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

MassHealth
Transmittal Letter MHC-51
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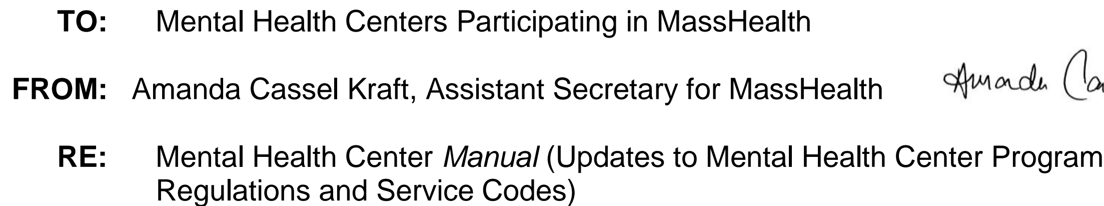

TO: Mental Health Centers Participating in MassHealth

FROM: Amanda Cassel Kraft, Assistant Secretary for MassHealth

RE: Mental Health Center *Manual* (Updates to Mental Health Center Program Regulations and Service Codes)

This letter transmits revisions to the *Mental Health Center Manual* and the list of service codes contained in Subchapter 6 of the *Mental Health Center Manual*, as described below.

Changes to the Mental Health Center Program Regulations

This letter transmits updates to the mental health center program regulation at 130 CMR 429.000. Relevant sections of 130 CMR 429.000 have been revised to reflect changes to programmatic regulations. Revisions include updates to service definitions, scope of services, staffing requirements, provider eligibility, reporting, and maximum allowable fees. Changes also update satellite clinic requirements and outreach requirements.

These regulations are effective January 1, 2023.

Updates to the Service Codes and Descriptions

1. Effective for dates of service beginning January 1, 2023, the following codes have been deleted, modified, or added to the of codes available in Subchapter 6 of the *Mental Health Center Manual.*

   Delete

   96101
   96118

   Modify

   90832
   90834
   90839
   90840
   90847
   90853
   90887
   S9485

Add

90837
90846
96116
96121
96130
96131
96132
96133
96136
96137
96138
96139
S9480
H0015
H0015-TF
H0046-HE

2. Effective for dates of service beginning January 1, 2023, the following modifiers have been added to the list of modifiers available in Subchapter 6 of the *Mental Health Center Manual*.

   Add

   - -AF
   - -AH
   - -GJ
   - -HE
   - -HL
   - -HO

Rates

Rates for MHCs participating in MassHealth are set by regulation by the Executive Office of Health and Human Services and are available at www.mass.gov/service-details/eohhs-regulations.

The applicable rate regulations for codes deleted, modified, or added to the Subchapter 6 of this *Mental Health Center Manual* are 101 CMR 306.00: *Payment for Mental Health Services Provided in Community Health and Mental Health Center* and 101 CMR 329.00: *Rates for Psychological and Independent Clinical Social Work Services*.

MassHealth Website

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

Sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins.

Questions

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at (800) 841-2900, email 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.)

Mental Health Center Manual

Pages iv, 4-1 through 4-26 and pages 6-1 through 6-12

OBSOLETE MATERIAL

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

Mental Health Center Manual

Pages 4-7, 4-8, 4-17 through 4-20, 4-25, and 4-26 — transmitted by Transmittal Letter MHC-39

Pages iv, 4-1 through 4-6, 4-9 through 4-16, and 4-21 through 4-24 — transmitted by Transmittal Letter MHC-48

Pages 6-1 through 6-12 — transmitted by Transmittal Letter MHC-50

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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 and satellite clinics. All mental health centers participating in MassHealth must comply with the MassHealth regulations, including but not limited to, 130 CMR 429.000 *Mental Health Center Services*, and 130 CMR 450.000: *Administrative and Billing Regulations.*

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.

Adverse Incident - an occurrence that represents actual or potential serious harm to the well-being of a member, or to others under the care of-the mental health center. Adverse incidents may be the result of the actions of a member served, actions of a staff member providing services, or incidents that compromise the health, safety, or operations of the center.

Behavioral Health Disorder – any disorder pertaining to mental health or substance use as defined by the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*

Behavioral Health Urgent Care Provider – a center that meets the requirements set forth in 130 CMR 429.405(D).

Case Consultation – intervention, including scheduled audio-only telephonic, audio-video, or in person meetings, for behavioral and medical management purposes on a member's behalf with agencies, employers, or institutions which may include the preparation of reports of the member's psychiatric status, history, treatment, or progress (other than for legal purposes) for other physicians, agencies, or insurance carriers.

Certified Peer Specialist (CPS) – a person who has been trained by an agency approved by the Department of Mental Health (DMH) who is a self-identified person with lived experience of a mental health disorder and wellness that can effectively share their experiences and serve as a mentor, advocate, or facilitator for a member experiencing a mental health disorder.

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.

Communication Protocol – formal descriptions of requirements that allow two or more providers to exchange information.

Core Discipline – licensed behavioral health disciplines, including, but not limited to: psychiatry, social work, psychology, or psychiatric nursing (including a psychiatric clinical nurse specialist), which compose a mental health center's multidisciplinary staff.

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

Crisis Intervention – an urgent evaluation including assessment of risk, diagnosis, short-term intervention, and rendering of a disposition for a member's presenting crisis, which may include referral to an existing or new behavioral health provider.

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

Direct and Continuous Supervision – ongoing supervision provided to unlicensed staff and not independently licensed staff at a frequency of no less than one hour of supervision per week for full-time employees. Supervision time may be pro-rated based on scheduled hours for employees employed less than full-time. Direct and continuous supervision must be delivered by an independently licensed staff member or certified peer supervisor who is employed by the agency.

Enhanced Structured Outpatient Addiction Program (E-SOAP) – American Society of Addiction Medicine (ASAM) Level Intensive Outpatient Services - a program that provides short-term, clinically intensive, structured day and/or evening SUD services. E-SOAP specifically serves specialty populations including homeless individuals and people at risk of homelessness; pregnant individuals; and adolescents. E-SOAP services must meet requirements as set forth in 130 CMR 418.

Family Consultation – a scheduled meeting 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 visit.

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.

Individual Therapy – psychotherapeutic services provided to an individual.

Intensive Outpatient Program (IOP) – a mental health treatment service that provides time-limited, multi-disciplinary, multimodal structured treatment in an outpatient setting for individuals requiring a clinical intensity that exceeds outpatient treatment. Service includes individual, group, and family therapy as well as case management services.

Medication for Addiction Treatment – use of a medication approved by the federal Food and Drug Administration (FDA), for the treatment of a substance use disorder.

Medication Visit – a member visit specifically for the prescription, review, and monitoring of psychotropic medication by a psychiatrist, psychiatric clinical nurse specialist, advanced

practice registered nurse, or physician assistant or administration of prescribed intramuscular medication by a physician. nurse, or Physician Assistant.

Mental Health Center (Center) – an entity that delivers a comprehensive group of diagnostic and psychotherapeutic treatment services to individuals seeking treatment for mental health disorders, which may include co-occurring substance use disorder, and their families, by an interdisciplinary team under the medical direction of a psychiatrist.

Mental Health Disorder – any disorder pertaining to mental health as defined by the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

Multiple-Family Group Therapy – the treatment of more than one family unit, at the same time in the same visit, by one or more authorized staff member. 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 center.

Outreach Program – mental health and substance use disorder treatment services being delivered by a clinical or paraprofessional staff member of the center off the premises of the mental health center or any of its satellite clinics, including, but not limited to, services in members' homes or other community environments.

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

Peer Recovery Coach – an individual currently in recovery who has lived experience with substance use or other addictive disorders and/or co-occurring mental health disorders and has been trained to help their peers with a similar experience to gain hope, explore recovery, and achieve life goals. Peer Recovery Coaches must meet requirements as set forth in 130 CMR 418.000.

Pharmacotherapy – providing therapeutic treatment with pharmaceutical drugs.

Physician – an individual licensed by the Massachusetts Board of Registration in Medicine in accordance with M.G.L. c. 112, § 2.

Preventive Behavioral Health Services – short-term group interventions, recommended by a physician or other licensed practitioner, practicing within their scope of licensure, that cultivate coping skills and strategies for symptoms of depression, anxiety, and other social/emotional concerns, to prevent the development of behavioral health disorders for children and adolescents under the age of 21.

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 411.000.

Quality Management Program – a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to members, with focused attention on addressing cultural, ethnic, and language differences.

Recovery Support Navigator – a paraprofessional specialist who receives specialized training in the essentials of substance use disorder and evidence-based techniques, such as motivational interviewing, and who supports members in accessing and navigating the substance use disorder treatment system through activities that can include care coordination, case management, and motivational support. Recovery support navigators must meet requirements as set forth in 130 CMR 418.

Release of Information (ROI) – a document that allows a patient to authorize and revoke what information they want to release from their patient record, who it can be released to, how long it can be released for, and under what statutes and guidelines it is released.

Satellite Clinic – a clinic 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.

Structured Outpatient Addiction Program (SOAP): ASAM Level Intensive Outpatient Services a substance use disorder treatment service that provides short-term, multi-disciplinary, clinically intensive structured treatment to address the sub-acute needs of members with substance use disorders and/or co-occurring disorders. These services may be used as a transition service in the continuum of care toward lower intensity outpatient services or accessed directly. SOAP services must meet requirements as set forth in 130 CMR 418.000.

Substance Use Disorder – any disorder pertaining to substance use as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Supervised Clinical Experience – a clinician's experience providing diagnostic and treatment services to individuals, families, and groups of individuals under the direct and continuous supervision of a qualified independently licensed professional as set forth in 130 CMR 429.423, who is employed by the same agency as the supervisee.

Telehealth – the use of synchronous or asynchronous audio, video, electronic media, or other telecommunications technology, including, but not limited to: (i) interactive audio-video technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical health, oral health, mental health, or substance use disorder condition.

Urgent Behavioral Health Needs - needs characterized by changes in behavior or thinking, role dysfunction, emerging intent of self-injury, or threats to others. Urgent behavioral health needs do not rise to the level of immediate risk of harm to self or others.

429.403: Eligible Members

(A) 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. Covered services for each MassHealth coverage type are set forth in 130 CMR 450.105: *Coverage Types*.

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

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

(D) For limitations on mental health disorder and substance use disorder services provided to members enrolled with a MassHealth managed care provider, see 130 CMR 450.105: *Coverage Types* and 130 CMR 450.124: *Behavioral Health Services*.

429.404: Provider Eligibility

(A) In State. Each center operated by a freestanding clinic or a satellite clinic is eligible to participate only if the center is:
- (1) enrolled as a Medicare provider;
- (2) enrolled and actively participating with the MassHealth agency as a billing provider as evidenced by the issuance of a Provider Identification and Service Location (PIDSL) number for the provision of mental health center services at that location; and
- (3) licensed by the Massachusetts Department of Public Health. The MassHealth agency may waive the clinic licensure requirement for centers that are:
  - (a) operated by a local department of public health; and
  - (b) comply with 130 CMR 429.404(A)(2).

(B) Out of State. Each out-of-state center operated by a freestanding clinic or satellite clinic is eligible to participate only if the center:
- (1) meets the following criteria:
  - (a) if the center is required by its own state's law to be licensed, each center must be licensed by the appropriate state agency under whose jurisdiction it operates;
  - (b) each center must participate in its own state's medical assistance program or its equivalent;
  - (c) each center must have a rate of reimbursement established by the appropriate rate setting regulatory body of its state.
- (2) is a Medicare-participating provider;
- (3) is enrolled by the MassHealth agency as a provider of mental health center services at that location; and obtains a MassHealth PIDSL number.

(C) Behavioral Health Urgent Care Provider Eligibility. To be designated as a Behavioral Health Urgent Care provider, a center must meet the eligibility requirements set forth in 130 CMR 429.404(A) and the following criteria:
- (1) Comply with the regulations in 130 CMR 429.000;
- (2) Attest at a time and in a form determined by the MassHealth agency to being able to meet the following requirements:
  - (a) Appointments
    1. Appointments for diagnostic evaluation services for new clients are available on the same or next day of clinic operation, when clinically indicated based on initial intake;
    2. Appointments for all existing clients with an urgent behavioral health need are available on the same or next day of clinic operation;

3. Urgent psychopharmacology appointments and Medication for Addiction Treatment evaluation are available within 72 hours of an initial diagnostic evaluation and based on a psychosocial assessment; and

4. All other treatment appointments including follow-up appointments are available within 14 calendar days.

(b) Hours: Meet the requirements as set forth in 429.434(D)

(3) Multiple Clinics: The Behavioral Health Urgent Care provider requirements shall be met at the clinic location level.

(D) Each center operated by a freestanding clinic or satellite clinic must meet the requirements listed in 130 CMR 429.000 in order to be enrolled by the MassHealth agency.

(E) Payment for services described in 130 CMR 429.000 will be made only to mental health centers participating in MassHealth on the date of service.

429.405: Provider Enrollment Process

(A) A separate, complete application for enrollment as a mental health center must be submitted for each parent clinic and each satellite clinic operated by the parent clinic that operates under a different tax identification number than the parent clinic. The applicant must submit the appropriate provider enrollment application to the MassHealth agency. The MassHealth agency may request additional information or perform a site inspection to evaluate the applicant's compliance with the regulations in 130 CMR 429.000.

(1) Based on the information in the enrollment application, information known to the MassHealth agency about the applicant, and on the findings from any site inspection deemed necessary, the MassHealth agency will determine whether the applicant is eligible for enrollment.

(2) The MassHealth agency will notify the applicant of the determination in writing within 60 days of the MassHealth agency receiving a completed application. An application shall not be considered complete until the applicant has responded to all MassHealth requests for additional information, and MassHealth has completed any required site inspection.

(B) If the MassHealth agency determines that the applicant is not eligible for enrollment, the notice will contain a statement of the reasons for that determination, including, but not limited to, incomplete application materials and recommendations for corrective action, if appropriate, so that the applicant may reapply for enrollment once corrective action has been completed.

(C) The enrollment is valid only for the center or centers 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 clinic or other location must separately apply for enrollment and be enrolled with the MassHealth agency to receive payment.

429.406: Required Notifications and Reports

(A) Annual Report. Each mental health center must submit a completed annual report, on forms furnished by the MassHealth agency, and file them with the MassHealth agency by September 30 of each year. The report must include at minimum:

(1) A statement that the program has reviewed and updated, as necessary, its written policies and procedures during the reporting period. Each program must provide a copy of

the program's written policies and procedures as requested by the MassHealth agency.
(2) A list of all Center Administrative and Clinical Management Staff as listed in 130 CMR 429.422(C) that includes the following information: staff name, license number, type of license, and board certification, if applicable, and a list of the clinical supervisor for any clinical staff who are unlicensed or not independently licensed;
(3) a statement describing the role of the psychiatrist;
(4) a statement describing the current language capacities, capacity to provide services to specialized populations, and utilization of evidenced-based modalities of the program;
(5) written attestation that the center is in compliance with 130 CMR 429.000; and
(6) any other information that the MassHealth agency may request.

(B) Staffing and Personnel Reports.
(1) Each center must report to the MassHealth agency within 30 days of any staffing changes of Center Administrative and Clinical Management Staff identified in 130 CMR 429.422(C).
(2) Each center must report to the MassHealth agency within 30 days any staffing changes to the Utilization Review Committee. The reports related to these staffing changes must include the staff member's name, license number, and type of license.
(3) In the event that any licensed staff member is sanctioned or disciplined by the Department of Public Health or out of state provider's relevant state licensing agency, or sanctioned by the staff member's board of licensure, the center must report the following to MassHealth within 10 days of notification of said sanction or disciplinary action: the name of the individual, the individual's license number, a copy of the official notification of sanction or disciplinary action, and a statement about intended next steps by both the center and the staff member to address the sanction or disciplinary action.
(4) Each center must provide additional staffing or personnel information as requested by the MassHealth agency.

(C) For each CANS assessment conducted, each center must report data collected during the assessment to the MassHealth agency, in the manner and format specified by the MassHealth agency.

(D) Adverse Incident Reports. Each center must report Adverse Incidents to the MassHealth agency within 24 hours of discovery of the incident, or, if the incident occurs on a holiday or weekend, on the next business day, in a format specified by the MassHealth agency.

(E) Each center must inform the MassHealth agency within 15 days of any citation or loss of licensure or accreditation issued to the center by another agency, including, but not limited to, the Department of Public Health, an out of state provider's relevant state licensing agency, the Joint Commission, or the Commission on Accreditation of Rehabilitation Facilities (CARF), or changes to or loss of Medicare participation and enrollment.

(F) Each center must comply with all reporting requirements that may pertain to the practice, facility, or staffing of the center as directed by the MassHealth agency.

429.407: Revocation of Enrollment and Sanctions

(A) The MassHealth agency has the right to review a mental health center's continued compliance with the conditions for enrollment 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 enrollment, subject to any applicable provisions of 130 CMR 450.000 *Administrative and Billing Regulations*, 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 enrollment, it may withhold payment, temporarily suspend the center from participation in MassHealth, or impose some other lesser sanction as the MassHealth agency sees fit, pursuant to the processes set forth in 130 CMR 450, as applicable.

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.

(1) 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:

(a) the center's full charges must be published in a fee schedule;

(b) the center's revenues must be based on the application of full charges with allowances noted for reduction of fees;

(c) the center's procedure for reduction of fees must be in accordance with written policies; and

(d) the center must maintain sufficient information to document the amount of the reductions.

(2) Centers designated as Behavioral Health Urgent Care Providers pursuant to 130 CMR 429.404 (A) may bill for the provision of these services according to rates set forth in 101 CMR 306.00.

(B) Administrative Operations. Payment by the MassHealth agency for mental health center services includes payment for administrative operations and for all aspects of service delivery not explicitly included in 130 CMR 429.000, such as, but not limited to:

(1) completion of member registration and intake, which may be completed on a telephonic or walk-in basis, and shall include accumulating and recording at least the minimally required member information necessary to facilitate diagnostic evaluation services, including the members' presenting concern, and for referral to an appropriate provider or service;

(2) communication with members or other parties that may include processes for appointment reminders or coordination of care;

(3) staff supervision or consultation with another staff member within the mental health center;

(4) providing information for the coordination of referrals; and

(5) recordkeeping.

429.409: Out of State Providers: Maximum Allowable Fees

Payment to a mental health center located out-of-state shall be in accordance with the applicable rate schedule of its state's medical assistance program, or its equivalent, and is

always subject to the applicable conditions, exclusions, and limitations set forth in 130 CMR 429.000.

429.410: Nonreimbursable Services

(A) Nonmedical Services. The MassHealth agency does not pay mental health centers for nonmedical services. These services include, but are not limited to, the following:

(1) vocational rehabilitation services;

(2) sheltered workshops (a program of vocational counseling and training in which participants receive paid work experience or other supervised employment);

(3) educational services;

(4) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is reimbursable);

(5) life enrichment services (ego enhancing services such as workshops or educational courses provided to functioning persons); and

(6) other services such as providing information, referral, and advocacy to certain age populations, liaising with other agencies, role modeling, and community organization.

(B) Travel Time for Outreach. Travel time to and from an outreach visit, including a member's home, place of residence, or an appropriate, mutually agreed-upon community-based location is not a reimbursable service.

(C) Nonmedical Programs. The MassHealth agency does not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other nonreimbursable services. Such programs include residential programs, day activity programs, drop-in centers, and educational programs.

(D) Research and Experimental Treatment. The MassHealth agency does not pay for research or experimental treatment.

(E) Referrals. A provider to whom a member is referred must bill the MassHealth agency directly for any services rendered as a result of the referral, not through the mental health center. In order to receive payment for referral services, the rendering provider must be a participating provider in MassHealth on the date of service. (See 130 CMR 429.421(6)).

429.411: Site Inspections

(A) The MassHealth agency may, at any time, conduct announced or unannounced site inspections of any center to determine compliance with applicable regulations. Such site inspections need not pertain to any actual or suspected deficiency in compliance with the regulations.

(B) After any site inspection where deficiencies are observed, the MassHealth agency will prepare a written site inspection report. The site inspection report will include the deficiencies found, and the period within which the deficiency must be corrected. The center shall submit a corrective action plan, within the timeframe set forth by the MassHealth agency, for each of the deficiencies cited in the report, including the specific corrective steps to be taken, a timetable for these steps, and the date by which full compliance will be achieved. The MassHealth agency will review the corrective action plan and will accept the corrective action plan only if it conforms to these requirements.

429.412: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary mental health center services for EPSDT eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 429.000, and with prior authorization.

(130 CMR 429.413 through 429.420 Reserved)

429.421: Scope of Services

(A) Required Services. Each center must have services available to treat a wide range of behavioral health disorders, including co-occurring substance use disorders. 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 429.421(A)(2). A center must have the capacity to provide at least the services set forth in 130 CMR 429.421(A). 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 429.421(A)(6).

(1) Diagnostic Evaluation Services.

(a) Diagnostic Evaluation Services that must occur on a member's initial date of service shall include:

1. Identification of the member's presenting compliant or problem at the time of assessment; and
2. A risk assessment.

(b) Diagnostic Evaluation Services that may occur on a member's initial date of service or over subsequent visits to complete the diagnostic evaluation, develop a treatment plan, and substantiate treatment rendered, shall include:

1. An assessment of the current status and history of the member's physical and psychological health, including any current or former substance use;
2. Current and former behavioral health disorder treatment, or any other related treatment, including pharmacotherapy or substance use disorder treatment; and
3. Current and former social, economic, developmental, and educational functioning, describing both strengths and needs.

(c) As treatment progresses, further diagnostic information shall be gathered and documented to inform longitudinal treatment planning.

(d) For members under the age of 21, a CANS assessment 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.

(2) Treatment Planning Services.

(a) Each center must complete a treatment plan for every member by the later of the member's fourth visit or 30 days after the initiation of treatment. Where an existing written treatment plan has been completed by a different provider prior to the member's initiation of treatment with the center, the center may rely on such treatment plan, provided that the treatment plan satisfies the requirements of 429.421(A)(2) and that the center reviews the treatment plan and updates the treatment plan, as clinically appropriate, upon initiation of treatment.

(b) The member's written treatment plan shall be appropriate to the member's presenting complaint or problem and based on information gathered during the intake and diagnostic evaluation process, including any substance use disorder screening results.

(c) The treatment plan must be in writing, and must include at least the following information, as appropriate to the member's presenting complaint or problem:

1. identified problems and needs relevant to treatment and discharge expressed in behavioral, descriptive terms;
2. the member's strengths and needs;

3. measurable treatment goals addressing identified problems, with time guidelines for accomplishing goals and working towards discharge;
4. identified clinical interventions, including pharmacotherapy, to obtain treatment goals;
5. evidence of member's input in formulation of the treatment plan, for example, the member's stated goals, and direct quotes from the member;
6. clearly defined staff responsibilities and assignments for implementing the plan;
7. the date the plan was last reviewed or revised; and
8. the signatures and licenses or degrees of staff involved in the review or revision.

(d) Treatment plans must be updated at least every six (6) months or sooner in the event of a significant change in clinical presentation or treatment needs, which may include, but is not limited to, admission to inpatient level of care or initiation of psychopharmacology or therapy services.

(e) Upon the member meeting the goals and objectives within the treatment plan, a written discharge summary must be completed by the clinician that describes the member's response to the course of treatment and referrals to aftercare and other resources.

(3) Case and Family Consultation and Therapy Services. These services must include case and family consultation, individual, group, couple, and family therapies provided by or supervised by the mental health professionals identified in 130 CMR 429.422.

(4) Pharmacotherapy Services.

(a) Pharmacotherapy services must include, but are not limited to, an assessment of the patient's:

1. psychiatric symptoms and disorders;
2. health status including medical conditions and medications;
3. use or misuse of alcohol or other substances; and
4. prior experience with psychiatric medications.

(b) Pharmacotherapy services must include medication prescribing, reviewing, and monitoring.

(c) Pharmacotherapy services must be provided by an appropriately licensed individual with the authority to prescribe medications.

(d) Pharmacotherapy services may be provided by a provider that is not employed by the center, who is operating under a documented agreement with the center.

(e) These requirements do not preclude the one-time administration of a medication in an emergency in accordance with a prescribing practitioner's order.

(5) Crisis Intervention Services. Each center must provide clinic coverage to respond to members experiencing a crisis 24 hours per day, seven days per week.

(a) During business hours, clinic coverage must include, at minimum, crisis evaluation by a qualified professional and triage to appropriate services for the member's presenting crisis.

(b) After hours crisis intervention services must include live telephonic access to qualified professionals and, if indicated, triage in real-time to an appropriate provider to determine whether a higher level of care and/or additional diversionary services are necessary. A pre-recorded message will not fulfill the requirement for access to a qualified professional.

(6) Referral Services.

(a) Each center must have written policies and procedures for addressing a member's behavioral health disorder needs that exceed the scope of services provided by the center including but not limited to substance use disorder needs. Policies and procedures must minimally include personnel, referral, coordination, and other procedural commitments to address the referral of members to the appropriate health care providers, including but not limited to substance use disorder providers.

(b) When referring a member to another provider for services, each center must ensure continuity of care, exchange of relevant health information, such as test results and records, and avoidance of service duplication between the center and the provider to whom a member is referred. Each center must also ensure that the referral process is completed successfully and documented in the member's medical record.

(c) In the case of a member who is referred to services outside of the center, the rendering provider must bill the MassHealth agency directly for any services rendered to a member. The rendering provider may not bill through the referring mental health center.

(B) Optional Services. The below services are reimbursed by the MassHealth agency and are intended to complement the required services set forth in 130 CMR 429.414(A). The following services set forth in 130 CMR 429.421(B) are billable services and are allowed but not required to be provided by a center. All optional services provided by the center must be set forth in a member's Treatment Plan developed pursuant to 130 CMR 429.421(A)(2).

(1) Certified Peer Specialist (CPS) Services. The MassHealth agency will pay for CPS services that promote empowerment, self-determination, self-advocacy, understanding, coping skills, and resiliency through a specialized set of activities and interactions when provided by a qualified Certified Peer Specialist to an individual with a mental health disorder.

(2) Structured Outpatient Addiction Program (SOAP). The MassHealth agency will pay for SOAP services delivered by centers in conformance with all applicable sections of 130 CMR 418.00: *Substances Use Disorder Treatment Services.*

(3) Enhanced Structured Outpatient Addiction Program (E-SOAP). The MassHealth agency will pay for E-SOAP services delivered by centers in conformance with all applicable sections of 130 CMR 418.00: *Substance Use Disorder Treatment Services.*

(4) Peer Recovery Coach Services. The MassHealth agency will pay for peer recovery coach services delivered by centers in conformance with all applicable sections of 130 CMR 418.00: *Substances Use Disorder Treatment Services.*

(5) Recovery Support Navigator Services. The MassHealth agency will pay for recovery support navigator services delivered by centers in conformance with all applicable sections of 130 CMR 418.00: *Substances Use Disorder Treatment Services.*

(6) Intensive Outpatient Program (IOP). The MassHealth agency will pay for the following clinical interventions, when delivered as part of an Intensive Outpatient Program.

(a) IOPs must provide a member with 3.5 hours of services each day for a minimum of five days per week. Specific IOP clinical interventions must include:

1. bio-psychosocial evaluation
2. individualized treatment planning based on results of bio-psychosocial evaluation
3. case and family consultation
4. crisis prevention planning, and safety planning for youth, as applicable
5. discharge planning and case management
6. individual, group, and family therapy
7. multi-disciplinary treatment team review

8. peer support and recovery-oriented services
9. provision of access to medication evaluation and medication management, as indicated, directly or by referral
10. psycho-education
11. substance use disorder assessment and treatment services
12. access to Medication evaluation and Medication management:

If medication evaluation and medication management services are not provided within the IOP service, the center may provide these services through the MHC.

(b) Preventive Behavioral Health Services. Preventive behavioral health services are provided to members under the age of 21 who have a positive behavioral health screen, or in the case of an infant, a caregiver who has had a positive post-partum depression screen. Preventive behavioral health services are delivered by a qualified behavioral health clinician. During the delivery of preventive behavioral health services, if the provider determines that a member has further clinical needs, members and families should be referred for evaluation, diagnostic, and treatment services. After six sessions, if the provider determines that further preventive behavioral health services are needed, providers should document the clinical appropriateness of ongoing preventive services.

429.422: Staff Composition Requirements

(A) Minimum Staffing Requirements. Each center must meet the minimum staffing and staff composition requirements outlined in 130 CMR 429.422 to adequately provide the required scope of services set forth in 130 CMR 421. The staff must include other related mental health professionals as appropriate to meet the needs of members, which includes staff necessary for the provision of intake, diagnostic evaluation, and treatment services.

(B) Minimum Staffing Composition.

(1) Psychiatrist. Each center must employ, whether on staff or by contract, at least one psychiatrist licensed by the Massachusetts Board of Registration in Medicine pursuant to M.G.L c. 112, §§ 2 through 12DD; c. 112 §§ 61 through 65 and 88 and 243 CMR 2.00 and certified by the American Board of Psychiatry and Neurology, the American Osteopathic Board of Neurology and Psychiatry, or board eligible for such certification. Such psychiatrist shall be responsible for prescribing, or monitoring and supervising the prescription of all medications.

(2) Multi-disciplinary Staff. In addition to the requirements under 130 CMR 429.422(B)(1), each center must have a multi-disciplinary staff that includes at least two of the following mental health professionals:

(a) Psychologist. A psychologist licensed by the Massachusetts Board of Registration of Psychologist, and specializing in clinical or counseling psychology, or a closely related specialty, pursuant to M.G.L. c. 112, §§ 118 through 127 and 251 CMR 3.00.

(b) Social Worker. An independent clinical social worker licensed by the Massachusetts Board of Registration of Social Worker pursuant to M.G.L. c 13, §84 and 258 CMR 9.00.

(c) Advanced Practice Registered Nurse. An advanced practice registered nurse who specializes in psychiatric treatment as follows:

1. Psychiatric Nurse. A registered nurse with a master's degree in psychiatric nursing licensed by the Board of Registration in Nursing pursuant to M.G.L. c. 112, § 80B and 244 CMR 4.00.
2. Psychiatric Clinical Nurse Specialist. A psychiatric clinical nurse specialist licensed by the Board of Registration in Nursing pursuant to M.G.L. c. 112, § 80B and 244 CMR 4.00.

(c) Licensed Mental Health Counselor. A licensed mental health counselor licensed by the Board of Registration of Allied Mental Health and Human Service Professions pursuant to M.G.L. c. 112, § 165 and 262 CMR 2.00.
(d) Licensed Alcohol and Drug Counselor I. An alcohol and drug counselor licensed by the Department of Public Health pursuant to 105 CMR 168.000.
(e) Licensed Marriage and Family Therapist. A marriage and family therapist licensed by the Board of Registration of Allied Mental Health and Human Services Professions pursuant to M.G.L. c. 112, §§ 163 through 172 and 262 CMR 3.
(f) Other Licensed Mental Health and Substance Use Disorder Practitioners. Other mental health and substance use disorder practitioners licensed by the Division of Professional Licensure, the Department of Public Health or any Board of Registration and deemed by the Department of Public Health to be mental health and substance use disorder professionals.

(3) Staff to Administer Medication Services. In addition to the staff required in 130 CMR 429.422(B)(1) and (2), centers may optionally staff physicians, nurse practitioners, and Physician Assistants to support prescriptive practice and integrated medical services, inclusive of addiction medicine, within the center.

(C) Minimum Requirements for Center Administrative and Clinical Management Staff

(1) Administrator. The mental health center must designate one individual as administrator. The administrator 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.
(a) The same individual may serve as both the administrator and clinical director.
(b) In a community health center, the administrator of the entire facility may also administer the mental health center.

(2) Clinical Director. The mental health center must designate a professional staff member to be the clinical director, responsible to the administrator, for the direction and control of all professional staff members and services.
(a) The clinical director must be independently licensed, certified, or registered to practice in one of the Core Disciplines listed in 130 CMR 429.422(B)(1) and (B)(2)(a)-(d), and must have had at least five years of fulltime, 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.
(b) The specific responsibilities of the clinical director include:

1. selection of clinical staff and maintenance of a complete staffing schedule;
2. establishment of job descriptions and assignment of staff;
3. overall supervision of staff performance;
4. accountability for adequacy and appropriateness of member care;

5. in conjunction with the medical director, accountability for employing adequate psychiatric staff to meet the psychopharmacological needs of members;
6. establishment and maintenance of policies and procedures for member care;
7. provision of some direct member care in circumstances where the clinical director is one of the three minimum full-time equivalent staff members of the center;
8. development of in-service training for professional staff; and
9. establishment of a Quality Management Program.

(3) Medical Director. Each center must designate a psychiatrist, 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 be available to the center and satellite sites during the center's operating hours, either onsite or remotely, for consultation and support of clinic operations to ensure the provision of high-quality care. The medical directors must be available to be onsite during any hours of clinic operation, as needed. When the clinic is dually enrolled as a community health center, the medical director must be available to the center at least four hours per week, either on-site or remotely, provided that the medical director must be available to be onsite during any hours of clinic operation, as needed.

(4) Psychiatrist.

(a) The roles and duties of administrator, clinical director, and medical director, as detailed in 130 CMR 429.422(C)(1)-(3), may be performed, 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 130 CMR 450.000 *Administrative and Billing Regulations.*

(b) The role of the psychiatrist in each center, apart from any duties that may be assumed under 130 CMR 429.422(C)(1)-(3), must include the following:

1. responsibility for the evaluation of the physiological, neurological, and psychopharmacological status of members receiving services;
2. involvement in diagnostic formulations and development and refinement of treatment plans, including reconciliation of psychopharmacological and other medications as required;
3. direct psychotherapy, when indicated;
4. participation in utilization review or quality-assurance activity, when indicated;
5. coordination of the center's relationship with hospitals and provision of general hospital consultations as required;
6. supervision of and consultation to other disciplines; and
7. clinical coverage on an "on call" basis at all hours of center operation.

429.423: Supervision, Training, and Other Staff Requirements

(A) Staff Supervision Requirements

(1) Unlicensed or Not Independently Licensed Staff. All professionals who are unlicensed, who are in a profession without licensure, or who are not independently licensed or certified as a peer supervisor must receive Direct and Continuous Supervision. Direct and Continuous Supervision may be provided using telehealth technology.

(2) Independently Licensed and Certified Peer Supervisor Staff. All independently licensed

professionals and certified peer supervisors must receive supervision in accordance with center policy. Supervision may be provided using telehealth technology.
(3) The supervising clinician is primarily responsible for the care of the member. For any care delivered by a professional under supervision there must be documentation in the clinical chart that the chart was reviewed by the supervising clinician.
(4) All supervision must be documented in files accessible for review by the MassHealth agency. Supervision notes must, at a minimum, contain information regarding frequency of supervision, format of supervision, supervisor's signature and credentials, and general content of supervision session.

(B) Staff Training. Centers must provide staff with specific training to provide services to members, including but not limited to:
(1) Training to assess and treat mental health disorders, which may include co-occurring substance use disorders, including the clinical and psychosocial needs of the target population using evidence-based practices (*e.g.*, staff treating children must have specialized training and experience in children's services);
(2) Training on Culturally and Linguistically Appropriate Services (CLAS) to ensure the content and process of all services are informed by knowledge, respect for, and sensitivity to culture, and are provided in the individual's preferred language and mode of communication. Training must include recognition and respect for the characteristics of the members served, such as behaviors, ideas, values, beliefs, and language;
(3) Training in maintaining a trauma-informed facility and upholding standards of trauma-informed care, including fostering trauma-informed environments;
(4) Training on currently available resources and services, including those in the community, and how to make appropriate referrals based on the needs of the member;
(5) Training on crisis prevention and de-escalation, risk management and safety planning, and conflict resolution; and
(6) Training on overdose prevention and response.

(C) Child and Adolescent Needs and Strengths Assessment (CANS). Any clinician 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) Staff Professional Standards. Any staff, of any discipline, operating in the center must comport with the standards and scope of practice delineated in their professional licensure and be in good standing with their board of professional licensure, as applicable. Each center must notify the MassHealth agency of any staff that are censured by the Department of Public Health or sanctioned by their board of licensure as set forth in 130 CMR 429.406.

(E) Staffing Plan. Centers must maintain a staffing plan that includes policies and procedures to ensure all staffing and supervision requirements pursuant to 130 CMR 429.423.

429.424: Qualifications of Professional and Paraprofessional Staff Members Authorized to Render Billable Mental Health Center Services

A center may only bill for medically necessary services provided by a professional or paraprofessional staff member qualified as follows:

(A) Psychiatrists and Medical Professionals
(1) At least one staff psychiatrist must meet the requirements set forth in 130 CMR 429.422.

(2) Additional psychiatrists must be licensed physicians in their second year of a psychiatric residency program accredited by the Accreditation Council for Graduate Medical Education.
(3) Psychiatrists and prescribers must have the appropriate Drug Enforcement Administration (DEA) and Department of Public Health (DPH) registrations for the prescribing of controlled substances.

(B) Nursing Staff.
(1) All Nurse Practitioners, Registered Nurses, Psychiatric Nurses, and Psychiatric Nurse Specialists must be licensed by the Board of Registration in Nursing pursuant to M.G.L. c. 112, § 80B and 244 CMR 4.00.
(2) Psychiatric Clinical Nurse Specialists. All psychiatric clinical nurse specialists in the center who are engaged in prescriptive practice with FDA approved medications for the treatment of opioid use disorders must have completed specialized training and be qualified to prescribe buprenorphine as pharmacotherapy for substance use disorder under state and federal law.

(C) Psychologist
(1) Psychologists must be licensed, as set forth in 130 CMR 429.422.
(2) Unlicensed psychology trainees must meet the following requirements:
(a) Post-Doctoral Fellows. Post-Doctoral Fellows must have a minimum of a doctoral degree in clinical or counseling psychology or a closely related specialty from an accredited educational institution and must meet the Professional Experience and Supervisory requirements set forth in 251 CMR 3.
(b) Psychology Interns. Psychology Interns must be enrolled in a structured, clinical, or counseling American Psychological Association (APA)-approved doctoral program.

(D) Social Worker
(1) Social Workers may be independently licensed, as set forth in 130 CMR 429.422.
(2) Social Workers without Independent Licensure must meet the following requirements:
(a) Licensed Clinical Social Workers (LCSW). LCSWs must 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.
(b) Post-Graduate, Unlicensed Social Workers. Unlicensed Social Workers must have received a master's degree in social work from a college or university accredited by the Council on Social Work education.
(c) Social Work Interns. Social Work Interns must be a second-year, clinical-track student in a structured field practicum that is a component of a Masters of Social Work program, fully accredited by the Council on Social Work Education.

(E) Mental Health Counselors
(1) Mental Health Counselors may be licensed as set forth in 130 CMR 429.422.
(2) Additional Mental Health Counselors must meet the following requirements:
(a) Post-Master's Mental Health Counselors. Post-Master's Mental Health Counselors must have a master's degree, or above, in a mental health field from an accredited educational institution, and must have completed one year of supervised clinical work in an organized graduate internship program.
(b) Mental Health Counselor Interns. Interns must be in a second-year, clinical-track structured field placement that is a component of a master's degree in mental health counseling or counseling psychology that is accepted by the Board of Allied Mental

Health and Human Services Professions.

(F) Alcohol and Drug Counselors

(1) Licensed Alcohol and Drug Counselors (LADC). LADCs may be licensed as a LADC I, as set forth in 130 CMR 429.422.

(2) LADC II or LADC Assistants. LADC IIs or LADC Assistants must be licensed and must support LADC Is in the delivery of services, but may not provide direct services.

(G) Marriage and Family Therapists

(1) Marriage and Family Therapists may be licensed, as set forth in 130 CMR 429.422.

(2) Additional Marriage and Family Therapists must meet the following requirements:

(a) Post-Master's Marriage and Family Therapists must have a master's degree, or above, in a mental health field from an accredited educational institution, and must have completed one year of supervised clinical work in an organized graduate internship program.

(b) Marriage and Family Therapy Interns. Interns must be in a second-year, clinical-track structured field placement that is a component of a master's degree in marriage and family therapy or a related field that is accepted by the Board of Allied Mental Health and Human Services Professions.

(H) Other Staff

(1) Billing providers of Structured Outpatient Addiction Programs (SOAP) and Enhanced Structured Outpatient Addiction Programs (E-SOAP) services must comply with the requirements of 130 CMR 429.000 and all applicable sections of 130 CMR 418.000: *Substances Use Disorder Treatment Services.*

(2) Billing peer and paraprofessional providers of Certified Peer Specialist services, Peer Recovery Coach services, and Recovery Support Navigator services must comply with the requirements of 130 CMR 429.000. Further, centers must staff Peer Recovery Coaches and Recovery Support Navigators in conformance with the requirements of all applicable sections of 130 CMR 418.000: *Substances Use Disorder Treatment Services.*

(130 CMR 429.425 through 429.432 Reserved)

429.433: Coordination of Medical Care

A mental health center must coordinate behavioral health disorder treatment with medical care for MassHealth members. If a member has not received a physical exam within 12 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 declines 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) The center must operate at least one freestanding location that is open and operated at least 40 hours a week.

(B) A mental health center operated by a licensed community health center must be open at least 20 hours a week.

(C) When the center is closed, after-hours coverage must be provided to triage needs and personnel shall be available to offer referral to qualified professionals, emergency services, or other mechanisms for effectively responding to a crisis, in accordance with the requirements set forth at 130 CMR 429.421(A)(5).

(D) Each center designated as a Behavioral Health Urgent Care provider pursuant to 130 CMR 429.405(D) must offer extended availability on Mondays through Fridays outside the hours of 9am-5pm. At minimum, such centers must offer at least 8 hours of extended availability per week during weekdays and at least two four-hour blocks of availability on weekends per month.

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 composed of the clinical director or the clinical director's designee and two other professional staff members who meet all the qualifications for their discipline, as outlined in 130 CMR 429.424. The composition of the utilization review committee must be reported to MassHealth as set forth in 130 CMR 429.406.

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

(C) The utilization review committee must verify for each case that:

(1) the diagnosis is, or has been, adequately documented;

(2) the treatment plan is, or was, appropriate and specifies the methods and duration of the projected treatment program;

(3) the treatment plan is being, or has been, carried out;

(4) the treatment plan is being, or has been, modified as indicated by the member's changing status;

(5) there is, or was, adequate follow-up when a member misses appointments or drops out of treatment;
(6) there is, or was, progress toward achievement of short and long-term goals; and
(7) for members under the age of 21, the CANS has been completed at the initial behavioral-health assessment and updated at least every 90 days thereafter.

(D) No staff member can participate in the utilization review committee's deliberations about any member the staff member is treating, or has treated, directly.

(E) The utilization review committee must maintain minutes that are sufficiently detailed to show the decisions of each review, and the basis on which any decisions are made. The MassHealth agency may conduct such audits of these minutes as it deems necessary.

(F) Based on the utilization review, the clinical director, or the clinical director's designee, must determine whether continuation, modification, or termination of treatment is necessary and promptly communicate this decision to the primary therapist.

429.436: Recordkeeping Requirements

(A) Each center must obtain written authorization from each member or the member's legal guardian to release information obtained by the center, to center staff, federal and state regulatory agencies, and, when applicable, referral providers, to the extent necessary to carry out the purposes of the center and to meet regulatory requirements. All such information must be released on a confidential basis and in accordance with all applicable requirements.

(B) Member Records:
(1) A center must maintain member records in accordance with 130 CMR 450.000: *Administrative and Billing Regulations* and 105 CMR 140.000: *Licensure of Clinics*, in addition to applicable recordkeeping requirements for clinics under M.G.L. c. 111 § 70. When a member is referred to any other provider, each center must maintain the original member record and forward a copy to the other provider.
(2) Member records must be complete, accurate, and properly organized.
(3) The member's record must include at least the following information:
(a) the member's name and case number, MassHealth identification number, address, telephone number, gender identity, date of birth, marital status, next of kin, school or employment status (or both), and date of initial contact;
(b) the place of service;
(c) a report of a physical examination performed within 12 months of the date of intake, including documentation the physical examination informed the treatment plan, or documentation that the member did not want to be examined and any stated reason for that preference;
(d) the name and address of the member's primary care or, if not available, another physician who has treated the member;
(e) the member's description of the problem, and any additional information from other sources, including the referral source, if any;
(f) the events precipitating the member's contact with the center;
(g) the relevant medical, psychosocial, educational, and vocational history;
(h) a comprehensive assessment of the member initiated at intake;
(i) the clinical impression of the member and a diagnostic formulation, including a specific diagnosis using standard nomenclature;

(j) short- and long-range goals that are measurable, realistic and obtainable, and a time frame for their achievement;
(k) the proposed schedule of therapeutic activities, both in and out of the center, necessary to achieve such goals and objectives and the responsibilities of each individual member of the interdisciplinary team;
(l) a schedule of dates for utilization review to determine the member's progress in accomplishing goals and objectives;
(m) the name, qualifications, and discipline of the therapist primarily responsible for the member;
(n) a written record of semi-annual reviews (every six [6] months) by the primary therapist, which relate to the short and long range goals;
(o) progress notes, including those related to the defined treatment plan goals on each visit written and signed by the primary therapist that include the therapist's discipline and degree.
(p) a treatment plan for the member signed by the primary therapist, or the supervisor of an unlicensed primary therapist, pursuant to 130 CMR 429.421(C);
(q) all information and correspondence regarding the member, including appropriately signed and dated consent forms;
(r) a drug-use profile (both prescribed and other);
(s) when the member is discharged, a discharge summary, including a brief summary of the member's condition and response to treatment, achievement of treatment and recovery goals, and recommendations for any future appropriate services; and
(t) for members under the age of 21, a CANS completed during the initial behavioral-health assessment and updated at least every 90 days thereafter.

(4) A brief history is acceptable for emergency or walk-in visits when the treatment plan does not call for extended care.

(C) Program Records. The mental health center must retain documentation reflecting compliance with the requirements of 130 CMR 429.

(D) Availability of Records. All records shall be made available to the MassHealth agency, upon request.

429.437: Written Policies and Procedures

Each mental health center must have and observe written policies and procedures that include:

(A) a statement of its philosophy and objectives and of the geographical area served;

(B) an intake policy;

(C) admission procedures, including criteria for client admission and procedures for multidisciplinary review of each individual referral;

(D) treatment procedures, including, but not limited to, development of the treatment plan, case assignment, case review, discharge planning, and follow-up on members who leave the center voluntarily or involuntarily;

(E) a medication policy that includes prescription, administration, and monitoring data;

(F) a referral policy, including procedures for ensuring uninterrupted and coordinated member care upon transfer

(G) procedures for walk-in members, and clinical emergencies during operating and nonoperating hours;

(H) record-keeping policies, including what information must be included in each record, and procedures to ensure confidentiality;

(I) personnel and management policies, including policies for hiring, training, evaluation, supervision and termination protocol for all staff;

(J) a utilization review plan; and

(K) explicit fee policies with respect to billing third party payers, cancellation procedures, and fee reductions.

429.438: Administration

(A) Organization. Each center must establish an organization chart showing major operating service programs of the center, with staff divisions, administrative personnel in charge of each service program, and their lines of authority, responsibility, and communication.

(B) Fiscal Management. Each center must establish a system of business management to ensure accurate accounting for sources and uses of funds, and proper expenditure of funds within established budgetary constraints and grant restrictions.

(C) Data Management. Each center must develop and maintain a statistical information system to collect member, service utilization, and fiscal data necessary for the effective operation of the center.

(D) Personnel Management. Each center must establish and maintain personnel policies and personnel records for each employee.

(E) Staff Development and Supervision.

(1) Each staff member must receive supervision appropriate to the person's skills and level of professional development. Supervision must be documented and must occur within the context of a formalized relationship with the supervisor and in accordance with 130 CMR 429.423(A). Documentation of supervision must be maintained by the supervisor.

(2) Each center must establish and implement procedures for staff training and evaluation. These procedures must require all staff who must be certified to administer the CANS, as described in 130 CMR 429.423, to complete the certification process established by the EOHHS.

(F) All documents described above must be made available to the MassHealth agency upon request.

429.439: Satellite Clinics

All clinic locations must meet, independently of its parent clinic, all requirements set forth in 130 CMR 429. Satellite locations must be able offer in person services for up to 20 hours per week; use of telehealth is acceptable when agreed upon by the member.

429.440: Outreach

(A) Services rendered in a member's home, place of residence, or an appropriate, mutually agreed-upon community-based location by clinicians who are employed by the mental health center may be billed by the clinic when provided in accordance with the requirements of 130 CMR 429.000. All services provided in community-based settings must be provided in accordance with all provisions in 130 CMR 429.

(B) All mental health center services must be billed with a Place of Service (POS) code denoting the location in which the treatment was delivered.

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(B).

(B) Multiple Visits on a Same Date of Service. The MassHealth agency pays for only one visit 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 except for the provision of Crisis Intervention.

(C) Multiple Therapies. The MassHealth agency pays for more than one mode of therapy used for a member during one week when it is clinically justified, and when any single approach has been shown to be necessary but insufficient. The need for multiple therapies must be documented in the member's record.

(D) Case Consultation.

(1) The MassHealth agency pays only for a case consultation that involves a personal meeting with a professional of another agency. Personal meetings may be conducted via audio-only telephonic, audio-video, or in person meetings.

(2) The MassHealth agency pays for case consultation only when written communication and other non-reimbursable 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 direct communication would impede a coordinated treatment program.

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

(E) Family Consultation. The MassHealth agency pays for consultation with family or other responsible persons who is not an eligible member, when such consultation is integral to the treatment of the member.

(F) Group Therapy.

(1) Payment is limited to one fee per group member with a maximum of 12 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 services.

(3) The MassHealth agency does not pay for group therapy when it is performed as an integral part of intensive outpatient program services.

(G) 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(D) either personally administers the testing or personally supervises such testing during its administration by an unlicensed psychologist trainee.

(2) A psychologist must determine the specific tests to administer. All tests must be published, valid, and in general use, as defined by listing the current edition of the Mental Measurement Yearbook or by conformity to the Standards for Educational and Psychological Tests of the American Psychological Association.

(3) Except as explained below, the MassHealth agency does not pay for psychological testing that only includes:

(a) periodic testing to measure the member’s response to psychotherapy;

(b) self-rating forms and other paper-and-pencil instruments, unless administered as part of a comprehensive battery of tests;

(c) group forms of intelligence tests; or

(d) 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 the following conditions exist and are documented in the billing provider’s medical record:

1. psychological testing is providing to ascertain changes relating to suicidal, homicidal, toxic, traumatic, or neurological conditions of the member; or

2. psychological testing is provided to ascertain changes following such special forms of treatment or interventions as electroconvulsive therapy (ECT) or psychiatric hospitalization.

(4) A responsible party requests the testing of a member. Responsible parties include, but are 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.

(H) Crisis Intervention. The MassHealth agency pays for crisis intervention as defined in 130 CMR 429.402.

(1) This service is limited to face-to-face contacts, which includes Telehealth, with the member.

(2) The need for crisis intervention must be fully documented in the member's record for each date of crisis intervention services.

(3) This service is limited to one initial unit of service and up to three add-on units of service per date of service.

(I) 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.

(2) The following conditions must be met:

(a) the member's record at the 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.

REGULATORY AUTHORITY

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

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
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.)
90834	Psychotherapy, 45 minutes with patient
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.)
90837	Psychotherapy, 60 minutes with patient
	Couple/Family Therapy
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849	Multiple-family group psychotherapy (per person per session, not to exceed 10 clients)
	Group Therapy
90853	Group psychotherapy (other than multiple-family group) (per person per session not to exceed 12 clients)
90853 EP	Group psychotherapy (other than of a multiple-family group) (per person not to exceed 12 clients) (preventive behavioral health session)
	Case Consultation
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
	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

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, first 60 minutes

90840 Psychotherapy for crisis, 30 minutes (List separately in addition to the code for primary procedure)

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 Crisis interventional mental health services, per diem. (The ESP provides crisis assessment, intervention, and stabilization services 24 hours per day, seven days per week, and 365 days per year, to individuals of all ages who are experiencing a behavioral health crisis. The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows an individual to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care (per 24-hour encounter))

Specialty Services

S9480 Intensive outpatient psychiatric services, per diemH0015
Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education (Structured Outpatient Addiction Program, 3.5 hours, not to exceed 2 units a day).

H0015-TF Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education (Enhanced Structured Outpatient Addiction Program, 3.5 hours, not to exceed 2 units a day).

H0046-HE Mental health services, not otherwise specified (Certified Peer Specialist Services).

(To view the rates for these services, please refer to 101 CMR 346.00: *Rates for Certain Substance-Related and Addictive Disorders Programs*.)

H2016-HM Comprehensive community support program, per diem (Enrolled Client Day) (recovery support service by a recovery advocate trained in Peer Recovery Coaching)

(To view the rates for these services, please refer to [101 CMR 444.00: *Rates for Certain Substance Use Disorder Services*].)

H2015-HF Comprehensive community support services, per 15 minutes (Recovery Support Navigator)

Covid-19 Vaccine Codes

91300 SL Pfizer-Biontech Covid-19 Vaccine (SARSCOV2 VAC 30MCG/0.3ML IM)
0001A Pfizer-Biontech Covid-19 Vaccine Administration – First Dose (ADM SARSCOV2 30MCG/0.3ML 1ST)
0002A Pfizer-Biontech Covid-19 Vaccine Administration – Second Dose (ADM SARSCOV2 30MCG/0.3ML 2ND
0003A Pfizer-BioNTech Covid-19 Vaccine Administration – Third Dose
0004A Pfizer-BioNTech Covid-19 Vaccine Administration – Booster
91307 SL Pfizer-BioNTech Covid-19 Pediatric Vaccine
0071A Pfizer-BioNTech Covid-19 Pediatric Vaccine - Administration - First dose
0072A Pfizer-BioNTech Covid-19 Pediatric Vaccine - Administration - Second dose
91301 SL Moderna Covid-19 Vaccine (SARSCOV2 VAC 100MCG/0.5ML IM)
0011A Moderna Covid-19 Vaccine Administration – First Dose (ADM SARSCOV2 100MCG/0.5ML 1ST)
0012A Moderna Covid-19 Vaccine Administration – Second Dose (ADM SARSCOV2 100M0CG/0.5ML 2ND)
0013A Moderna Covid-19 Vaccine Administration – Third Dose
91306 SL Moderna Covid-19 Vaccine (Low Dose)
0064A Moderna Covid-19 Vaccine (Low Dose) Administration – Booster
91303 SL Janssen Covid-19 Vaccine (SARSCOV2 VAC AD26 .5ML IM)
0031A Janssen Covid-19 Vaccine Administration (ADM SARSCOV2 VAC AD26 .5ML)
0034A Janssen Covid-19 Vaccine Administration – Booster (ADM SARSCOV2 VAC AD26 .5ML

Evaluation and Management Codes

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

New Patient

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date or the encounter.
99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 30-44 minutes of total time spent on the date of the encounter.
99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 45-59 minutes of total time spent on the date of the encounter.
99205 Office or other outpatient visit for the evaluation and management of a new patient, which

requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 60-74 minutes of total time spent on the date of the encounter.

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.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medica decision making. When using time for code selection, 10-19 minutes of total time spent on the date of the encounter.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medica decision making. When using time for code selection, 20-29 minutes of total time spent on the date of the encounter.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medica decision making. When using time for code selection, 30-39 minutes of total time spent on the date of the encounter.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medica decision making. When using time for code selection, 40-54 minutes of total time spent on the date of the encounter.

99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

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.

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.

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.

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.

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.

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.

Psychological Assessment

(To view the rates for these services, please refer to 101 CMR 329.00: Rates for Psychological and Independent Clinical Social Work Services.)

96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgement, *e.g.*, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour.

96121 Each additional hour. (List separately in addition to code for primary procedure.) (Add-on code to 96116.)

96130 Psychological testing evaluation services by physician or other qualified health care

professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.

96131	Each additional hour. (List separately in addition to code for primary procedure.) (Add-on code to 96130.)
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
96133	Each additional hour. (List separately in addition to code for primary procedures.) (Add-on code to 96132.)
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes.
96137	Each additional 30 minutes. (List separately in addition to code for primary procedure.) (Add-on code to 96136.)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes.
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes. (List separately in addition to code for primary procedure.) (Add-on code to 96138.)

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'.
-AF	Specialty physician (This modifier is to be applied to service codes billed by the mental health center which were performed by a psychiatrist)
-AH	Clinical psychologist (This modifier is to be applied to service codes billed by the mental health center which were performed by doctoral level clinician, including PhD, PsyD, EdD)
-GJ	Opt-out physician or practitioner emergency or urgent service. (Urgent Care services. To identify services provided by Mental Health Centers that are designated as Behavioral Health Urgent Care provider sites.)
-HA	Service Code 90791 must be accompanied by this modifier to indicate that the Child and Adolescent Needs and Strengths (CANS) is included in the psychiatric diagnostic interview examination. This modifier may be billed only by psychiatrists or psychiatric clinical nurse specialists.
-HE	Mental health program (Certified Peer Specialist Services)
-HL	Intern (This modifier is to be applied to service codes billed by the mental health center

which were performed by intern level clinicians, including Post-Doctoral Fellows and Psychology Interns, Post-Master's Mental Health Counselors and Mental Health Counselor Interns, Post-Master's Marriage and Family Therapist, Licensed Alcohol and Drug Counselor IIs (LADC II), Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor)

-HO Master's degree level (This modifier is to be applied to service codes billed by the mental health center which were performed by Master's level clinician, including Licensed Clinical Social Workers (LCSWs), Licensed Independent Clinical Social Workers (LICSWs), Licensed Alcohol and Drug Counselor I, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist)

-EP Group psychotherapy modifier for preventive behavioral health session (only used with 90853)

-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.)

-SL State supplied vaccine or antibodies (This modifier must be applied to codes 91300, 91301, 91303, 91306, and 91307 to identify administration of vaccines or antibodies provided at no cost, whether by the Massachusetts Department of Public Health; another federal, state, or local agency; or a vaccine manufacturer. If the providers receive the vaccine from one of these sources at no cost, providers must bill the code for the vaccine itself, with modifier SL, and the associated code for administration of the vaccine.)

-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)

603 Telephonic Service Codes and Descriptions

Service
Code-Modifier Service Description

98966 Telephone assessment and management service provided by a qualified non physician care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days not leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

98967 Telephone assessment and management service provided by a qualified non physician care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days not leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

98968 Telephone assessment and management service provided by a qualified non physician care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days not leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

99441 Telephone evaluation and management servicers by a physician or other qualified Health care professional who may report evaluation and management services Provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure

within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

99442 Telephone evaluation and management servicers by a physician or other qualified Health care professional who may report evaluation and management services Provided to and established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

99443 Telephone evaluation and management servicers by a physician or other qualified Health care professional who may report evaluation and management services Provided to and established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

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