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

MASSHEALTH
TRANSMITTAL LETTER OPD-52
January 2004

TO: Outpatient Hospitals Participating in MassHealth

FROM: Beth Waldman, Acting Commissioner Beth Waldman

RE: *Outpatient Hospital Manual* (Prior Authorization for Certain Therapy Visits)

This letter transmits revisions to the outpatient hospital regulations (130 CMR 410.00) about therapy services. Effective February 1, 2004, a provider must obtain prior authorization from MassHealth before providing more than eight physical-therapy visits, eight occupational-therapy visits, and 15 speech/language therapy visits (including group therapy and evaluation) to a member within a 12-month period.

The 12-month period for the initial eight or 15 visits begins on the date of the first therapy visit on or after February 1, 2004. For example, if a member's first therapy visit is February 20, 2004, the 12-month period is February 20, 2004, through February 19, 2005. To simplify accounting of therapy visits, and to allow time for providers to request prior authorization without interrupting an established regimen of therapy to members currently receiving therapy services, MassHealth will begin counting therapy visits for dates of service on or after February 1, 2004. Regardless of the number of therapy visits a member has had before February 1, MassHealth will count the first visit occurring on or after February 1, 2004, as the first visit toward the eight or 15 visits that are allowed without prior authorization. No payment is made for services in excess of eight physical therapy, eight occupational therapy, and 15 speech/language therapy visits to a provider in a 12-month period unless prior authorization has been obtained from MassHealth.

Examples:

1. If a member's first physical-therapy visit after February 1, 2004, is March 22, 2004, then the 12-month period for physical therapy is March 22, 2004 through March 21, 2005. MassHealth will pay the provider for seven additional physical-therapy visits before March 22, 2005, without prior authorization. To avoid disruption in treatment, providers are encouraged to request prior authorization as soon as they believe that medically necessary therapy will exceed the number of visits allowed without prior authorization.

2. If the same member receives occupational therapy in addition to physical therapy, and the first occupational-therapy visit is April 29, 2004, then the 12-month period for occupational therapy is April 29, 2004, through April 28, 2005. MassHealth will pay the provider for seven additional occupational-therapy visits before April 29, 2005, without prior authorization.

Pursuant to 130 CMR 410.452(B), "MassHealth pays for no more than one individual treatment and one group therapy session for a member per day." If a member receives both individual and group therapy on a single day, the member will have used two visits toward the eight or 15 allowed.

Maintenance Program

The attached revisions to the outpatient hospital regulations also clarify that MassHealth does not pay for performance of a maintenance program. A maintenance program is defined as repetitive activities intended to maintain function that can be performed safely and effectively without the skilled assistance of a qualified therapist. MassHealth pays for designing a maintenance program and instructing the member, member's family, or other persons in its use as part of a regular treatment visit, not as a separate service.

Requesting Prior Authorization

To request prior authorization, the provider must complete the Request for Prior Authorization form as instructed in MassHealth's billing instructions, or use the Web-based Automated Prior Authorization System (APAS), which is available at www.masshealth-apas.com.

In addition, the provider must complete a Request and Justification for Therapy Services form and attach it to the prior-authorization request, whether the request is submitted on paper or using APAS. The therapist must sign the Request and Justification for Therapy Services form. If you are using APAS, you can either download this MassHealth form from APAS, or complete it on line and submit it electronically as part of the request.

You can also download the Request and Justification form from the MassHealth Provider Services Web site at www.mahealthweb.com. Click on Publications and Forms. If you prefer, you can also request supplies of this form from this Web site or by submitting a written request to the following address or fax number.

MassHealth
Attn: Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: 703-917-4937

When requesting forms, include the name and quantity of the form, your MassHealth provider number, street address (no post office boxes), and contact name and telephone number.

Billing for Services with Prior Authorization

MassHealth will notify the provider and member in writing of its decision on the request for prior authorization. When billing for services, you must enter the prior-authorization number on the claim as indicated below. This prior-authorization number is printed on the approval letter, and if you used APAS to request prior authorization, it is also listed on APAS. When billing for authorized services:

- Enter the six-character prior-authorization number in Item 63, Line A on the UB-92 claim form or its electronic equivalent. If you are billing in the 837I format, refer to the Detail Data section of the *MassHealth 837I Companion Guide* for correct placement of this number on the claim.

- Do not include on the same claim form (or electronic equivalent) any therapy services that are part of the original eight or 15 that **do not** require prior authorization.

- Submit a separate claim form (or its electronic equivalent) for each type of therapy (physical, occupational, or speech/language) for members who have received authorization for more than one type. (**Note:** Each type of therapy will have a separate prior-authorization number.)

Provider-Type-Specific Billing Requirements

These new requirements apply to acute outpatient hospitals, hospital-licensed health centers, and chronic and rehabilitation hospitals. Refer to the appropriate sections below for information and billing instructions that are unique for each type of provider.

Billing Requirements for Chronic Disease and Rehabilitation Hospitals

Chronic disease and rehabilitation hospitals should continue to bill for physical, occupational, and speech/language therapy services on the UB-92, or its electronic equivalent. Revenue codes for therapy services now require HCPCS codes and HCPCS modifiers. The number of units listed in Item 46 of the UB-92 claim form, or the electronic equivalent, must be the number of units represented by the HCPCS (CPT) code for the service provided, as listed in the narrative of the Ingenix CPT Manual. (**Please Note:** Revenue Codes 422, 432, and 442, "hourly charge" for physical therapy, occupational therapy, and speech/language pathology, respectively, have been deleted for dates of service on or after February 1, 2004.

Chronic disease and rehabilitation hospitals should use the following modifiers, as appropriate, when billing for physical, occupational, or speech/language therapy. (Example: To indicate a therapeutic procedure provided by a physical therapist, enter 97110-GP in Item 44 of the UB-92, or its electronic equivalent, along with the appropriate revenue code.)

GN = Speech/language therapy
GO = Occupational therapy
GP = Physical therapy

Refer to Attachment 1 of this transmittal letter for a list of revenue codes and HCPCS codes that providers should use when billing for physical, occupational, or speech/language therapy. Any claim for therapy services without a HCPCS code will be denied.

Note: Effective for dates of service on or after February 1, 2004, claims for **all other revenue codes** for outpatient services by chronic disease and rehabilitation hospitals will require both revenue codes and HCPCS codes. The HCPCS codes for outpatient services other than physical, occupational, or speech/language therapy may be found on the Centers for Medicare and Medicaid Services Web site at www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp. Claims for outpatient services without a HCPCS code will be denied.

Billing Requirements for Acute Outpatient Hospitals and Hospital-Licensed Health Centers

Acute outpatient hospitals and hospital-licensed health centers should bill for therapy services on the UB-92, or its electronic equivalent. Revenue codes and HCPCS codes are required for these therapy services.

Physical, occupational, and speech/language therapy visits are characterized by a date of service and the number of units billed on that date of service. A visit is not characterized by the number of modalities or procedures provided on a date of service, nor by the time required to provide the service. Acute outpatient hospitals and hospital-licensed health centers may bill up to:

- two units per day for speech/language therapy, which constitutes one visit, and a total of 30 units (15 visits), before prior authorization is required;
- four units per day for physical therapy, which constitutes one visit, with a total of 32 units (eight visits), before prior authorization is required; and
- four units per day for occupational therapy, which constitutes one visit, with a total of 32 units (eight visits) before prior authorization is required.

Refer to Attachment 2 of this transmittal letter for information about allowable revenue codes, HCPCS, and maximum allowable units per day and per therapy type.

Effective Date

These regulations are effective February 1, 2004.

Questions

If you have any questions about the information in this letter, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

NEW MATERIAL

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

Outpatient Hospital Manual

Pages iv, 4-3, 4-4, 4-9 through 4-12, and 4-31 through 4-34

OBSOLETE MATERIAL

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

Outpatient Hospital Manual

Pages iv, 4-9, and 4-10 — transmitted by Transmittal Letter OPD-48

Pages 4-3 and 4-4 — transmitted by Transmittal Letter OPD-50

Pages 4-11, 4-12, and 4-31 through 4-34 — transmitted by Transmittal Letter OPD-35

Physical, Occupational, and Speech/Language Therapy Revenue Codes, HCPCS, and Modifiers for Chronic Disease and Rehabilitation Hospitals

Modifier	HCPC Code	PT Rev Code	OT Rev Code	SP/LT Rev Code
GN	92506			440, 441, 444, 449
GN	92507			440, 441, 449
GN	92508			443
GN	92526			440, 441, 444
GP	97001	420, 421, 423, 424, 429,		
GP	97002	420, 421, 424, 429		
GO	97003		430, 431, 434	
GO	97004		430, 431, 433, 434	
GP, GO	97014	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97016	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97018	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97020	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97022	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97024	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97026	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97028	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97032	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97033	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97034	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97035	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97036	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97039	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97110	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97112	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97113	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97116	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97124	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97139	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97140	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97150	423	433	
GP, GO	97504	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97520	420, 421, 423, 429	430, 431, 433, 439	
GP, GO, GN	97530	420, 421, 423, 429	430, 431, 433, 439	440, 441, 443, 449
GP, GO, GN	97532	420, 421, 423, 429	430, 431, 433, 439	440, 441, 443, 449
GP, GO, GN	97533	420, 421, 423, 429	430, 431, 433, 439	440, 441, 443, 449
GP, GO	97535	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97542	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97703	420, 421, 423, 429	430, 431, 433, 439	
GP, GO	97750	420, 421, 423, 429	430, 431, 433, 439	

Physical, Occupational, and Speech/Language Therapy Revenue Codes, and HCPCS Codes for Acute Outpatient Hospitals and Hospital-Licensed Health Centers

Speech/Language Therapy: A maximum of two units per day; two units constitute a visit.

CPT-4 Code	Revenue Codes	Max. Units Per Day
92506	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449, 470, 471, 472, 479	2
92507	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449, 470, 471, 472, 479	2
92508	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449, 470, 471, 472, 479	2
92526	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449, 470, 471, 472, 479	2

Total maximum allowable units before prior authorization is needed: 30.

Physical Therapy: See maximum units per day; four units constitute a visit.

CPT-4 Code	Revenue Codes	Max. Units Per Day
97001	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97002	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97010	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97012	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97014	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97016	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97018	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97020	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97022	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97024	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97026	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97028	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97032	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97033	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97034	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97035	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97036	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97039	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97110	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97112	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97113	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97116	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97124	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97140	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97150	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97504	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4

Total maximum allowable units before prior authorization is needed: 32.

Occupational Therapy: See maximum units per day; four units constitute a visit.

CPT-4 Code	Revenue Codes	Max Units Per Day
97003	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97004	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	1
97520	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97530	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97532	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97533	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97535	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4
97542	420, 421, 423, 424, 429, 430, 431, 433, 434, 439, 440, 441, 443, 444, 449	4

Total maximum allowable units before prior authorization is needed: 32.

4. PROGRAM REGULATIONS

Legend Drug – any drug for which a prescription is required by applicable federal or state law or regulation.

Maintenance Program — repetitive activities intended to maintain function that can be performed safely and effectively without the skilled assistance of a qualified therapist.

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by MassHealth. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 410.463(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 410.000.

Mental Illness – mental and emotional disorders as defined in the current *International Classification of Diseases, Clinical Modification* or the American Psychiatric Association's *Diagnostic and Statistical Manual* and manifested by impaired functioning in one or more of the following: emotional stability, vocational/educational productivity, social relations, and self-care.

Mentally Incompetent Individual – an individual who has been declared mentally incompetent for any purpose by a federal, state, or local court of jurisdiction, unless the individual has been declared competent to consent to sterilization.

Multiple-Source Drug – a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Nonlegend Drug – any drug for which no prescription is required by federal or state law.

Observation Services – outpatient hospital services provided anywhere in an acute inpatient hospital, to evaluate a member's condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Occupational Therapy – evaluation and treatment that includes the administration and interpretation of tests necessary for effective treatment planning; the development of daily living skills, perceptual motor skills, sensory integrative functioning, play skills, and prevocational and vocational work capacities; the design, fabrication, or application of selected orthotic and prosthetic devices or selected adaptive equipment; the use of designated modalities, superficial heat and cold, and neuromuscular facilitation techniques to improve or enhance joint motion muscle function; the design and application of specific therapeutic activities and exercises to enhance or monitor functional or motor performance and to reduce stress; and the adaptation of environments for the handicapped.

Outpatient Hospital Services – medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, day-surgery services, and recovery-room services.

Outpatient Services – medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home.

Outpatient Visit – an in-person encounter between an eligible member and a licensed practitioner (such as a physician, optician, optometrist, dentist, or therapist) or other medical professional under the direction of a licensed practitioner for the provision of outpatient services as defined in 130 CMR 410.402.

Pharmacy On-Line Processing System (POPS) – the on-line, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

Physical Therapy – evaluation and treatment that includes the performance and interpretation of tests; the use of therapeutic exercise, physical activities, mobilization, functional and endurance training, traction, bronchopulmonary hygiene postural drainage, temporary splinting and bracing, massage, heat, cold, water, radiant energy, electricity, or sound; and instruction of both the patient and the family in physical-therapy procedures as part of a patient's ongoing program.

Reconstructive Surgery – a surgical procedure that is performed to correct, repair, or ameliorate the physical effects of physical disease or defect (for example, correction of a cleft palate), or traumatic injury.

Sheltered Workshop – a program of vocational counseling and training in which the participants receive paid work experience or other supervised employment.

Speech/Language Therapy – evaluation of speech, language, voice, and fluency disorders. Such treatment includes improvement of receptive and expressive language abilities, articulation, oral motor function, rate, rhythm, and vocal quality.

Sterilization – any medical procedure, treatment, or operation performed to make an individual permanently incapable of reproducing.

Trimester – one of three three-month terms in a normal pregnancy. If the pregnancy has existed for less than 12 weeks, the pregnancy is in its first trimester. If the pregnancy has existed for 12 or more weeks but less than 24 weeks, the pregnancy is in its second trimester. If the pregnancy has existed for 24 or more weeks, the pregnancy is in its third trimester. For the purposes of 130 CMR 410.000, the elapsed period of gestation is calculated in accordance with regulations of the Massachusetts Department of Public Health currently or hereafter in force.

(B) Hospital-based home health agencies must be certified by the Medicare program and must provide to MassHealth, upon its request, documentation of that certification.

410.408: Prior Authorization

(A) For certain outpatient services described in 130 CMR 410.000, MassHealth requires that the hospital outpatient department obtain prior authorization. No payment is made for outpatient services whenever a hospital is required, but fails, to obtain prior authorization from MassHealth or its designee. It is the responsibility of the hospital to obtain the necessary prior authorization.

(B) Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as member eligibility or resort to health insurance payment.

(C) All requests for prior authorization must be submitted in accordance with the instructions in Subchapter 5 of the *Outpatient Hospital Manual*.

(D) Time requirements for response from MassHealth and rules that apply in determining the period within which MassHealth acts on specific requests for prior authorization are set forth in MassHealth's administrative and billing regulations in 130 CMR 450.000. A service is authorized on the date MassHealth transmits its decision about the request for prior authorization to the provider.

(E) Written notification of the prior-authorization decision is sent to the provider and indicates approval, deferral because additional information is necessary, modification, or denial. In the case of a modification or denial, the member is also notified. Notification of denial includes the reason for the decision. The member or the provider has the right to resubmit a request and provide additional information. The member may appeal the modification or denial of a prior-authorization request within 30 days after the date of the notice of denial. Procedures for such an appeal are set forth in 130 CMR 610.000.

(F) Members enrolled with a MassHealth managed care provider require service authorization before certain mental health and substance abuse services are provided. For more information, see 130 CMR 450.124.

(G) The hospital must obtain prior authorization for the following outpatient therapy services:
(1) more than eight occupational-therapy visits or eight physical-therapy visits, including a comprehensive evaluation and group-therapy visits, for a member within a 12-month period; and
(2) more than 15 speech/language therapy visits, including a comprehensive evaluation and group-therapy visits, for a member within a 12-month period.

410.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any outpatient service covered by MassHealth is conditioned upon its full and complete documentation in the member's medical record. If the information in the member's record is not sufficient to document the service for which payment is claimed by the provider, MassHealth will not pay for the service or, if payment has been made, will consider such payment to be an overpayment subject to recovery as defined in MassHealth's administrative and billing regulations in 130 CMR 450.000. Medical record requirements as set forth in 130 CMR 410.000 constitute the standard against which the adequacy of records is measured, as set forth in 130 CMR 450.000.

(B) MassHealth may request, and the hospital outpatient department must provide, any and all medical records (or clear photocopies of such records) corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, § 38, and 130 CMR 450.000. All components of a member's complete medical record (such as lab slips and X rays) do not need to be maintained in one file as long as all components are accessible to MassHealth upon its request.

(C) The medical record must contain sufficient data to document fully the nature, extent, quality, and necessity of the care provided to a member for each date of service claimed for payment, as well as any data that will update the member's medical course. The data maintained in the member's medical record must also be sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals.

(D) Although basic data collected during previous visits (such as identifying data, chief complaint, or history) need not be repeated in the member's medical record for subsequent visits, the medical records for hospital outpatient services provided to members must include at least the following information:

(1) the member's name and date of birth;
(2) the date of each service;
(3) the reason for the visit;
(4) the name and title of the person who performed the service;
(5) the member's medical history;
(6) the diagnosis or chief complaint;
(7) a clear indication of all findings, whether positive or negative, on examination;
(8) any tests administered and their results;
(9) a description of any treatment given;
(10) any medications administered or prescribed, including strength, dosage, regimen, and duration of use;
(11) any anesthetic agent administered;
(12) any medical goods or supplies dispensed or supplied;
(13) recommendations and referrals for additional treatments or consultations, when applicable;
(14) the federally required consent form for sterilization or hysterectomy, when applicable; and
(15) such other information as is applicable for the specific service provided, or as is otherwise required in 130 CMR 410.000.

(E) When a member is referred from a private physician to a hospital outpatient department exclusively for the purpose of a diagnostic test, the following information, at a minimum, must be included in the member's medical record:

(1) the member's name and date of birth;
(2) the signed referral from the private physician authorizing the procedure;
(3) the date of service;
(4) the name and title of the person who performed the service; and
(5) a clear indication of all findings, whether positive or negative.

(F) For therapist services, in addition to the applicable information required in 130 CMR 410.409(D), the member's medical record must include at least the following (see 130 CMR 410.453);

(1) a licensed physician's written referral for evaluation, referral for treatment, and renewal of referral (if applicable) every 60 days (see 130 CMR 410.451(B));
(2) the written comprehensive evaluation report (see 130 CMR 410.451(C));
(3) the name, address, and telephone number of the member's primary physician;
(4) a treatment notation for each date on which therapy was provided that includes at least the following:
  (a) the specific therapeutic procedures and methods used;
  (b) the amount of time spent in treatment; and
  (c) the signature and title of the person who provided the service;
(5) at least weekly documentation of the following:
  (a) the member's response to treatment;
  (b) any changes in the member's condition;
  (c) the problems encountered or changes in the treatment plan or goals, if any;
  (d) the location where the service was provided if different from that in the evaluation report; and
  (e) the signature and title of the therapist; and
(6) a discharge summary, when applicable.

(G) (1) For mental health services, in addition to the applicable information required in 130 CMR 410.409(D), the member's medical record must include at least the following (see 130 CMR 410.478):

(a) the member's case number, address, telephone number, sex, age, marital status, next of kin, and school or employment status (or both);
(b) the date of initial contact and, if applicable, the referral source;
(c) a report of a physical examination performed within six months (if such an examination has not been performed in that period, one must be given within 30 days after the member's request for services or, if the member refuses to be examined, the record must document the reasons for the exam postponement);
(d) the name and address of the member's primary physician or medical clinic (a physician or medical clinic must be recommended if there is not one currently attending the member);
(e) a description of the nature of the member's condition;
(f) the relevant medical, social, educational, and vocational history;
(g) a comprehensive functional assessment of the member;
(h) the clinical impression of the member and a diagnostic formulation, including a specific diagnosis using ICD-9-CM or DSM III diagnosis codes;
(i) the member's treatment plan, updated as necessary, including long-range goals, short-term objectives, and the proposed schedule of therapeutic activities;

(j) a schedule of dates for utilization review to determine the member's progress in accomplishing goals and objectives;
(k) the name, qualifications, and discipline of the primary therapist;
(l) a written record of utilization reviews by the primary therapist;
(m) documentation of each visit, including the member's response to treatment, written and signed by the person providing the service, and including the therapist's discipline and degree;
(n) all information and correspondence about the member, including appropriately signed and dated consent forms;
(o) a medication-use profile; and
(p) when the member is discharged, a discharge summary.

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

(H) Hospital pharmacies must maintain a record for each member of the drug and amount dispensed, the date, and the original prescription (see 130 CMR 410.467).

(I) For vision care services, in addition to the applicable information required in 130 CMR 410.409(D), the record must fully disclose all pertinent information about the services provided, including the date of service, the dates on which materials were ordered and dispensed, and a description of materials (including the frame style and the manufacturer's name) ordered and dispensed (see 130 CMR 410.483).

(1) All health care findings resulting from a visual analysis, whether they are normal or abnormal, must be recorded. When extenuating circumstances prevent the use of one or more procedures normally done in a visual analysis, the record must contain the reasons that the tests were not performed.

(2) For comprehensive eye examinations and diagnoses, the record must contain the following information or test results:
(a) case history;
(b) visual acuity testing;
(c) ophthalmoscopy and external eye health examination;
(d) ocular mobility testing, heterophoria testing, and fusion testing;
(e) pupillary reflex testing;
(f) refraction (retinoscopy, subjective refraction, and keratometry);
(g) confrontation fields or other screening tests;
(h) tonometry, when medically indicated;
(i) case analysis and disposition; and
(j) biomicroscopy, when medically indicated.

(3) All consultation services must be fully documented in the record. A record for a consultation must contain the following information:
(a) the member's complaints and symptoms;
(b) the condition of the eye; and
(c) if applicable, the name of the person to whom a referral was made.

(4) All screening services must be fully documented in the record. A record for a screening service must note the chief complaint and must contain all findings of two or more of the following tests:

410.445: Psychiatric Day Treatment Program Services

(A) A psychiatric day treatment program is a planned combination of diagnostic, treatment, and rehabilitative services provided to mentally or emotionally disturbed persons who need more active or inclusive treatment than is typically available through a weekly visit for outpatient mental health services, but who do not need full-time hospitalization or institutionalization. Such a program uses multiple, intensive, and focused activities in a supportive environment to enable these individuals to acquire more realistic and appropriate behavior patterns, attitudes, and skills for eventual independent functioning in the community.

(B) MassHealth pays for services provided as part of an organized psychiatric day treatment program by hospital outpatient departments that are enrolled with MassHealth as psychiatric day treatment programs. These services must be provided in compliance with MassHealth's regulations governing psychiatric day treatment program services in 130 CMR 417.000. (See Subchapter 5 of the *Outpatient Hospital Manual* for instructions about obtaining the *Psychiatric Day Treatment Program Manual*, which contains the necessary regulations.)

(C) Acute hospital-based psychiatric day treatment programs are paid according to the outpatient payment methodology established by the signed provider agreement with MassHealth.

(D) Nonacute hospital-based psychiatric day treatment programs are paid according to the outpatient payment methodology established by the Massachusetts Division of Health Care Finance and Policy (DHCFP) (see 130 CMR 410.406).

410.446: Dental Services

(A) MassHealth pays for dental services provided by hospital outpatient departments. These services must be provided in compliance with MassHealth's regulations governing dental services in 130 CMR 420.000. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the *Dental Manual*, which contains the necessary regulations.)

(B) Acute hospital-based providers of dental services are paid according to the outpatient payment methodology established by the signed provider agreement with MassHealth.

(C) Nonacute hospital-based providers of dental services are paid according to the outpatient payment methodology established by the DHCFP (see 130 CMR 410.406).

(130 CMR 410.447 through 410.450 Reserved)

410.451: Therapist Services: Covered Services

(A) MassHealth pays for occupational, physical, and speech/language therapy provided in hospital outpatient departments by or under the supervision of licensed therapists. Therapist services include the following:

(1) individual treatment;
(2) comprehensive evaluation;
(3) group therapy; and
(4) design and fitting of an adaptive device.

(B) All therapy must be provided subsequent to a written referral from a licensed physician. MassHealth will pay for continuing physical or occupational therapy only when the physician's referral is renewed in writing every 60 days, subject to the prior-authorization requirements described in 130 CMR 410.408(G).

(C) Before therapy is initiated, a comprehensive evaluation of the member's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop a treatment plan. A comprehensive evaluation must include preparation of a written report for the member's medical record that contains at least the following information:

(1) the member's name and address;
(2) the name of the referring physician;
(3) objective evaluation findings;
(4) a detailed treatment plan prescribing the type, amount, estimated frequency, and duration of therapy and indicating the diagnosis and anticipated goals, or the reason treatment is not indicated;
(5) a description of any conferences with the member, the member's family or physician, or other interested persons;
(6) other health care evaluations, as indicated;
(7) a description of the member's psychosocial and health status that includes:
    (a) the present effects of the disability on both member and family;
    (b) a brief history, the date of onset, and any past treatment of the disability;
    (c) the member's level of functioning, both current and before onset of the disability, if applicable; and
    (d) any other significant physical or mental disability that may affect therapy;
(8) for speech/language therapy only:
    (a) assessments of articulation, stimulability, voice, fluency, and receptive and expressive language;
    (b) a description of the member's cognitive functioning; and
    (c) a description of the member's communication needs and motivation for treatment;
(9) for physical or occupational therapy only: a description of the member’s physical limitations; and
(10) the therapist's signature and the date of the evaluation.

(D) The hospital must obtain prior authorization as a prerequisite to payment for certain outpatient therapy services pursuant to 130 CMR 410.408(G).

410.452: Therapist Services: Service Limitations

(A) MassHealth does not pay for performance of a maintenance program. MassHealth pays for designing a maintenance program and instructing the member, member's family, or other persons in its use as part of a regular treatment visit, not as a separate service.

(B) For each type of therapy, MassHealth pays for no more than one individual treatment and one group therapy session for a member per day.

410.453: Therapist Services: Recordkeeping Requirements

In addition to the information required in 130 CMR 410.409, the member's record must include the following:

(A) a licensed physician's written referral for evaluation, referral for treatment, and renewal of referral (if applicable) every 60 days (see 130 CMR 410.451(B));

(B) the written comprehensive evaluation report (see 130 CMR 410.451(C));

(C) the name, address, and telephone number of the member's primary physician;

(D) a treatment notation for each date on which therapy was provided that includes at least the following:
(1) the specific therapeutic procedures and methods used;
(2) the amount of time spent in treatment; and
(3) the signature and title of the person who provided the service;

(E) at least weekly documentation of the following:
(1) the member's response to treatment;
(2) any changes in the member's condition;
(3) the problems encountered or changes in the treatment plan or goals, if any;
(4) the location where the service was provided if different from that in the evaluation report; and
(5) the signature and title of the therapist; and

(F) a discharge summary, when applicable.

(130 CMR 410.454 Reserved)

410.455: Laboratory Services: Introduction

130 CMR 410.455 through 410.459 establish the requirements and procedures for clinical laboratory services provided by hospital outpatient departments. A clinical laboratory service includes the following types of services: microbiological, serological, chemistry, hematological, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

410.456: Laboratory Services: Payment

(A) Maximum Allowable Fee.

(1) The maximum allowable payment for an acute hospital outpatient department or hospital-licensed health center laboratory service is the lowest of the following:

(a) the hospital's charge as currently filed with the DHCFP;

(b) the amount described at 42 U.S.C. 1396b(i)(7); or

(c) the usual and customary fee.

(2) The maximum allowable payment for a nonacute hospital outpatient laboratory service is the lowest of the following:

(a) the percentage of charge as established by the DHCFP under 114.1 CMR 28.10;

(b) the amount set by the Medicare fee schedule as described at 42 U.S.C. 1396b(i)(7); or

(c) the usual and customary fee.

(B) Usual and Customary Fee. The term usual and customary means the lowest fee charged by a hospital outpatient department laboratory for any laboratory service (including both individual and profile tests) specified in the hospital outpatient department's charge book or by such hospital, with the exception of a fee offered for a bulk purchase. (A bulk purchase is a single purchase of a laboratory service (one or more tests) to be uniformly and concurrently performed on a minimum of 40 specimens of the same type. A single purchase of various, nonuniform laboratory services, such as by a physician, will not be considered a bulk purchase, regardless of the number of specimens presented by such a purchaser to the hospital outpatient department laboratory.)