Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter IN-26
June 2008

TO: Independent Nurses Participating in MassHealth

FROM: Tom Dehner, Medicaid Director

RE: Independent Nurse Manual (Revised Regulations)

This letter transmits revised regulations governing independent nurses. The revised regulations contain a requirement that all nursing services be provided under a written plan of care established individually for the member by the member's physician. Additionally, the member's physician must recertify and sign the plan of care every 60 days. The new section describing this requirement specifies the information that must be contained in the plan of care, describes how a physician's verbal orders should be incorporated into the plan of care, and explains the procedure for making corrections to the plan of care.

Other revisions include

- a requirement to maintain a copy of the member's medical record in the member's home to ensure continuity of care between continuous skilled nursing providers;
- the specification of additional information that must be kept in the medical record;
- a requirement for the nurse to obtain a signed medical release form to gain access to a member's medical information from other health-care providers; and
- updated terminology and other editorial revisions.

These regulations are effective June 15, 2008.

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

NEW MATERIAL

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

Independent Nurse Manual

Pages iv, vi, vii, and 4-1 through 4-14

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Independent Nurse Manual

Pages iv, vi, vii, 4-7, 4-8, 4-11, and 4-12 — transmitted by Transmittal Letter IN-23

Pages 4-1 through 4-6, 4-9, and 4-10 — transmitted by Transmittal Letter IN-25

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

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

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

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For 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 MassHealth’s effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and its members.

414.401: Introduction

The regulations in 130 CMR 414.000 state the requirements for the payment 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 130 CMR 414.402 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.

Certification Period – a period of no more than 60 days for which the member's physician has certified that the plan of care is medically appropriate and necessary.

Community Case Manager – a registered nurse employed by the MassHealth agency 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.

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

Continuous Skilled Nursing Services – a nurse visit of more than two continuous hours of nursing services.

Co-Vending – the practice of sharing the provision of a member's nursing services between one or more home health agencies or independent nurses.

Independent Nurse – a nurse who independently enrolls as a provider in MassHealth to provide continuous skilled-nursing services.

Medical History – a component of the medical record that provides a summary of all health-related information about the member. A history includes, but is not limited to, medical and nursing-care histories as well as summaries of physician physical examination and nursing-assessment results.

Medical Record – documentation, maintained by the independent nurse, that includes medical history, nursing progress notes, and demographic and other information related to the member.

Medical Records Release Form – a signed authorization from the member or the member's parent if the member is a minor, or legal guardian, that allows access to confidential health information about the member from other health-care providers.

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

Nursing Progress Notes – a component of the medical record that indicates the outcome of nursing interventions.

Nursing Services – the assessment, planning, intervention, 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, who is primarily responsible for providing ongoing care to the member.

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

414.403: Eligible Members

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

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

414.404: Provider Eligibility

MassHealth pays for nursing services furnished by an independent nurse who

(A) is licensed and is in good standing 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 contract and is assigned a MassHealth provider number. The MassHealth agency does not pay an independent nurse for nursing services provided before the date on which the nurse is approved by the MassHealth agency to participate in MassHealth.

(130 CMR 414.405 through 414.407 Reserved)

414.408: Member Eligibility for Continuous Skilled Nursing Services

(A) The MassHealth agency 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 visit of more than two continuous hours in duration. The MassHealth agency or its designee approves the amount of nursing services based on the level of skilled-nursing care determined by the MassHealth agency or its designee to be medically necessary for the member. Nursing services are payable 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);
(3) prior authorization is obtained from MassHealth as provided in 130 CMR 414.413 and 450.303;
(4) the nurse's assessment is either documented separately or incorporated into the physician's plan of care; and
(5) all of the conditions of coverage provided in 130 CMR 414.409 are met.

414.409: Conditions of Payment

(A) Place of Service. The MassHealth agency pays for nursing services to a member who meets the clinical criteria in 130 CMR 414.408 and resides in a noninstitutional setting, which may include, without limitation, a homeless shelter or other temporary residence or a community setting. In accordance with 42 CFR 440.70(c), the MassHealth agency does not pay for nursing services provided in a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other institutional setting providing medical, nursing, rehabilitative, or related care.

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

(C) Limit of Hours. The MassHealth agency 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 MassHealth agency 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 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 MassHealth agency 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 MassHealth agency or its designee.

(G) Caregivers. The MassHealth agency does not pay for nursing services when such services are provided by the spouse of a member, the parent of a minor member, including an adoptive parent, or the member's foster parent, or any other individual with legally binding financial or caregiving responsibility for the member.

(H) Least Costly Form of Care. The MassHealth agency 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.

(I) Safe Maintenance in the Community. The member's physician and independent nurse must determine that the member can be maintained safely in the community.

(J) Prior Authorization. Nursing services provided by an independent nurse require prior authorization. See 130 CMR 414.413 and 450.303 for requirements. The MassHealth agency pays for all medically necessary nursing services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 414.000, and with prior authorization.

(K) Coordination of Services. The independent nurse and other nursing providers must maintain the member's medical record in the member's home. The record must include the total number of approved nursing hours for the member, the names and telephone numbers of all the providers involved in co-vending care, the number of nursing hours approved for each provider by the MassHealth agency or its designee, and all other recordkeeping requirements as described in 130 CMR 414.417.

(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 MassHealth agency 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 MassHealth agency 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 before a request for additional services.

414.410: Multiple-Patient Care

(A) The MassHealth agency 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 MassHealth agency 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 it is safe and appropriate for one nurse to provide nursing services to the members simultaneously; and
(4) the MassHealth agency has separately approved prior authorization for each member as described in 130 CMR 414.413.

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

414.411: Complex Case Management

The MassHealth agency 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 a complex-care member is provided with a coordinated community-long-term-care service package that meets the member's individual needs and to ensure that the MassHealth agency pays for nursing and other community-long-term-care services only if they are medically necessary in accordance with 130 CMR 450.204. The MassHealth member eligibility verification system identifies complex-care members.

(A) Case Management Activities.
(1) Enrollment. The MassHealth agency or its designee automatically enrolls members under the age of 22 years who require a nurse visit of more than two continuous hours of nursing, assigns such members a community case manager (CCM), and informs the member of the name, telephone number, and role of the assigned CCM.
(2) Comprehensive Needs Assessment. The CCM 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, without limitation
(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 CCM will

(a) develop a service plan, in consultation with the member, the member's physician, and the member's primary caregiver that

(i) lists those MassHealth-covered services to be authorized by the CCM;

(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 414.414;

(b) provide the member with copies of the service plan, one copy of which the member or the member's primary caregiver must sign and return to the CCM. On the copy being returned, the member or the member's primary caregiver 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; and

(c) provide information to the independent nurse about services authorized in the service plan that are applicable to the independent nurse.

(4) Service Authorizations. The CCM will authorize those community-long-term-care services in the service plan, including nursing, that require prior authorization and that are medically necessary, as provided in 130 CMR 414.412, and coordinate all nursing services and any subsequent changes with the independent nurse.

(5) Discharge Planning. The CCM may participate in member hospital discharge-planning meetings as necessary to ensure that medically necessary community-long-term-care services necessary to discharge the member from the hospital to the community are authorized and to identify third-party payers.

(6) Service Coordination. The CCM will work collaboratively with any other identified case managers assigned to the member.

(7) Case Manager Follow-up and Reassessment. The CCM will provide ongoing case management for members to

(a) determine whether the member continues to meet the definition of a complex-care member; and

(b) reassess whether services in the service plan are appropriate to meet the member's needs.

(B) Independent Nurse – Coordination with the CCM. The independent nurse must closely communicate and coordinate with the MassHealth agency's or its designee's CCM about the status of the member's nursing needs.

414.412: Plan of Care

All nursing services must be provided under an individualized plan of care developed for the member. The physician must sign the plan of care before services are provided to the member.

(A) Providers Qualified to Establish a Plan of Care.
(1) The member's physician must establish a written plan of care and recertify and sign the plan of care every 60 calendar days.
(2) The independent nurse may establish an additional plan of care, when appropriate, that may be incorporated into the physician's plan of care, or be prepared separately. The additional plan of care does not substitute for the physician's plan of care.
(3) If an independent nurse is co-vending a case with other providers, each provider is responsible for ensuring that the record includes each independent nurse and each home health agency's own plan of care, including their own set of written physician's orders.

(B) Content of the Plan of Care. The plan of care must include
(1) the member's name and date of birth;
(2) all pertinent diagnoses, including the member's mental status;
(3) types of medical supplies and durable medical equipment required;
(4) the member's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments;
(5) the total number of nursing hours requested and, if co-vending, the number of hours provided by each provider;
(6) any safety measures to prevent injury;
(7) a plan for medical emergencies;
(8) goals toward discharge planning from continuous skilled nursing services; and
(9) any additional items the independent nurse or physician chooses to include.

(C) Physician Verbal Orders.
(1) A physician may provide verbal orders during the authorized certification period if changes in the member's condition require an immediate modification of the plan of care. The independent nurse must document the physician's verbal orders in writing and sign and date the notation in the medical record. The physician must sign and date the independent nurse's notation of the order, or otherwise provide the independent nurse with a written order within 30 calendar days of the date of a physician's verbal order.
(2) The independent nurse must maintain a copy of the physician's modification to the plan of care in the member's medical record in the member's home. Orders that will continue into the next certification period must be incorporated into the next plan of care before it is signed by the physician.

(D) Corrections to the Plan of Care. When correcting errors on a plan of care before it is signed by the physician, the independent nurse must cross out the error with a single line and place his or her initials and the date next to the correction. The use of correction fluid or correction tape on a place of care is not permitted.

(E) MassHealth Members Enrolled in the Primary Care Clinician (PCC) Plan. If a member is enrolled in the PCC Plan, the independent nurse must provide the PCC with a copy of the member's plan of care for each certification period.

414.413: Prior Authorization

(A) General Terms.

(1) The MassHealth agency does not pay for continuous skilled-nursing services without prior authorization.

(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 payable each calendar week and the duration of the prior-authorization period. The authorization is issued in the member's name.

(4) Prior authorization for nursing services may be approved for co-vending home health agencies and independent nurses, 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 does not exceed what the MassHealth agency or its designee has determined to be medically necessary for the member.

(5) The independent nurse must complete the request and justification form, as defined in 130 CMR 414.402, 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 MassHealth agency or its designee for review along with the completed prior-authorization request.

(6) The independent nurse may initiate the prior-authorization process by telephone, through the MassHealth automated prior authorization system, or by submitting a completed paper prior-authorization request form to the MassHealth agency or its designee. The independent nurse must submit all prior-authorization requests in accordance with the MassHealth agency's administrative and billing instructions and submit them to the appropriate addresses listed in Appendix A of the *Independent Nurse Manual*.

(7) If nursing services in excess of the authorized weekly amount are necessary, the independent nurse must contact the MassHealth agency or its designee by telephone to request additional hours. The verbal request for additional hours must be followed up in writing within two 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 refer potential complex-care members to the MassHeath agency or its designee for a comprehensive needs assessment.

(2) If authorized services need to be adjusted because the complex-care member's medical needs have changed, the independent nurse must contact the MassHealth agency or its designee by telephone to request an adjustment to the prior authorization.

(3) Any verbal request for changes in service authorization must be followed up in writing to the MassHealth agency or its designee within two weeks of the date of the verbal request.

(C) Assessment. The independent nurse must perform an assessment of any member aged 22 years or over who requires more than two continuous hours of nursing services and refer members under the age of 22 years to the MassHealth agency or its designee for complex case management.

414.414: Notification of Approval or Denial of Prior Authorization

(A) Notification of Approval. For all approved prior-authorization requests for nursing services, the MassHealth agency or its designee sends written notice to the member and the independent nurse specifying 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 MassHealth agency 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 MassHealth agency if the MassHealth agency 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 MassHealth agency's Board of Hearings conducts the hearing in accordance with 130 CMR 610.000.

(130 CMR 414.415 Reserved)

414.416: Overtime

(A) The MassHealth agency 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 MassHealth agency 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 or independent nurses has been provided that demonstrates, to the satisfaction of the MassHealth agency 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 MassHealth agency 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 independent 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 MassHealth 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 medical record. The independent nurse must maintain records for each member to whom nursing services are provided.

(B) In order for a medical 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 MassHealth agency may disallow payment (see MassHealth administrative and billing regulations at 130 CMR 450.000).

(C) The independent nurse must maintain a medical record of nursing services provided to each member. The medical record must be reviewed and updated by the independent nurse at least monthly. To ensure the continuity of care, the independent nurse and, if co-vending, the other providers must leave a copy of the member's original medical record, including current progress notes, medication-administration sheet, prior-authorization form, plan of care, and physician orders, including any verbal orders, in the member's home. The medical record must contain at least the following:

(1) the member's name, address, phone number, date of birth, MassHealth ID number;

(2) the name and phone number of the member's primary care physician;

(3) the primary caregiver's name, address, phone number, and relationship to member;

(4) the name and phone number of the member's emergency contact person;

(5) a copy of the approved prior-authorization decision;

(6) a copy of the plan of care signed by the member's physician and, if appropriate, verbal orders signed by the physician;
(7) a medical history as defined in 130 CMR 414.402;
(8) easily reviewable and legible nursing progress notes for each visit, signed by the independent nurse, that include 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 description of the assessed signs and symptoms of illness;
(d) any treatments and drugs administered and the member's response;
(e) the member's vital signs and any other required measurements;
(f) progress toward achievement of long- and short-term goals as specified in the plan of care, including, when applicable, an explanation of why goals are not achieved as expected;
(g) a pain assessment;
(h) the status of any equipment maintenance and management; and
(i) any contacts with physicians or other health-care providers about the member's needs or change in plan of care;
(9) 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;
(10) 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;
(11) any clinical tests and their results;
(12) a signed medical records release form; and
(13) a request and justification form for all non-complex-care members.

(D) The independent nurse is responsible for maintaining the member's medical record. The independent nurse must maintain the member's original medical record along with current and previous certification period documentation in accordance with 130 CMR 414.417(A) and (B).

(E) Upon the request of the member or the member's legal representative, the independent nurse must make a copy of the medical record available to the person or entity that the member or the member's representative designates.

(F) The MassHealth agency or its designee may request, and the independent nurse must furnish, copies of any and all medical records of members corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, § 38 and 130 CMR 450.000.

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 MassHealth agency 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 payable services is not an action by the MassHealth agency or its designee that a member may appeal, but such failure or refusal constitutes a violation of 130 CMR 414.000 for which administrative sanctions may be imposed.

(B) When an independent nurse believes that services ordered by the attending physician are not payable under 130 CMR 414.000, the independent nurse must refer the matter to the MassHealth agency for a payment decision. If and to the extent the MassHealth agency determines that the ordered services are payable, the independent nurse must provide those services.

REGULATORY AUTHORITY

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

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