




Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth



MassHealth
Transmittal Letter IN-27
November 1, 2013

TO: Independent Nurses Participating in MassHealth
FROM: Kristin L. Thorn, Medicaid Director 
RE: *Independent Nurse Manual (Revised Regulations)*

This letter transmits revisions to the independent nurse program regulations in Subchapter 4 of the *Independent Nurse Manual*. These revisions are effective for dates of service on or after November 8, 2013.

Prior Authorization Process for MassHealth Coverage of Continuous Skilled Nursing Services for Members Aged 22 Years or Older

MassHealth is changing the prior authorization (PA) process for continuous skilled nursing (CSN) services for members aged 22 or older. See 130 CMR 414.411. Effective November 1, 2013, all referrals for CSN services will be processed by MassHealth's designee, the University of Massachusetts Medical School (UMMS) Community Case Management (CCM), regardless of the member's age. As with members under age 22 years, CCM clinical managers will now conduct an in-person assessment and authorization for CSN services for members of any age.

If the member is eligible for CSN services, the member will be identified in the MassHealth Eligibility Verification System (EVS) as a Complex Care member. The member will be assigned a clinical manager who will assess and authorize the member for CSN services and other community long-term-care services as described in the regulations.

With CCM managing the PA process for CSN services, the Request and Justification for Continuous Skilled Nursing Services form is no longer needed and has been removed from the MassHealth website. Independent nurses seeking approval for CSN services for their MassHealth members must contact CCM directly at 1-800-863-6068.

Any prior-authorization requests that MassHealth receives before November 8, 2013, will be processed in accordance with billing instructions in effect on the date of receipt.

Conditions of Payment

MassHealth has revised the conditions of payment section of the regulations at 130 CMR 414.409. This section now includes requirements addressing provider responsibility for the teaching and training of caregivers and the availability of caregivers as part of the treatment service.

MassHealth has also revised the limit of hours restriction under 130 CMR 414.416. Under the revised rules, providers will be limited to billing MassHealth a maximum of 60 hours in a consecutive seven-day period, and no more than 12 hours within a twenty-four-hour period.

Definitions (130 CMR 414.402) and Recordkeeping (130 CMR 414.417)

MassHealth has revised other sections of the regulations including the definition and recordkeeping sections. The definition of calendar week has been revised and additional definitions have been added to 130 CMR 414.402. Recordkeeping requirements at 130 CMR 414.417 have also been amended.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

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 and 4-1 through 4-14

OBSOLETE MATERIAL

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

Independent Nurse Manual

Pages iv and 4-1 through 4-14 — transmitted by Transmittal Letter IN-26

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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 and apply to nurses who contract independently with MassHealth. All independent nurses participating in MassHealth must comply with MassHealth regulations including, but not limited to, 130 CMR 414.000 and 450.000: *Administrative and Billing Regulations*.

414.402: Definitions

The following terms 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 450.000: *Administrative and Billing Regulations*.

Calendar Week – seven consecutive days beginning Sunday at midnight and ending Saturday at 11:59 p.m.

Care Management – a function performed by the MassHealth agency or its designee that assesses and reassesses the medical needs of complex-care members and authorizes or coordinates community long-term-care (CLTC) services that are medically necessary for such members to remain safely in the community.

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.

Clinical Manager – a registered nurse employed by the MassHealth agency or its designee, who performs the in-person assessment of a member for MassHealth coverage of continuous skilled nursing (CSN) services and, if it is determined that CSN services are medically necessary, coordinates authorization of medically necessary community long-term-care (CLTC) services for the member.

Community Long-Term-Care (CLTC) Services – certain MassHealth-covered services intended to enable a member to remain in the community. Such services 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 MassHealth agency or its designee.

Complex-Care Member – a MassHealth member 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 (CSN) Services – a nurse visit of more than two continuous hours of nursing services.

Co-Vending – an arrangement through which a member’s CSN services are provided by one or more home health agencies or independent nurses, with each provider possessing its own MassHealth prior authorization to provide nursing services to the member.

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Home Health Agency – a public or private organization that provides nursing and other therapeutic services to individuals whose place of residence conforms to the requirements of 42 CFR 440.70(c). Home health agency providers are governed by MassHealth regulations at 130 CMR 403.000: *Home Health Agency Services*.

Household – a place of residence where two or more people are living that is (a) a group home, a residential care home, or other group living situation; (b) at the same street address if it is a single family house that is not divided into apartments or units; or (c) at the same apartment number or unit number if members live in a building that is divided into apartments or units.

Independent Nurse – a licensed nurse who independently enrolls as a provider in MassHealth to provide CSN services. Independent nurse providers are governed by MassHealth regulations at 130 CMR 414.000.

Medical History – a component of the member’s 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, the member’s plan of care, and other information related to the member.

Medical Records Release Form – a signed authorization from the member or the member’s parent or legal guardian, if the member is a minor, that allows the designated releasee to access the member’s confidential health information 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.

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 414.000 and 450.000: *Administrative and Billing Regulations*. 130 CMR 450.105: *Coverage Types*

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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: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

414.404: Provider Eligibility

To participate in MassHealth as a MassHealth independent nurse provider, a nurse must

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

(B) meet all provider eligibility requirements at 130 CMR 450.212: *Provider Eligibility: Eligibility Criteria*, et seq., including 130 CMR 450.212(A)(6);

(C) sign a MassHealth provider contract and receive 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; and

(D) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B).

(130 CMR 414.405 through 414.407 Reserved)

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414.408: Continuous Skilled Nursing Services

(A) Member Eligibility for Continuous Skilled Nursing Services. A member is clinically eligible for MassHealth coverage of continuous skilled nursing (CSN) services when all of the following criteria are met:

- (1) there is a clearly identifiable, specific medical need for a nursing visit of more than two continuous hours;
- (2) the CSN services require the skills of a registered nurse or of a licensed practical nurse in accordance with 130 CMR 414.408(B); and
- (3) the CSN services are medically necessary to treat an illness or injury in accordance with 130 CMR 414.409(D).

(B) Clinical Criteria for Nursing Services.

- (1) A nursing service is a service that must be provided by a registered nurse or a licensed practical nurse to be safe and effective, considering the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.
- (2) Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections, or insertion of catheters). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only a registered nurse or licensed practical nurse can safely and effectively provide the service.
- (3) When a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct intervention of a registered nurse or licensed practical nurse, the service is not considered a nursing service, unless there is no one trained, able, and willing to provide it.
- (4) Nursing services for the management and evaluation of a plan of care are medically necessary when only a registered nurse or licensed practical nurse can ensure that essential care is effectively promoting the member's recovery, promoting medical safety, or avoiding deterioration.
- (5) Medical necessity of services is based on the condition of the patient at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period.
- (6) A member's need for nursing care is based solely on his or her unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

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.

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(C) Limit of Hours. The MassHealth agency does not pay an independent nurse for more than 60 hours of nursing care provided during any consecutive seven-day period or for more than 12 hours within a 24-hour period, regardless of the number of MassHealth members receiving care from the independent nurse.

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

(E) Plan of Care. The MassHealth agency pays only for nursing services provided pursuant to a plan of care authorized by a physician and that meets the plan of care requirements at 130 CMR 414.412(B).

(F) Continuous Skilled Nursing (CSN). The MassHealth agency pays for CSN services when

- (1) the member meets the clinical eligibility criteria for CSN services as stated in 130 CMR 414.408;
- (2) the CSN services are provided under an individualized plan of care developed for the member in accordance with 130 CMR 414.412; and
- (3) prior authorization for CSN services has been obtained from the MassHealth agency or its designee, in accordance with 130 CMR 414.413.

(G) 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 authorized by the MassHealth agency or its designee.

(H) CSN Provided by Caregivers. The MassHealth agency does not pay for continuous skilled 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.

(I) 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 the independent nurse to provide such services.

(J) 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.

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

(L) Teaching Activities. As part of a regular nursing treatment service, the independent nurse must teach a member, family member, or caregivers how to manage the member's treatment regimen. Ongoing teaching is required, as necessary, where there is a change in the procedure or the member's condition.

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

(N) Continuous Skilled Nursing (CSN) Services Documentation in the Member's Home. The independent nurse and other nursing providers must maintain a copy of 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(E).

414.410: Multiple-Patient Care

(A) The MassHealth agency pays for one nurse to provide CSN services simultaneously to more than one member, 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 receive services in the same household and during the same time period;
- (3) the MassHealth agency or its designee has determined that it is appropriate for one nurse to provide nursing services to the members simultaneously; and
- (4) the independent nurse has received a separate prior authorization from the MassHealth agency or its designee 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-Care Members

For complex-care members, as defined in 130 CMR 414.402, the MassHealth agency or its designee provides care management that includes service coordination with independent nurses as appropriate. The purpose of care 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: *Medical Necessity*. The MassHealth member eligibility verification system identifies complex-care members.

(A) Care Management Activities.

- (1) Enrollment. The MassHealth agency or its designee automatically assigns a clinical manager to members whom it has determined require a nurse visit of more than two continuous hours of nursing and informs such members of the name, telephone number, and role of the assigned clinical manager.

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(2) Comprehensive Needs Assessment. The clinical manager performs 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. If the member is determined to meet the criteria for a Complex Care member, the clinical manager will complete a comprehensive needs assessment. The comprehensive needs assessment will identify

- (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 Record. The clinical manager

- (a) develops a service record, in consultation with the member, the member's primary caregiver, and where appropriate, the independent nurse and the member's physician, that
 - (i) lists those MassHealth-covered services to be authorized by the clinical 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 414.414;

- (b) provide the member with copies of the service record, one copy of which the member or the member's primary caregiver must sign and return to the clinical manager. 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 record that are applicable to the independent nurse.

(4) Service Authorizations. The clinical manager will authorize those community-long-term-care services in the service record, including nursing, that require prior authorization and that are medically necessary, as provided in 130 CMR 414.413, and coordinate all nursing services and any subsequent changes with the independent nurse.

(5) Discharge Planning. The clinical manager 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 clinical manager will work collaboratively with any other identified case managers assigned to the member.

(7) Clinical Manager Follow-up and Reassessment. The clinical manager will provide ongoing care 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 Clinical Manager. The independent nurse must closely communicate and coordinate with the MassHealth agency's or its designee's clinical manager about the status of the member's nursing needs.

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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, sign, and date 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 member's medical 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 teaching activities to be conducted by the nurse to teach the member, family member, or caregiver how to manage the member's treatment regimen (ongoing teaching may be necessary where there is a change in member's condition or treatment);
- (7) any safety measures to prevent injury;
- (8) a plan for medical emergencies;
- (9) goals toward discharge planning from CSN services; and
- (10) 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 the 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 and dated 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 plan of care is not permitted.

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(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 Requirements

(A) Prior Authorization must be obtained from the MassHealth agency or its designee as a prerequisite for payment for CSN services and before services are provided to the member. Without such prior authorization, CSN services will not be paid by the MassHealth agency.

(B) 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.

(C) The MassHealth agency or its designee will conduct the assessment of need for CSN services and coordinate other MassHealth community long-term-care services for the member, as appropriate. When the MassHealth agency or its designee conducts an assessment of need for CSN services and authorizes CSN services for the member, the member will select the independent nurse who will be responsible for providing CSN services. The MassHealth agency or its designee will provide written notification of its assessment to the member, and if applicable, the independent nurse selected by the member.

(D) The MassHealth agency or its designee will specify on the prior authorization for CSN services the number of CSN hours that have been determined to be medically necessary and that are authorized for the member per calendar week and the duration of the prior authorization. Any CSN hours provided to the member by the independent nurse that exceed what the MassHealth agency or its designee has authorized in a calendar week are not payable by MassHealth.

(E) If the frequency of the nursing services needs to be adjusted because the member's medical needs have changed, the independent nurse must contact the MassHealth agency or its designee to request an adjustment to the prior authorization.

(F) Prior authorization for CSN services may be approved for more than one home health agency or independent nurse, or both, provided that

- (1) each provider is authorized only for a specified portion of the member's total hours; and
- (2) the sum total of the combined hours approved for co-vending providers does not exceed what the MassHealth agency or its designee has determined to be medically necessary and authorized for the member per calendar week.

(G) The independent nurse must submit all prior-authorization requests in accordance with the MassHealth agency's administrative and billing regulations and instructions and must submit such requests to the appropriate addresses listed in Appendix A of the *Independent Nurse Manual*.

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

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414.414: Notice of Approval or Denial of Prior Authorization

(A) Notice 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) Notice 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 Office of Medicaid Board of Hearings conducts the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(130 CMR 414.415 Reserved)

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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 one MassHealth member; and
- (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.

(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 authorized for a total of more than 60 hours of nursing care provided during any consecutive seven-day period, regardless of the number of MassHealth members receiving care from the independent nurse.

414.417: Recordkeeping Requirement and Utilization Review

(A) The record maintained by an independent nurse for each member must conform to 130 CMR 450.000: *Administrative and Billing Regulations*. 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 nursing services 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 130 CMR 450.000: *Administrative and Billing Regulations*).

(C) The independent nurse must submit requested documentation to the MassHealth agency or its designee for purposes of utilization review and provider review and audit, within the MassHealth agency's or its designee's time specifications. The MassHealth agency or its designee may periodically review a member's plan of care and other records to determine if services are medically necessary in accordance with 130 CMR 414.409(D). The independent nurse must provide the MassHealth agency or its designee with any supporting documentation the MassHealth agency or its designee requests, in accordance with M.G.L. c. 118E, § 38 and 130 CMR 450.000: *Administrative and Billing Regulations*.

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(D) The independent nurse must maintain an up-to-date medical record of nursing services provided to each member that must be reviewed by the independent nurse at least monthly. 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 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) documentation on the teaching provided to the member, member's family, or caregiver by the independent nurse on 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;
- (12) any clinical tests and their results; and
- (13) a signed medical records release form.

(E) When providing CSN services, the independent nurse and, if co-vending, other providers must leave a copy of the member's medical record, including current progress notes, medication administration sheet, prior-authorization form, plan of care, and physician orders in the member's home for the purpose of ensuring continuity of care.

(F) 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).

(G) 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.

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414.418: Maximum Allowable Fees

(A) Independent nurse providers must accept MassHealth payment in full for nursing services according to the rates and regulations established by the Division of Health Care Finance and Policy (DHCFP) as set forth in 114.3 CMR 50.00: *Home Health Services*. Payments are subject to the conditions, exclusions, and limitations set forth in 130 CMR 414.000 and 450.000: *Administrative and Billing Regulations*.

(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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