Commonwealth of Massachusetts
Executive Office of Health and Human Services
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MASSHEALTH
TRANSMITTAL LETTER OPD-56
June 2005

TO: Outpatient Hospitals Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: *Outpatient Hospital Manual* (Prior Authorization Policy for Rehabilitative Therapy Services and Revised Policy for Laboratory Services)

This letter transmits revisions to the outpatient hospital regulations. Some of the revisions reflect the policy changes that MassHealth announced under Acute Outpatient Hospital Bulletin 11 and Chronic Outpatient Hospital Bulletin 1, dated December 2004. All changes to these regulations are summarized below.

Increase in Number of Payable Visits Before PA Is Required

The revised regulations increase the number of medically necessary physical therapy (PT), occupational therapy (OT), and speech therapy (ST) visits that are payable by MassHealth within a 12-month period before prior authorization (PA) is required. The number of medically necessary visits payable by MassHealth without PA is now **20 PT visits**, **20 OT visits**, and **35 ST visits** within a 12-month period.

Therapy Evaluations and Reevaluations

MassHealth no longer requires PA for comprehensive evaluations or reevaluations, and no longer counts them as part of the therapy visits that are payable without PA within a 12-month period.

Please Note: Although the attached regulations are revised July 1, 2005, the increase in the number of payable therapy visits and the elimination of the PA requirement for therapy evaluations and reevaluations have been in effect since January 1, 2005, as stated in the above-mentioned bulletins.

Maintenance Programs

The attached revisions also provide a revised definition of maintenance program and change the policy on coverage for maintenance programs. See 130 CMR 410.452.

MassHealth defines maintenance programs as “repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment and skill of a licensed therapist for safety and effectiveness.”

130 CMR 410.452 now states, in part:

> (A) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. The MassHealth agency does not pay a therapist for performance of a maintenance program, except as provided in 130 CMR 410.452(B).
>
> (B) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

Definitions

- The attached regulations contain a revision to the definition of Outpatient Services to include those services provided by satellite clinics. This revision was made to be consistent with the language in the MassHealth Request for Applications (RFA) for in-state acute outpatient hospitals.
- The attached regulations contain a definition for Satellite Clinic.
- MassHealth has also revised the definitions for Occupational Therapy, Physical Therapy, and Speech/Language Therapy to make them consistent with industry standards.

Laboratory Services Payment

The attached regulations also contain updates that are consistent with the RFA and the MassHealth policy for laboratory services:

- MassHealth has revised 130 CMR 410.455 to explicitly state that MassHealth does not pay for routine specimen collection as a separate service.
- MassHealth has revised 130 CMR 410.456 to conform to the payment methodology for the RFA for outpatient hospitals.

Tips on Requesting PA

MassHealth encourages providers to use its Web-based Automated Prior Authorization System (APAS) at www.masshealth-apas.com when requesting PA for therapy services in excess of 20 PT visits, 20 OT visits, or 35 ST visits, within a 12-month period. To receive more information about requesting PA using APAS, including training and access to APAS, call 1-866-378-3789.

A number of PA requests for therapy services have been returned to providers or delayed in processing because of confusion about how to request PA. The following are guidelines for completing PA requests for PT, OT, and ST.

Responsibility for Requesting PA

If a therapist is requesting PA, the request must include the physician's orders. If a physician is providing the therapy, the physician must request PA.

Note: A nurse may sign the Request and Justification for Therapy Services (R&J) form, as long as the form indicates that the therapy notes are attached and signed by the therapist (or physician who will provide the therapy).

General Instructions

When requesting PA, whether on the Automated Prior Authorization System (APAS) or on the paper Request for Prior Authorization, you must:

- submit a complete, legible Request and Justification form (R&J);
- submit a current (within 60 days) physician prescription for initial requests, and a physician's order for renewal for subsequent requests;
- submit a copy of the most recent comprehensive evaluation or reevaluation;
- summarize the member's medical necessity in Section VII of the R&J form and submit all appropriate information for substantiating medical necessity for the requested service;
- use the most appropriate code for the service (see below for more information about service codes); and
- make sure that the services on the PA request are consistent with the units shown on the R&J form.

Service Codes

- **For acute outpatient hospitals**, service codes are listed in Acute Outpatient Hospital Bulletin 11. To view this bulletin on the Web, go to www.mass.gov/masshealthpubs. Click on "Provider Library," then on "MassHealth Service Codes and Descriptions."

- **For chronic outpatient hospitals**, service codes for therapy services are listed in Chronic Outpatient Hospital Bulletin 1. To view this bulletin on the Web, go to www.mass.gov/masshealthpubs. Click on "Provider Library," then on "Provider Bulletins."

Calculating Units

Note: Some codes are not expressed in 15-minute units. Refer to Acute Outpatient Hospital Bulletin 11 and Chronic Outpatient Hospital Bulletin 1 for a list of therapy codes along with the allowable revenue codes and maximum allowable units.

To calculate the total number of units, identify the number of:

- visits needed per week;
- weeks for which you will need to schedule visits; and
- units of service for each visit, including modalities of service. Note: The total number of units of PT, OT, or ST service codes provided should not exceed four per visit or one hour per visit, and should reflect the actual time the member is being treated.

Example: If the R&J form indicates that you plan to see the member twice a week, for one hour each visit, for a four-week period, the number of units is as follows:

- 2 visits x 4 15-minute units = 8 15-minute units per week
- 8 15-minute units x 4 weeks = 32 15-minute units over the course of four weeks.

Units must be distributed between the services being provided. If you are requesting PA to provide four different services (for example, ultrasound (97035), manual therapy techniques (97140), therapeutic exercise (97110), and gait training (97116)) during each of two visits per week for a one-month period, the breakdown of units for the duration of the PA might look like this:

Service Code	Units per Week	No. of Days
97035	8	30
97140	8	30
97110	8	30
97116	8	30
	32	**30**

If you are requesting to provide therapy services to a member for an hour two times a week for a one-month period, but plan to provide more of one service (for example, therapeutic exercise (97110), and not provide another (for example, gait training), the breakdown of units for the duration of the PA might look like this:

Service Code	Units per Week	No. of Days
97035	8	30
97140	8	30
97110	16	30
	32	**30**

Revised R&J

MassHealth has revised the R&J form to reflect the revised regulations. The revised form also clarifies that a summary of the member's medical necessity must be provided in Section VII of the R&J. This requirement is in addition to the requirement to attach supporting documentation to the form. The revised form is available on the MassHealth Web site at www.mass.gov/masshealthpubs. Click on "Provider Library," then on "Provider Forms." You may continue to submit PA requests with the previous version of the R&J form, but you should make note of the new language.

To order supplies of the new form, send a written request to MassHealth Customer Service or call them at

MassHealth
P.O. Box 9118
Hingham, MA 02043
Telephone: 1-800-841-2900
E-mail: publications@mahealth.net
Fax: 617-988-8973.

Include your provider number, mailing address, contact name, and desired quantity with all requests for forms.

MassHealth Guidelines

To provide additional assistance to MassHealth providers requesting prior authorization for therapy services, MassHealth has developed Guidelines for Medical Necessity Determination for Physical Therapy, for Occupational Therapy, and for Speech and Language Therapy. These Guidelines are intended to clarify the specific medical information that MassHealth needs to determine medical necessity. They are not intended to replace or supersede program regulations. All MassHealth Guidelines for Medical Necessity Determination are available at www.mass.gov/masshealth/guidelines. From this site, you can also sign up to receive e-mail notification of updates to the MassHealth Guidelines.

Other Changes

MassHealth has also revised 130 CMR 410.404(A)(2) to conform to the general provisions of the chronic disease and rehabilitation hospital RFA for MassHealth participation.

Effective Date

These regulations are effective July 1, 2005.

Questions

If you have any questions about the information in this transmittal letter before July 1, 2005, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231. If you will be making your inquiry on or after July 1, 2005, please call MassHealth Customer Service at 1-800-841-2900 or e-mail your inquiry to providersupport@mahealth.net.

NEW MATERIAL

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

Outpatient Hospital Manual

Pages 4-3 through 4-10 and 4-29 through 4-34

OBSOLETE MATERIAL

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

Outpatient Hospital Manual

Pages 4-3 through 4-6 — transmitted by Transmittal Letter OPD-54

Pages 4-7 and 4-8 — transmitted by Transmittal Letter OPD-48

Pages 4-9, 4-10, and 4-31 through 4-34 — transmitted by Transmittal Letter OPD-52

Pages 4-29 and 4-30 — transmitted by Transmittal Letter OPD-35

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

Maintenance Program – repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment and skill of a licensed therapist for safety and effectiveness.

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by the MassHealth agency. 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 – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence, preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

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, and day-surgery 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 or other hospital satellite clinics, 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 Online Processing System (POPS) – the online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

Physical Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

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.

Satellite Clinic – a facility that operates under a hospital's license, is subject to the fiscal, administrative, and clinical management of the hospital, provides services to members solely on an outpatient basis, is not located at the same site as the hospital's inpatient facility, and demonstrates to EOHHS's satisfaction that it has CMS provider-based status in accordance with 42 CFR 413.65.

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

Speech/Language Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of presence of a communication disability), and those that impair comprehension, spoken, written, or other symbol systems used for communication.

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.

Unit-Dose Distribution System — a means of packaging or distributing drugs, or both, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken.

Vocational Rehabilitative Services — services such as vocational assessments, job training, career counseling, and job placement.

410.403: Eligible Members

(A) (1) MassHealth Members. MassHealth covers outpatient hospital services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105 specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

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

410.404: Provider Eligibility

Payment for the services described in 130 CMR 410.000 is made only to hospital outpatient departments participating in MassHealth on the date of service.

(A) In State

(1) To participate in MassHealth, acute hospital outpatient departments and hospital-licensed health centers located in Massachusetts must:

(a) operate under a hospital license issued by the Massachusetts Department of Public Health;

(b) have a signed provider agreement that specifies a payment methodology with the MassHealth agency; and

(c) participate in the Medicare program.

(2) To participate in MassHealth, nonacute hospital outpatient departments located in Massachusetts must:

(a) operate under a hospital license issued by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health;

(b) have a signed provider agreement for participation in the MassHealth program; and

(c) participate in the Medicare program.

(B) Out of State

(1) Out-of-state hospital outpatient and hospital-licensed health center services provided to an eligible MassHealth member are covered in the following instances:

(a) emergency care hospital outpatient services are provided to a member;

(b) hospital outpatient services are provided to a member who lives in a community near the border of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont and for whom the out-of-state hospital is nearer than one in Massachusetts providing equivalent medical services;

(c) hospital outpatient services are provided to a member who is authorized to reside or who is placed out of state by the Massachusetts Department of Social Services or by a Chapter 766 core team evaluation;

(d) hospital outpatient services are provided to a member who has been authorized by the MassHealth agency to reside in an out-of-state nursing facility; or

(e) prior authorization has been obtained from the MassHealth agency for nonemergency services provided to a member by an out-of-state hospital outpatient department that is more than 50 miles from the Massachusetts border.

(2) To participate in MassHealth, an out-of-state hospital outpatient department or hospital-licensed health center must obtain a MassHealth provider number and meet the following criteria:

(a) it operates under a hospital license from or is approved as a hospital by the governing or licensing agency in its state;

(b) it participates in the Medicare program; and

(c) it participates in that state's Medicaid program (or the equivalent).

(3) Payment for out-of-state hospital outpatient and hospital-licensed health center services is made in accordance with the Medicaid (or equivalent) fee schedule of that state.

410.405: Noncovered Services

(A) The MassHealth agency does not pay for any of the following services:

(1) nonmedical services, such as social, educational, and vocational services;

(2) cosmetic surgery;

(3) canceled or missed appointments;

(4) telephone conversations and consultations;

(5) court testimony;

(6) research or the provision of experimental, unproven, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, the MassHealth agency will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993;

(7) the provision of whole blood; however, administrative and processing costs associated with the provision of blood and its derivatives are covered; and

(8) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).

(B) The MassHealth agency does not pay for mental health services such as, but not limited to, the following (see 130 CMR 410.472):

(1) vocational rehabilitation services;
(2) sheltered workshops;
(3) recreational services;
(4) life-enrichment services; and
(5) alcohol or drug drop-in centers.

(C) The MassHealth agency does not pay for pharmacy services such as, but not limited to, the following (see 130 CMR 410.462 through 410.465):

(1) any drug used for the treatment of obesity;
(2) any drug used for smoking cessation;
(3) cough and cold preparations;
(4) less-than-effective drugs;
(5) hormone therapy related to sex-reassignment surgery; and
(6) drugs related to the treatment of male or female infertility.

(D) The MassHealth agency does not pay for vision care services such as, but not limited to, the following (see 130 CMR 410.481 through 410.489):

(1) absorptive lenses of greater than 25 percent absorption;
(2) photochromatic lenses, sunglasses, or fashion tints;
(3) treatment of congenital dyslexia;
(4) extended-wear contact lenses;
(5) invisible bifocals; and
(6) the Welsh 4-Drop Lens.

(E) The MassHealth agency does not pay an independent practitioner for services provided to members in an outpatient department except when that practitioner has an active provider number issued by the MassHealth agency and meets one of the following criteria.

(1) The practitioner serves in an attending, visiting, or supervisory role at the hospital where the services are provided, is legally responsible for the management of the member's care, is physically present and actively involved in the treatment for which payment is claimed, and provides a service for which the MassHealth agency pays an independent practitioner when provided in an outpatient hospital setting. Supervisory surgeons must be scrubbed and physically present during the major portion of an operation.

(2) The independent practitioner, if serving as a salaried intern, resident, fellow, or house officer, provides services during off-duty hours at an institution that does not pay his or her salary.

(3) The independent practitioner receives a salary from an institution for administrative or teaching services, but not for delivery of care, and provides direct medical care to a member that meets the conditions set forth in 130 CMR 410.405(E)(1).

410.406: Payment

(A) Acute hospital outpatient departments and hospital-licensed health centers in Massachusetts are paid for services provided to eligible members according to the rate for services established in the signed MassHealth provider agreement, subject to the limitations set forth in 130 CMR 410.406.

(B) For purposes of making payments to acute hospital outpatient departments and hospital-licensed health centers in Massachusetts, the following limitations apply.

(1) The MassHealth agency does not pay for outpatient services provided to a member who is an inpatient at the same or a different hospital on the same day.

(2) The MassHealth agency pays only for emergency outpatient services provided to a member on the day that the member is discharged from the hospital, whether from the same or a different facility.

(3) If a member receives outpatient services at one facility and, later on the same day, is admitted as an inpatient to another facility, the MassHealth agency pays both hospitals for services.

(4) When a member is admitted to inpatient status through the emergency department or outpatient department, the hospital must bill for only the inpatient stay. The MassHealth agency does not pay for services furnished in the emergency department or outpatient department on the admitting day.

(C) Nonacute hospital outpatient departments in Massachusetts are paid for services provided to eligible members according to the rate of payment established for each hospital in the signed MassHealth provider agreement, subject to the limitations set forth in 130 CMR 410.406(C)(1) and (2).

(1) Charges.

(a) The MassHealth agency pays only those charges contained in the charge book that the hospital has currently filed with DHCFP and no more than those charges.

(b) For changes in charges, the appropriate regulations of the DHCFP apply.

(c) In those cases where a specific rate has been established by DHCFP for a specific service or program (such as for adult day health services), the MassHealth agency pays no more than that rate.

(2) Payments. For purposes of making payments to nonacute outpatient hospitals, the following limitations apply.

(a) The MassHealth agency does not pay for outpatient services provided to a member who is an inpatient at the same or a different hospital on the same day.

(b) The MassHealth agency pays only for emergency outpatient services provided to a member on the day that he or she is discharged from the hospital, whether from the same or a different facility.

(c) If a member receives outpatient services at one facility and, later on the same day, is admitted as an inpatient to another facility, the MassHealth agency pays both hospitals for services.

(d) When a member is admitted to inpatient status through the emergency department or outpatient department, the hospital must bill for only the all-inclusive per diem rate for that day. The MassHealth agency does not pay for services furnished in the emergency department or outpatient department on the admitting day.

(D) The MassHealth agency pays for laboratory services in accordance with 130 CMR 410.456.

410.407: Certification

(A) Hospital outpatient departments must receive certification from the MassHealth agency before providing the following services:

(1) adult day health services (for requirements, see 130 CMR 410.443);

(2) adult foster care services (for requirements, see 130 CMR 410.444); and

(3) psychiatric day treatment program services (for requirements, see 130 CMR 410.445).

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

410.408: Prior Authorization

(A) For certain outpatient services described in 130 CMR 410.000, the MassHealth agency 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 the MassHealth agency 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 the MassHealth agency and rules that apply in determining the period within which the MassHealth agency acts on specific requests for prior authorization are set forth in the MassHealth administrative and billing regulations in 130 CMR 450.000. A service is authorized on the date the MassHealth agency 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 receipt 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 behavioral health 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 20 occupational-therapy visits or 20 physical-therapy visits, including group-therapy visits, for a member within a 12-month period; and
(2) more than 35 speech/language therapy visits, including 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, the MassHealth agency 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 the MassHealth 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) The MassHealth agency 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 the MassHealth agency 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.

410.441: Early Intervention Program Services

(A) An early intervention program provides services such as therapy and social, medical, educational, and developmental services for children aged three years or younger who are at biological, environmental, or established risk, and for their families.

(B) The MassHealth agency pays for services provided as part of an organized early intervention program by hospital outpatient departments. These services must be furnished in compliance with the MassHealth regulations governing early intervention program services in 130 CMR 440.000. (See Subchapter 5 of the *Outpatient Hospital Manual* for instructions about obtaining the *Early Intervention Program Manual*, which contains the necessary regulations.)

(C) Acute and nonacute hospital-based early intervention programs are paid according to the regulations governing early intervention program services in 130 CMR 440.000.

410.442: Home Health Agency Services

(A) A home health agency is a public or private agency or organization, or a subdivision of such an agency or organization, that is primarily engaged in furnishing part-time skilled nursing and other therapeutic services to patients in their homes.

(B) The MassHealth agency pays for home health services provided by hospital-based home health agencies. These services must be furnished in compliance with the MassHealth regulations governing home health agency services in 130 CMR 403.000. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the *Home Health Agency Manual*, which contains the necessary regulations.)

(C) Acute hospital-based home health agencies will be paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based home health agencies will be paid according to the regulations governing home health agency services in 130 CMR 403.000.

410.443: Adult Day Health Program Services

(A) An adult day health program is an organized program of health care and supervision, restorative services, and social activities whose general goal is to provide an alternative to long-term institutional care.

(B) The MassHealth agency pays for services provided as part of an organized adult day health program by a hospital outpatient department. These services must be furnished in accordance with the MassHealth regulations governing adult day health programs in 130 CMR 404.000. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the *Adult Day Health Manual*, which contains the necessary regulations.)

(C) Acute hospital-based adult day health programs will be paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based adult day health programs will be paid according to the regulations governing adult day health services in 130 CMR 404.000.

410.444: Adult Foster Care Services

(A) An adult foster care program provides room, board, and personal care services in a family-like setting to elderly or disabled individuals who are at imminent risk of institutional placement.

(B) The MassHealth agency pays for services provided by hospital-based adult foster care programs. These services must be furnished in compliance with the "Adult Foster Care Guidelines" issued by the MassHealth agency. (See Subchapter 5 of the *Outpatient Hospital Manual* for information about obtaining the "Guidelines" and the *Adult Foster Care Manual*.)

(C) Acute hospital-based adult foster care programs will be paid according to the outpatient payment methodology established by the signed MassHealth provider agreement.

(D) Nonacute hospital-based adult foster care programs will be paid according to the payment methodology established by the Office of Purchased Services in the Executive Office of Administration and Finance.

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) The MassHealth agency 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 the MassHealth 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 MassHealth provider agreement.

(D) Nonacute hospital-based psychiatric day treatment programs are paid according to the regulations governing psychiatric day treatment services in 130 CMR 417.000.

410.446: Dental Services

(A) The MassHealth agency pays for dental services provided by hospital outpatient departments. These services must be provided in compliance with the MassHealth 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 MassHealth provider agreement.

(C) Nonacute hospital-based providers of dental services are paid according to the regulations governing dental services in 130 CMR 420.000.

(130 CMR 410.447 through 410.450 Reserved)

410.451: Therapist Services: Covered Services

(A) The MassHealth agency 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 or licensed nurse practitioner. The MassHealth agency pays for continuing physical, occupational, or speech/language therapy only when the 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 or nurse practitioner;
(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 clinician, 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) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 410.452(B).

(B) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

(C) For each type of therapy, the MassHealth agency pays for no more than one individual visit 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 or licensed nurse practitioner'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

(A) 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.

(B) The MassHealth agency does not pay separately for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipuncture; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue.) Specimen collection and preparation is considered part of the laboratory service.

410.456: Laboratory Services: Payment

(A) Maximum Allowable Fee. The maximum allowable payment for an acute or nonacute hospital outpatient department or hospital-licensed health center laboratory service is the lowest of the following:

(1) the amount in effect for the date of service in the DHCFP Clinical Laboratory Services fee schedule at 114.3 CMR 20.00 and 114.3 CMR 16.00;

(2) the amount that would be recognized under 42 U.S.C. 1395l(h) for tests performed for a person with Medicare Part B benefits; or

(3) 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, non-uniform laboratory services, such as by a physician, is not considered a bulk purchase, regardless of the number of specimens presented by such a purchaser to the hospital outpatient department laboratory.)