

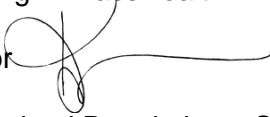


**Commonwealth of Massachusetts**  
**Executive Office of Health and Human Services**  
**Office of Medicaid**  
*www.mass.gov/masshealth*



MassHealth  
Transmittal Letter MHC-47  
April 2014

**TO:** Mental Health Centers Participating in MassHealth

**FROM:** Kristin L. Thorn, Medicaid Director 

**RE:** *Mental Health Center Manual* (Revised Regulations, Service Codes, and Descriptions)

This letter transmits revisions to the mental health center regulations and Subchapter 6 of the mental health center manual to implement the requirements of Massachusetts state law at St. 2013, c.118, §32 regarding the adoption of evaluation and management (E/M) codes for dates of service beginning January 1, 2014, and to ensure alignment of these publications with the mental health center pricing regulations at 101 CMR 306.000.

These changes include clarification of “crisis intervention” services as “psychotherapy in crisis” services, and specifying the types of staff members, including psychiatric nurse mental health clinical specialists, who are authorized to provide mental health services for which mental health centers may bill. Relevant sections of 130 CMR 429.000 have also been revised to reflect the transfer of the authority for rate setting from the Division of Health Care Finance and Policy (Division) to the Executive Office of Health and Human Services (EOHHS).

### **MassHealth Website**

This transmittal letter and attached pages are available on the MassHealth website at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### **Questions**

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

### **NEW MATERIAL**

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

#### **Mental Health Center Manual**

Pages iv, 4-1 through 4-6, 4-9 through 4-16, 4-21 through 4-24, and 6-1 through 6-10

### **OBSOLETE MATERIAL**

(The pages listed here are no longer in effect.)

#### **Mental Health Center Manual**

Pages iv, 4-1, 4-2, 4-5, 4-6, 4-9 through 4-14, and 4-21 through 4-26  
— transmitted by Transmittal Letter MHC-39

Pages 4-3 and 4-4 — transmitted by Transmittal Letter MHC-32

Pages 4-15 and 4-16 — transmitted by Transmittal Letter MHC-43

Pages 6-1 through 6-10 — transmitted by Transmittal Letter MHC-42

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429.401: Introduction

130 CMR 429.000 establishes requirements for participation of mental health centers in MassHealth and governs mental health centers operated by freestanding clinics, satellite facilities of clinics, and identifiable units of clinics. All mental health centers participating in MassHealth must comply with the MassHealth regulations, including but not limited to MassHealth regulations set forth in 130 CMR 429.000 and 450.000.

429.402: Definitions

The following terms used in 130 CMR 429.000 have the meanings given in 130 CMR 429.402 unless the context clearly requires a different meaning.

After-Hours Telephone Service — telephone coverage during the hours when the center is closed for members who are in a crisis state.

Autonomous Satellite Program — a mental health center program operated by a satellite facility with sufficient staff and services to substantially assume its own clinical management independent of the parent center.

Case Consultation — environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions which may include the preparation of reports of the patient's psychiatric status, history, treatment, or progress (other than for legal purposes) for other physicians, agencies, or insurance carriers.

Child and Adolescent Needs and Strengths (CANS) — a tool that provides a standardized way to organize information gathered during behavioral-health clinical assessments. A Massachusetts version of the tool has been developed and is intended to be used as a treatment decision support tool for behavioral-health providers serving MassHealth members under the age of 21.

Core Discipline — one of the following disciplines: psychiatry, social work, psychology, or psychiatric nursing (including a psychiatric nurse mental health clinical specialist), most or all of which are represented by the professionals qualified in these disciplines who comprise a mental health center's core team.

Core Team — a group of three or more mental-health professionals that must include a psychiatrist and one each of at least two of the following professionals: a licensed psychologist, independently licensed clinical social worker, psychiatric nurse mental health clinical specialist, or psychiatric nurse. The members of this group collaborate in developing a diagnostic evaluation and treatment plan for the patient, utilizing their particular skills, competencies, and perspectives.

Couple Therapy — psychotherapeutic services provided to a couple whose primary complaint is the disruption of their marriage, family, or relationship.

Dependent Satellite Program — a mental health center program in a satellite facility that is under the direct clinical management of the parent center.

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Diagnostic Services — the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan.

Family Consultation — a scheduled meeting of at least one-half hour with one or more of the parents, legal guardian, or foster parents of a child who is being treated by clinical staff at the center, when the parents, legal guardian, or foster parents are not clients of the center.

Family Therapy — the psychotherapeutic treatment of more than one member of a family simultaneously in the same session.

Freestanding Clinic — any institution licensed as a clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, s. 51, that is not part of a hospital and that possesses its own legal identity, maintains its own patient records, and administers its own budget and personnel. Such institutions include mental health centers and community health centers.

Group Therapy — the application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

Home Visits — crisis intervention, individual, group, or family therapy, and medication provided in the residence (excluding a medical institution) of a current member, when the member is unable to be served on the center's premises.

Identifiable Unit — a separate organizational unit that is located in a separate part of a clinic, and that is identifiable in its fiscal, personnel, and program elements.

Individual Therapy — psychotherapeutic services provided to an individual.

Long-Term Therapy — a combination of diagnostics and individual, couple, family, and group therapy planned to extend more than 12 sessions.

Medication Visit — a member visit specifically for the prescription, review, and monitoring of psychotropic medication by a psychiatrist, or psychiatric nurse mental health clinical specialist, or administration of prescribed intramuscular medication by a physician or a nurse.

Mental Health Center (Center) — an entity that delivers a comprehensive group of diagnostic and psychotherapeutic treatment services to mentally or emotionally disturbed persons and their families by an interdisciplinary team under the medical direction of a psychiatrist.

Mental Illness — mental and emotional disorders as defined in the current *International Classification of Diseases, Clinical Modification* or the American Psychiatric Association's *Diagnostic and Statistical Manual*, and manifested by impaired functioning in behavior, feeling, thinking, or judgment to the extent that the affected person, or someone else, can observe that the person affected is unable to fulfill reasonable personal and social expectations.

Multiple-Family Group Therapy — the treatment of more than one family unit at the same time in the same session, by one or more authorized staff members. There is more than one family member present per family unit and at least one of the family members per family unit must be an identified patient of the clinic program.

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Outreach Program — a mental-health-center program located off the premises of the mental health center that:

- (1) is located in the same Department of Mental Health area as the mental health center or in a contiguous area;
- (2) is open to patients no more than 20 hours per week; and
- (3) on a regular basis offers no more than 40 staff hours per week of mental health services.

Parent Center — the central location of the mental health center, at which most of the administrative, organizational, and clinical services are performed.

Professional Staff Member Authorized to Render Billable Mental Health Center Services — a person trained in the discipline of psychiatry, clinical or counseling psychology, social work, psychiatric nursing (includes a psychiatric nurse mental health clinical specialist), counseling, or occupational therapy as described in 130 CMR 429.424.

Psychological Testing — the use of standardized test instruments to evaluate aspects of an individual's functioning, including aptitudes, educational achievements, cognitive processes, emotional conflicts, and type and degree of psychopathology, subject to the limitations of 130 CMR 429.441(F).

Psychotherapy in Crisis — an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma.

Satellite Facility — a mental health center program at a different location from the parent center that operates under the license of and falls under the fiscal, administrative, and personnel management of the parent center and that meets the following criteria.

- (1) It is open to patients more than 20 hours a week.
- (2) It offers more than 40 person hours a week of services to patients.

Short-Term Therapy — a combination of diagnostics and individual, couple, family, and group therapy planned to terminate within 12 sessions.

Supervised Clinical Experience — experience in providing diagnostic and treatment services in an organized mental health setting to individuals, families, and groups of individuals under the direct and continuing supervision of a professional qualified in psychiatry, clinical or counseling psychology, psychiatric social work, or psychiatric nursing (includes psychiatric nurse mental health clinical specialist).

#### 429.403: Eligible Members

(A)(1) MassHealth Members. MassHealth covers mental health center services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the MassHealth agency's regulations. The MassHealth agency'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) Members 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.

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

(C) For limitations on mental health and substance abuse services provided to members enrolled with a MassHealth managed care provider, see 130 CMR 450.124.

#### 429.404: Provider Eligibility

(A) In State. Payment for the services described in 130 CMR 429.000 will be made only to mental health centers participating in MassHealth on the date of service. A center operated by a freestanding clinic, a satellite facility of a clinic, or an identifiable unit of a clinic, is eligible to participate only if the center is licensed by the Massachusetts Department of Public Health, is a Medicare-participating provider, and is certified by the MassHealth agency for the provision of mental health services at that location. However, the MassHealth agency may waive the clinic-licensure requirement for community health centers operated by local health departments that are thus exempt from licensure by the Massachusetts Department of Public Health under M.G.L. c. 111, s. 52, and that the MassHealth agency has certified as performing community health center services.

(B) Out of State. To participate in MassHealth, an out-of-state mental health center must obtain a MassHealth provider number and meet the following criteria:

- (1) if the center is required by its own state's law to be licensed, the center must be licensed by the appropriate state agency under whose jurisdiction it operates;
- (2) the center must participate in its own state's medical assistance program or its equivalent;
- (3) the center must be a Medicare-participating provider; and
- (4) the center must have a rate of reimbursement established by the appropriate rate setting regulatory body of its state.

#### 429.405: In-State Providers: Certification

(A) A center operated by a freestanding clinic, or an identifiable unit of a clinic, must meet the requirements listed in 130 CMR 429.421 through 429.441 in order to be certified by the MassHealth agency. A center operated by a satellite facility of a freestanding clinic must meet all the requirements for certification as well as the additional requirements outlined in 130 CMR 429.439, except for a dependent satellite program that is exempt from full compliance with 130 CMR 429.421, subject to the conditions set forth in 130 CMR 429.439(D).

(B) A separate application for certification as a mental health center must be submitted for each parent center and satellite facility operated by the applicant. The application must be made on the form provided by the MassHealth agency and must be submitted to the MassHealth agency's Mental Health Center Program. The MassHealth agency may request additional information from the applicant to evaluate the center's compliance with the regulations in 130 CMR 429.000.

(C) Based on the information revealed in the certification application and the findings of a site inspection, the MassHealth agency will determine whether the applicant is certifiable or not. The MassHealth agency will notify the applicant of the determination in writing within 60 days after the date of the site visit. If the MassHealth agency determines that the applicant is not certifiable, the notice will contain a statement of the reasons for that determination,

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recommendations for corrective action, and an assessment of the applicant's prospects for certification, so that the applicant may reapply for certification once corrective action has been taken.

(D) The certification is valid only for the center described in the application and is not transferable to other centers operated at other locations by the applicant. Any additional center established by the applicant at a satellite facility must obtain separate certification from the MassHealth agency in order to receive payment.

429.406: In-State Providers: Reporting Requirements

(A) All mental health centers must complete an annual report on forms furnished by the MassHealth agency and file them with the MassHealth agency within 90 days after the close of the MassHealth agency's fiscal year. The report must include the current staffing pattern, indicate any revisions or changes in written policies and procedures, describe the role of the psychiatrist, and provide any other information that the MassHealth agency may request.

(B) The MassHealth agency may conduct a site visit to verify compliance with 130 CMR 429.000. If deficiencies are observed during such a site visit, the MassHealth agency will send the center a letter itemizing these deficiencies. The center must then submit a plan of correction for all deficiencies cited in the letter, including the specific corrective steps to be taken, a timetable for these steps, and the date by which full compliance will be achieved, which must be no later than three months after the date of the MassHealth agency's letter. The MassHealth agency will accept the plan of correction only if it conforms to these requirements.

(C) All centers must submit promptly to the MassHealth agency the name and resume of any new clinical director or administrator. (See 130 CMR 429.423.)

(D) All centers must comply with all reporting requirements established under regulations of the Executive Office of Health and Human Services (EOHHS).

429.407: In-State Providers: Revocation of Certification

(A) The MassHealth agency has the right to review a mental health center's continued compliance with the conditions for certification referred to in 130 CMR 429.405 and the reporting requirements in 130 CMR 429.406 upon reasonable notice and at any reasonable time during the center's hours of operation. The MassHealth agency has the right to revoke the certification, subject to any applicable provisions of the MassHealth administrative and billing regulations at 130 CMR 450.000, if such review reveals that the center has failed to or ceased to meet such conditions.

(B) If the MassHealth agency determines that there exists good cause for the imposition of a lesser sanction than revocation of certification, it may withhold payment, temporarily suspend the center from participation in MassHealth, or impose some other lesser sanction as the MassHealth agency sees fit.



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429.408: In-State Providers: Maximum Allowable Fees

(A) The MassHealth agency pays for mental health center services with rates set by EOHHS, subject to the conditions, exclusions, and limitations set forth in 130 CMR 429.000. EOHHS fees for mental health center services are contained in 101 CMR 306.00.

(B) In the event that the center has a sliding-scale charge structure, the maximum published charges will be considered the center's usual charge to the general public, provided the following conditions are met:

- (1) the center's full charges must be published in a fee schedule;
- (2) the center's revenues must be based on the application of full charges with allowances noted for reduction of fees;
- (3) the center's procedure for reduction of fees must be in accordance with written policies; and
- (4) the center must maintain sufficient information to document the amount of the reductions.

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429.421: Scope of Services

(A) Requirements.

(1) A mental health center must have services available to treat a wide range of mental and emotional disorders, and it must provide comprehensive diagnostic assessments for a wide range of problems. In certain rare circumstances, the MassHealth agency may waive the requirement that the center directly provide one or more of these services if the center has a written referral agreement with another source of care to provide such services, and makes such referrals according to the provisions of 130 CMR 429.411.

(2) All services must be clinically determined to be medically necessary and appropriate, and must be delivered by qualified staff in accordance with 130 CMR 429.424, and as part of the treatment plan in accordance with 130 CMR 429.432. These services are provided in intermittent sessions that ordinarily last less than two hours and are available on a walk-in or an appointment basis. Except for diagnostic and crisis intervention/emergency services, mental health centers must deliver all services to members with a psychiatric diagnosis and who function at a sufficient level to benefit from treatment.

(B) Diagnostic and Treatment Services. A center must have the capacity to provide at least the following diagnostic and treatment services, as defined in 130 CMR 429.402:

- (1) diagnostic services;
- (2) psychological testing;
- (3) long-term therapy;
- (4) short-term therapy;
- (5) individual therapy;
- (6) couple therapy;
- (7) family therapy;
- (8) group therapy;
- (9) medication visit;
- (10) case consultation; Case consultation must consist of a scheduled meeting between the clinical staff at the mental health center and other providers of treatment concerning a member who is a center's client. Other providers of treatment are professional staff, who are not employed by the mental health center, but who are actively providing care or treatment for the member, including professional staff providing services on behalf of an employer. The purpose of case consultation must include at least one of the following:
  - (a) identifying and planning for additional services;
  - (b) coordinating a treatment plan with other providers involved in the member's care;
  - (c) reviewing the member's progress; or
  - (d) revising the treatment plan as required.
- (11) family consultation;
- (12) psychotherapy in crisis/emergency services;
- (13) after-hours telephone service; The telephone service must provide arrangements for effectively responding to the crisis. (A tape-recorded telephone message instructing patients to call a hospital emergency room is not acceptable.) Acceptable arrangements include
  - (a) professional staff members available to talk to clients over the telephone and, if indicated, to arrange for further care and assistance directly or through referral; or
  - (b) an after-hours live telephone service and a referral arrangement with a local hospital emergency department or other emergency service, established through a written agreement that sets forth the policy, personnel, referral, coordination, and other procedural commitments as set forth in 130 CMR 429.411; and
- (14) home visits.

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429.422: Staff Composition Requirements

(A) The mental health center must have a balanced interdisciplinary staffing plan that includes three or more core professional staff members who meet the qualifications outlined in 130 CMR 429.424 for their respective professions. Of these, one must be a psychiatrist, and two must be from separate nonphysician core disciplines, including psychology, social work, or psychiatric nursing. Certain additional staffing requirements are contained in 130 CMR 429.423.

(B) The staff must have specific training and experience to treat the target populations of the center. For example, staff treating children are required to have specialized training and experience in children's services. As further described in 130 CMR 429.424, staff who provide individual, group, family therapy, and multiple family group therapy to members under the age of 21 must be certified every two years to administer the Child and Adolescent Needs and Strengths (CANS), according to the process established by EOHHS.

(C) For clinic-licensed mental health centers, the staff composition requirements are contained in 130 CMR 429.422 and 429.423. Clinic-licensed mental health centers must employ the equivalent of at least three full-time professional staff members, two of whom must be core team members who meet qualifications outlined in 130 CMR 429.423 for their respective disciplines. When a clinic-licensed mental health center has 10 employees or fewer, the core team members must work a minimum of 20 hours a week.

(D) Dependent satellite programs must employ at least two full-time equivalent professional staff members from separate nonphysician core disciplines. The Director of Clinical Services at the parent center must ensure that supervision requirements of 130 CMR 429.438(E) are performed. If the satellite program's staff do not meet the qualifications for core disciplines as outlined in 130 CMR 429.424, they must receive supervision from qualified core staff professionals of the same discipline at the parent center.

(E) For clinic-licensed community health centers, the center must employ at least two half-time professional staff members from separate, nonphysician core disciplines who meet the qualifications outlined in 130 CMR 429.424 for their respective disciplines.

(F) Autonomous satellite programs, as defined in 130 CMR 429.402, must meet the requirement's specified in 130 CMR 429.422(C).

429.423: Position Specifications and Qualifications

(A) Administrator. The mental health center must designate one individual as administrator, who is responsible for the overall operation and management of the center and for ensuring compliance with MassHealth regulations. The administrator must have previous training or experience in personnel, fiscal, and data management, as described in 130 CMR 429.438.

- (1) The same individual may serve as both the administrator and clinical director.
- (2) In a community health center, the administrator of the entire facility may also administer the mental health center program.

(B) Director of Clinical Services. Mental health centers must designate a professional staff member to be the clinical director who is then responsible to the administrator for the direction and control of all professional staff members and services.

- (1) The clinical director must be licensed, certified, or registered to practice in one of the

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core disciplines listed in 130 CMR 429.424, and must have had at least five years of full-time, supervised clinical experience subsequent to obtaining a master's degree, two years of which must have been in an administrative capacity. The clinical director must be employed on a full-time basis. When the clinic is licensed as a community health center, the clinical director must work at the center at least half-time.

- (2) The specific responsibilities of the clinical director include
- (a) selection of clinical staff and maintenance of a complete staffing schedule;
  - (b) establishment of job descriptions and assignment of staff;
  - (c) overall supervision of staff performance;
  - (d) accountability for adequacy and appropriateness of patient care;
  - (e) in conjunction with the medical director, accountability for employing adequate psychiatric staff to meet the psychopharmacological needs of clients;
  - (f) establishment of policies and procedures for patient care;
  - (g) program evaluation;
  - (h) provision of some direct patient care in circumstances where the clinical director is one of the three minimum full-time equivalent staff members of the center;
  - (i) development of in-service training for professional staff; and
  - (j) establishment of a quality management program.

(C) Medical Director. The mental health center must designate a psychiatrist who meets the qualifications outlined in 130 CMR 429.424(A) as the medical director, who is then responsible for establishing all medical policies and protocols and for supervising all medical services provided by the staff. The medical director must work at the center a minimum of eight hours a week. When the clinic is licensed as a community health center, the medical director must work at the center at least four hours a week.

(D) Psychiatrist.

(1) The roles and duties of administrator, director of clinical services, and medical director, as detailed in 130 CMR 429.423(A), (B), and (C), may be assumed, all or in part, by a psychiatrist on the center's staff, provided that provision of services to members and performance of all relevant duties in these regulations are carried out to meet professionally recognized standards of health care, as required by MassHealth administrative and billing regulations at 130 CMR 450.000.

(2) The role of the psychiatrist in the center, apart from any duties that may be assumed under 130 CMR 429.423(A), (B), or (C), must include the following:

- (a) responsibility for the evaluation of the physiological, neurological, and psychopharmacological status of the center's clients;
- (b) involvement in diagnostic formulations and development of treatment plans;
- (c) direct psychotherapy, when indicated;
- (d) participation in utilization review or quality-assurance activity;
- (e) coordination of the center's relationship with hospitals and provision of general hospital consultations as required;
- (f) supervision of and consultation to other disciplines; and
- (g) clinical coverage on an "on call" basis at all hours of center operation.

429.424: Qualifications of Professional Staff Authorized to Render Billable Mental Health Center Services by Core Discipline

(A) Psychiatrist.

(1) At least one staff psychiatrist must either currently be certified by the American Board of Psychiatry and Neurology, or be eligible and applying for such certification.

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(2) Any additional psychiatrists must be, at the minimum, licensed physicians in their second year of a psychiatric residency program accredited by the Council on Medical Education of the American Medical Association. Such physicians must be under the direct supervision of a fully qualified psychiatrist.

(3) Any psychiatrist or psychiatric resident who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by EOHHS.

**(B) Psychologist.**

(1) At least one staff psychologist must be licensed by the Massachusetts Board of Registration of Psychologists with a specialization listed in clinical or counseling psychology or a closely related specialty.

(2) Additional psychological associates trained in the field of clinical or counseling psychology or a closely related specialty must

(a) have a minimum of a master's degree or the equivalent graduate study in clinical or counseling psychology or a closely related specialty from an accredited educational institution;

(b) be currently enrolled in or have completed a doctoral program in clinical or counseling psychology or a closely related specialty; and

(c) have had two years of full-time supervised clinical experience subsequent to obtaining a master's degree in a multidisciplinary mental-health setting. (One year of supervised clinical work in an organized graduate internship program may be substituted for each year of experience.) All services provided by such additional staff members must be under the direct and continuing supervision of a psychologist meeting the requirements set forth in 130 CMR 429.424(B)(1).

(3) Any psychologist who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by EOHHS.

**(C) Social Worker.**

(1) At least one staff social worker must have received a master's degree in social work from an accredited educational institution and must have had at least two years of full-time supervised clinical experience subsequent to obtaining a master's degree. This social worker must also be licensed or have applied for and have a license pending as an independent clinical social worker by the Massachusetts Board of Registration of Social Workers.

(2) Any additional social workers on the staff must provide services under the direct and continuous supervision of an independent clinical social worker. Such additional social workers must be licensed or applying for licensure as certified social workers by the Massachusetts Board of Registration of Social Workers and have received a master's degree in social work and completed two years of full-time supervised clinical work in an organized graduate internship program.

(3) Any social worker who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by EOHHS.

**(D) Psychiatric Nurse.**

(1) At least one psychiatric nurse must be currently registered by the Massachusetts Board of Registration in Nursing and must have a master's degree in nursing from an accredited National League of Nursing graduate school with two years of full-time supervised clinical experience in a multidisciplinary mental-health setting and be eligible for certification as a

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clinical specialist in psychiatric/mental-health nursing by the American Nursing Association.

(2) Any other nurses must be currently registered by the Massachusetts Board of Registration in Nursing and must have a bachelor's degree from an educational institution accredited by the National League of Nursing and two years of full-time supervised skilled experience in a multidisciplinary mental-health setting subsequent to that degree, or a master's degree in psychiatric nursing.

(E) Psychiatric Nurse Mental Health Clinical Specialist. A psychiatric nurse mental health clinical specialist is a licensed registered nurse who is authorized by the Board of Registration in Nursing as practicing in an expanded role and who meets the requirements of 244 CMR 4.13(3): *Psychiatric Nurse Mental Health Clinical Specialist*. A psychiatric nurse mental health clinical specialist can perform prescribing duties within their scope of practice.

(F) Counselor.

(1) All counselors and unlicensed staff included in the center must be under the direct and continuous supervision of a fully qualified professional staff member trained in one of the core disciplines described in 130 CMR 429.424(A) through (D).

(2) All counselors must hold a master's degree in counseling education, counseling psychology, or rehabilitation counseling from an accredited educational institution and must have had two years of full-time supervised clinical experience in a multidisciplinary mental-health setting subsequent to obtaining the master's degree. (One year of supervised clinical work in an organized graduate internship program may be substituted for each year of full-time experience.)

(3) Any counselor who provides individual, group, or family therapy to members under the age of 21 must be certified every two years to administer the CANS, according to the process established by EOHHS.

(G) Occupational Therapist.

(1) Any occupational therapist must be currently registered by the American Occupational Therapy Association and must have

(a) a master's degree in occupational therapy from an accredited program in occupational therapy; or

(b) a bachelor's degree in occupational therapy from an accredited program in occupational therapy and a master's degree in a related field such as psychology, social work, or counseling.

(2) In addition, any occupational therapist must have at least two years of full-time supervised clinical experience subsequent to obtaining a master's degree. (One year of supervised clinical work in an organized graduate internship program may be substituted for each year of full-time experience.)

(130 CMR 429.425 through 429.430 Reserved)

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429.431: Operating Procedures

(A) A professional staff member authorized to render billable mental health center services as described in 130 CMR 429.424, must conduct a comprehensive evaluation of each member before initiating therapy. For members under the age of 21, a CANS must be completed during the initial behavioral-health assessment before the initiation of therapy and be updated at least every 90 days thereafter by a CANS-certified provider, as described in 130 CMR 429.424.

(B) The center must accept a member for treatment, refer the member for treatment elsewhere, or both, if the intake evaluation substantiates a mental or emotional disorder.

(C) One professional staff member must assume primary responsibility for each member (the primary therapist).

(D) The center program must make provisions for responding to persons needing services on a walk-in basis.

(E) The center must take appropriate steps to facilitate uninterrupted and coordinated member care whenever it refers a member elsewhere for treatment not available at the center or for subsequent treatment.

(F) Before referring a member elsewhere, the center must, with the member's consent, send a summary of or the actual record of the member to that referral provider before initiating therapy.

429.432: Treatment Planning and Case Review

A multidisciplinary team composed of mental health professionals, in accordance with the Department of Public Health (DPH) regulations at 105 CMR 140.530, must conduct treatment planning, assessments, and case review for each member as follows.

(A) The multidisciplinary team must conduct case review according to the DPH regulations at 105 CMR 140.540; must prepare a treatment plan that complies with DPH regulations at 105 CMR 140.520(C); and must establish criteria for determining when termination of treatment is appropriate.

(B) For members under the age of 21, the multidisciplinary team must ensure that the CANS has been completed at the initial behavioral-health assessment and is updated at least every 90 days thereafter.

(C) The multidisciplinary team must review each case at termination of treatment and prepare a termination summary that describes the course of treatment and the aftercare program or resources in which the member is expected to participate.

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429.433: Coordination of Medical Care

A mental health center must coordinate psychotherapeutic treatment with medical care for MassHealth members. If a member has not received a physical exam within six months of the date of intake, the mental health center must advise the member that one is needed. If the member does not have an existing relationship with a physician, the mental health center must assist the member in contacting the MassHealth agency's customer service toll-free line to receive help in selecting a physician. If the member does not want a physical examination, the member's record must document the member's preference and any stated reason for that preference.

429.434: Schedule of Operations

- (A) There must be at least one location where a freestanding mental health center operates a program that is open at least 40 hours a week.
- (B) A mental health center operated by a clinic-licensed community health center must be open at least 20 hours a week.
- (C) When the center is closed, telephone coverage must be provided by personnel offering referral to operating emergency facilities, on-call clinicians, or other mechanisms for effectively responding to a crisis, in accordance with the requirements set forth at 130 CMR 429.421(B)(13).



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429.435: Utilization Review Plan

The mental health center must have a utilization review plan that meets the following conditions.

(A) A utilization review committee must be formed, composed of the clinical director (or his or her designee) and two other professional staff members who meet all the qualifications for their discipline, as outlined in 130 CMR 429.424.

(B) The utilization review committee must review each of the center's cases in accordance with the Department of Public Health regulations found at 105 CMR 140.540 and following the member's termination.

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(2) In an autonomous satellite program, the supervisor must meet the qualifications required of a core staff member in his or her discipline, as set forth in 130 CMR 429.424.

(3) In a dependent satellite program, the supervisor must meet the basic qualifications required for his or her discipline, as set forth in 130 CMR 429.424, and receive regular supervision and consultation from qualified core staff at the parent center.

(D) If a dependent satellite program does not offer the entire range of services available at the parent center, the dependent satellite program must refer clients to the parent center or a facility that offers such services. The parent center must determine the necessity for treatment and the appropriateness of the treatment plan for such clients and institute a clear mechanism through which this responsibility is discharged, by consultation with the satellite program team, regular supervision of the satellite program by supervisory-level professional core staff in the parent center, or by other appropriate means. For staff composition requirements pertaining to dependent satellite programs, see 130 CMR 429.422(D).

#### 429.440: Outreach Programs

An outreach program operated by a mental health center is eligible for payment if it meets the standards described in 130 CMR 429.440(A) through (G).

(A) Outreach program staff members must receive supervision and in-service training in accordance with the requirements specified in 130 CMR 429.438(E).

(B) The director of clinical services must meet at least on a monthly basis with outreach program staff members and have direct contact with outreach program clients as necessary to provide medical diagnosis, evaluation, and treatment in accordance with the requirements outlined in 130 CMR 429.423(B).

(C) Outreach programs must maintain the records of their clients on the premises of the parent center.

(D) Outreach programs must be subject to all written policies and procedures of the parent center governing the kinds of services that the outreach program offers.

(E) Outreach programs must meet the requirements of 130 CMR 429.439(D) applicable to dependent satellite programs.

(F) Outreach program services must conform to the definition in 130 CMR 429.402.

(G) Services provided at outreach programs are subject to the requirements in 130 CMR 429.431, 429.432, and 429.435.

#### 429.441: Service Limitations

(A) Diagnostic and Treatment Services. The MassHealth agency pays for diagnostic and treatment services only when a professional staff member, as defined by 130 CMR 429.424, personally provides these services to the member or the member's family, or personally consults with a professional outside of the center. The services must be provided to the member on an individual basis, and are not reimbursable if they are an aspect of service delivery, as defined in 130 CMR 429.408(C).

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(B) Multiple Sessions on a Same Date of Service. The MassHealth agency pays for only one session of a single type of service (except for diagnostics) provided to an individual member on one date of service. Return visits on the same date of service are not reimbursable.

(C) Case Consultation.

(1) The MassHealth agency pays only for a case consultation that involves a personal meeting with a professional of another agency.

(2) The MassHealth agency pays for case consultation only when telephone contact, written communication, and other nonreimbursable forms of communication clearly will not suffice. Such circumstances must be documented in the member's record. Such circumstances are limited to situations in which both the center and the other party are actively involved in treatment or management programs with the member (or family members) and where a lack of face-to-face communication would impede a coordinated treatment program.

(3) The MassHealth agency does not pay a center for court testimony.

(D) Family Consultation. The MassHealth agency pays for consultation with the natural or foster parent or legal guardian of a member less than 21 years of age who lives with the child and is responsible for the child's care, and who is not an eligible member, when such consultation is integral to the treatment of the member.

(E) Group Therapy.

(1) Payment is limited to one fee per group member with a maximum of 10 members per group regardless of the number of staff members present.

(2) The MassHealth agency does not pay for group therapy when it is performed as an integral part of a psychiatric day treatment program.

(F) Psychological Testing. The MassHealth agency pays a center for psychological testing only when the following conditions are met.

(1) A psychologist who meets the qualifications listed in 130 CMR 429.424(B) either personally administers the testing or personally supervises such testing during its administration by an unlicensed psychologist.

(2) A battery of tests is performed. These tests must meet the following standards:

(a) the tests are published, valid, and in general use, as evidenced by their review in the current edition of the *Mental Measurement Yearbook* or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological Association;

(b) unless clinically contraindicated due to hearing, physical, or visual impairment or linguistic challenges, a personality evaluation contains the findings of at least two of the following test types or their age-appropriate equivalents: Rorschach, TAT (Thematic Apperception Test), TED (Tasks of Emotional Development), or MMPI (Minnesota Multiphasic Personality Inventory), and one or more of the following test types: figure drawing, Bender Gestalt, or word association;

(c) unless clinically contraindicated due to hearing, physical, or visual impairment or linguistic challenges, intelligence testing includes either a full Wechsler or Stanford-Binet instrument; and

(d) unless clinically contraindicated due to hearing, physical, or visual impairment or

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linguistic challenges, assessment of brain damage must contain at least the findings of a Wechsler Intelligence Scale and tests of recent memory, visual-space perception, and other functions commonly associated with brain damage.

- (3) Except as explained below, the MassHealth agency does not pay for
- (a) self-rating forms and other paper-and-pencil instruments, unless administered as part of a comprehensive battery of tests;
  - (b) group forms of intelligence tests; or
  - (c) a repetition of any psychological test or tests provided by the mental health center or any independent psychologist to the same member within the preceding six months, unless accompanied by documentation demonstrating that the purpose of the repeated testing is to ascertain the following types of changes (submission of such documentation with the claim for payment is sufficient when the psychological test or tests are to be performed on the same member a second time within a six-month period):
    - (i) following such special forms of treatment or intervention as electroshock therapy or psychiatric hospitalization (periodic testing to measure the member's response to psychotherapy is not reimbursable); or
    - (ii) relating to suicidal, homicidal, toxic, traumatic, or neurological conditions.
- (4) Testing of a member requested by responsible parties, such as but not limited to physicians, clinics, hospitals, schools, courts, group homes, or state agencies, must be documented in the member's record. Such documentation must include the referral source and the reason for the referral.

(G) Home Visits.

- (1) The MassHealth agency pays for intermittent home visits.
- (2) Home visits are reimbursable on the same basis as comparable services provided at the center. Travel time to and from the member's home is not a reimbursable service.
- (3) A report of the home visit must be entered into the member's record.

(H) Multiple Therapies. The MassHealth agency pays for more than one mode of therapy used for a member during one week only if clinically justified; that is, when any single approach has been shown to be necessary but insufficient. The need for additional modes of treatment must be documented in the member's record.

(I) Psychotherapy in Crisis Services. The MassHealth agency pays for psychotherapy in crisis as defined in 130 CMR 429.402.

- (1) This service is limited to face-to-face contacts with the member; psychotherapy in crisis service via telephone contact is not a reimbursable service.
- (2) The need for psychotherapy in crisis services must be fully documented in the member's record for each date of psychotherapy in crisis services.

(J) Outreach Services Provided in Nursing Facilities.

- (1) The MassHealth agency pays a center for diagnostic and treatment services provided to a member residing in a nursing facility under the following circumstances and conditions:
  - (a) the nursing facility specifically requests treatment, and the member's record at the nursing facility documents this request;
  - (b) the treatment provided does not duplicate services that should be provided in the nursing facility; and
  - (c) such services are generally available through the center to members not residing in that nursing facility.

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- (2) The following conditions must be met:
- (a) the member's record at the parent center must contain all of the information listed in 130 CMR 429.436;
  - (b) the member's record at the nursing facility must contain information pertaining to diagnostic and treatment services including, but not limited to, medication, treatment plan, progress notes on services, case review, and utilization review; and
  - (c) the member must function at a sufficient level to benefit from treatment as established by a clinical evaluation and by accepted standards of practice.

429.442: Child and Adolescent Needs and Strengths (CANS) Data Reporting

For each Child and Adolescent Needs and Strengths (CANS) conducted, the mental health center must report data collected during the assessment to the MassHealth agency, in the manner and format specified by the MassHealth agency.

REGULATORY AUTHORITY

130 CMR 429.000: M.G.L. c. 118E, ss. 7 and 12.

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## 601 Service Codes and Descriptions

MassHealth pays for the services represented by the codes listed in Subchapter 6 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 429.000 and 450.000.

### Service

Code-Modifier   Service Description

#### **Psychiatric Evaluation**

- 90791      Psychiatric diagnostic evaluation
- 90791 HA    Psychiatric evaluation performed with a CANS (Children and Adolescent Needs and Strengths)

#### **Individual Therapy**

- 90832      Psychotherapy, 30 minutes with patient and/or family member
- 90833      Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure.) (Must be submitted on the same claim.)
- 90834      Psychotherapy, 45 minutes with patient and/or family member
- 90836      Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure.) (Must be submitted on the same claim.)

#### **Couple/Family Therapy**

- 90847      Family psychotherapy (conjoint psychotherapy) (with patient present)
- 90849      Multiple-family group psychotherapy (per person per session, not to exceed 10 clients)

#### **Group Therapy**

- 90853      Group psychotherapy (other than of a multiple-family group) (per person not to exceed 10 clients)

#### **Case Consultation**

- 90882      Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions

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Service

Code-Modifier   Service Description

**Family Consultation**

90887      Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (per one-half hour)

**Crisis Intervention for Youth Services (for youths up to 21 years of age only)**

H2011-U1      Crisis intervention service, per 15 minutes. Youth Mobile Crisis intervention modifier for service provided by a Master Level Clinician (used with H2011 only)

H2011-U2      Crisis intervention services, per 15 minutes. Youth Mobile Crisis intervention modifier for service provided by a paraprofessional (used with H2011 only)

**Psychotherapy for Crisis**

90839      Psychotherapy for crisis, up to 74 minutes

90840      Psychotherapy for crisis, 30 minutes (not to exceed two units in one day following 90839)

**Note:** Do not report 90839, 90840 in conjunction with 90791, psychotherapy codes 90832 through 90836, or other psychiatric services. Only use 90840 in conjunction with 90839.

**Emergency Service Program**

S9485      Emergency Services program (ESP). The ESP provides crisis assessment, intervention, and stabilization services 24 hours per day, seven days a week, and 365 days per year to individuals of all ages who are experiencing a behavioral health crisis.

**Evaluation and Management Codes**

Medication Visits—Services for medication visits shall be billed using the following appropriate Evaluation and Management Codes

**New Patient**

99201      Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem-focused history; a problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. Office or other outpatient visit for the evaluation and management of a new patient

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601 Service Codes and Descriptions (cont.)

Service

Code-Modifier   Service Description

- 99202      Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
- 99203      Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
- 99204      Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
- 99205      Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**Established Patient**

- 99211      Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.



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Service

Code-Modifier   Service Description

- 99212            Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
- 99213            Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem-focused history; an expanded problem-focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
- 99214            Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
- 99215            Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**Nursing Facility Care–New Patient**

- 99304            Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

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Service

Code-Modifier   Service Description

99305            Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

99306            Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.

**Subsequent Nursing Facility Care**

99307            Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem-focused interval history; a problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit.

99308            Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

99309            Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

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99310            Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

**Rest Home–New Patient**

99324            Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a problem-focused history; a problem-focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.

99325            Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.

99326            Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

99327            Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

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601 Service Codes and Descriptions (cont.)

Service

Code-Modifier   Service Description

99328            Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.

**Rest Home–Established Patient**

99334            Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused interval history; a problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.

99335            Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

99336            Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

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601 Service Codes and Descriptions (cont.)

Service

Code-Modifier   Service Description

99337            Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

**Home Visits–New Patient**

99341            Home visit for the evaluation and management of a new patient, which requires these three key components: a problem-focused history; a problem-focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99342            Home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99343            Home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99344            Home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

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601 Service Codes and Descriptions (cont.)

Service

Code-Modifier   Service Description

99345      Home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.

**Home Visit–Established Patient**

99347      Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused interval history; a problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99348      Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99349      Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99350      Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

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601 Service Codes and Descriptions (cont.)

Service

Code-Modifier    Service Description

**Psychological Testing**

- 96101            Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
- 96118            Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales, and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

602 Service Code Modifiers and Descriptions

Modifier

Modifier Description

- 25              Significant, separately identifiable Evaluation and Management Service by the same physician or other qualified health professional on the same day of the procedure or other service. Modifier '-25' applies to two E/M services provided on the same day.
- 59              Distinct Procedure Service. To identify a procedure distinct or independent from other services performed on the same day add the modifier '-59' to the end of the appropriate service code. Modifier '-59' is used to identify services/procedures that are not normally reported together, but are appropriate under certain circumstances. However when another already established modifier is appropriate, it should be used rather than modifier '-59'.
- SA              Nurse Practitioner rendering service in collaboration with a physician. (This modifier is to be applied to service codes billed by the mental health center which were performed by a psychiatric nurse mental health clinical specialist.)
- U1              Youth Mobile Crisis intervention modifier for service provided by a Master Level Clinician (only used with H2011)
- U2              Youth Mobile Crisis intervention modifier for service provided by a paraprofessional (only used with H2011)

This publication contains codes that are copyrighted by the American Medical Association. Certain terms used in the service descriptions for HCPCS codes are defined in the Current Procedural Terminology (CPT) code book.