physician and that are within the range of reimbursable services is not an action by the Division or its designee that a member may appeal; but such failure or refusal constitutes a violation of these regulations for which administrative sanctions may be imposed. The Division will receive and act upon complaints from physicians, continuing-care coordinators, and other social-services agencies, as well as from members and their families. A failure or refusal by a physician to order services or to certify their medical necessity is not an action by the Division or its designee that a member may appeal.

(B) When an independent nurse believes that services ordered by the attending physician are not reimbursable under these regulations, the independent nurse must refer the matter to the Division for a payment decision. If and to the extent the Division determines that the ordered services are reimbursable, the independent nurse must provide those services.

REGULATORY AUTHORITY

130 CMR 414.000: M.G.L. c. 118E, ss. 7 and 12.

This page is reserved.

601 Explanation of Abbreviation

The abbreviation "P.A." indicates that Division authorization is required (see the program regulations in Subchapter 4 of the *Independent Nurse Manual*).

602 Definitions

Nursing services provided on a "weekend" or "holiday" will be automatically reimbursed in accordance with the applicable fee schedule of the Division of Health Care Finance and Policy (DHCFP). Providers must use a service code that accurately reflects the nursing service provided.

(A) Day – the hours from 7:00 A.M. to 3:00 P.M., Sunday through Saturday.

(B) Night – the hours from 3:00 P.M. through 7:00 A.M., Sunday through Saturday.

(C) Nursing modifiers:
- (1) UJ-night
- (2) TT-one nurse to two patients (day)
- (3) U1-one nurse to two patients (night)
- (4) U2-one nurse to three patients (day)
- (5) U3-one nurse to three patients (night)

603 Service Codes and Descriptions: Individual Patient Nursing

Service Code-Modifier	Service Description
T1002	RN services, up to 15 minutes (day) (P.A.)
T1003	LPN/LVN services, up to 15 minutes (day) (P.A.)
T1002-UJ	RN services, up to 15 minutes (night) (P.A.)
T1003-UJ	LPN/LVN services, up to 15 minutes (night) (P.A.)

604 Service Codes and Descriptions: Multiple-Patient Nursing

Service Code-Modifier	Service Description
	The following service codes are to be used for nursing care provided simultaneously by one nurse to two members.
T1002-TT	RN services, up to 15 minutes (day) (each member) (P.A.)
T1003-TT	LPN/LVN services, up to 15 minutes (day) (each member) (P.A.)
T1002-U1	RN services, up to 15 minutes (night) (each member) (P.A.)
T1003-U1	LPN/LVN services, up to 15 minutes (night) (each member) (P.A.)

604 Service Codes and Descriptions: Multiple-Patient Nursing (cont.)

Service Code-Modifier	Service Description
	The following service codes are to be used for nursing care provided simultaneously by one nurse to three members.
T1002-U2	RN services, up to 15 minutes (day) (each member) (P.A.)
T1003-U2	LPN/LVN services, up to 15 minutes (day) (each member) (P.A.)
T1002-U3	RN services, up to 15 minutes (night) (each member) (P.A.)
T1003-U3	LPN/LVN services, up to 15 minutes (night) (each member) (P.A.)

605 Service Codes and Descriptions: Overtime

The service codes in this section are for overtime nursing care provided to an individual member. These service codes apply only to nursing services provided by an independent nurse, as described in 130 CMR 414.416.

Service Code-Modifier	Service Description
T1002-TU	RN services, up to 15 minutes (overtime on day) (P.A.)
T1003-TU	LPN/LVN services, up to 15 minutes (overtime on day) (P.A.)
T1002-U4	RN services, up to 15 minutes (overtime on night) (P.A.)
T1003-U4	LPN/LVN services, up to 15 minutes (overtime on night) (P.A.)