Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MASSHEALTH
TRANSMITTAL LETTER PHY-106
June 2005

TO: Physicians Participating in MassHealth

FROM: Beth Waldman, Medicaid Director

RE: *Physician Manual* (Prior Authorization Policy for Rehabilitative Therapy Services)

This letter transmits revisions to the physician regulations. The revisions reflect the policy changes that MassHealth announced under Physician Bulletin 81, dated December 2004.

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. In addition, MassHealth no longer requires PA for a second comprehensive evaluation 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 bulletin.

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 433.431(C) and 433.471(B)(2).

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 physician or licensed therapist for safety and effectiveness.”

130 CMR 433.431(C) states:

(C)(1) 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 433.431(C)(2).
(2) In certain instances, the specialized knowledge and judgment of a licensed physician or 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 physician or a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed physician or licensed therapist, rather than a non-physician or non-therapist, must be documented in the medical record.

Parallel language can be found at 433.471(B)(2).

New Definitions

MassHealth has also added definitions for Occupational Therapy, Physical Therapy, and Speech/Language Therapy.

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 physician is providing the therapy, the physician must request PA. If a physician employs a therapist and the therapist does not have a MassHealth provider number, the physician must request the PA. If the provider bills for services under a group practice provider number, it is important to remember that the PA must be submitted under the provider's individual servicing provider number.

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 and number of units you are requesting on the PA request are consistent with the units shown on the R&J form.

Service Codes

Service codes are listed in Subchapter 6 of the *Physician Manual*. To view Subchapter 6 on the Web, go to www.mass.gov/masshealthpubs. Click on "Provider Library," then on "MassHealth Service Codes and Descriptions."

Calculating 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. 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.

Note: Most therapy codes are expressed in 15-minute units, but there are exceptions. The following codes that require PA are billed with a different unit structure.

Codes	Maximum Allowed Units/Visit
97010	1
97012	1
97016	1
97018	1
97020	1
97022	1
97024	1
97026	1
97028	1
97150	1
92506	1
92507	1
92508	1
92526	1
92610	1

Units must be distributed among 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. In addition, the sites of service delivery have been expanded to include rehabilitation centers and "other" locations. 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.

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.)

Physician Manual

Pages iv, 4-3 through 4-10, 4-21 through 4-26, 4-47, and 4-48

OBSOLETE MATERIAL

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

Physician Manual

Pages iv, 4-3, 4-4, 4-9, 4-10, 4-21, 4-22, 4-47, and 4-48 — transmitted by Transmittal Letter PHY-99

Pages 4-5 and 4-6 — transmitted by Transmittal Letter PHY-93

Pages 4-7 and 4-8 — transmitted by Transmittal Letter PHY-98

Pages 4-23 through 4-26 — transmitted by Transmittal Letter PHY-92

4. PROGRAM REGULATIONS

Part 1. General Information

433.401: Definitions 4-1
433.402: Eligible Members 4-5
433.403: Provider Eligibility 4-5
433.404: Nonpayable Circumstances 4-6
433.405: Maximum Allowable Fees 4-7
433.406: Individual Consideration 4-7
433.407: Service Limitations: Medical and Radiology Services 4-7
433.408: Prior Authorization 4-8
433.409: Recordkeeping (Medical Records) Requirements 4-9
433.410: Report Requirements 4-10
(130 CMR 433.411 and 433.412 Reserved)

Part 2. Medical Services

433.413: Office Visits: Service Limitations 4-11
433.414: Hospital Emergency Department and Outpatient Department Visits 4-11
433.415: Hospital Services: Service Limitations and Screening Requirements 4-12
433.416: Nursing Facility Visits: Service Limitations 4-12
433.417: Home Visits: Service Limitations 4-12
433.418: Consultations: Service Limitations 4-13
433.419: Nurse Midwife Services 4-13
433.420: Obstetric Services: Introduction 4-14
433.421: Obstetric Services: Global-Fee Method of Payment 4-14
(130 CMR 433.422 and 433.423 Reserved)
433.424: Obstetric Services: Fee-for-Service Method of Payment 4-17
433.425: Ophthalmology Services: Service Limitations 4-17
433.426: Audiology Services: Service Limitations 4-18
433.427: Allergy Testing: Service Limitations 4-18
433.428: Psychiatry Services: Introduction 4-18
433.429: Psychiatry Services: Scope of Services 4-20
433.430: Dialysis: Service Limitations 4-22
433.431: Physical Medicine: Service Limitations 4-22
433.432: Other Medical Procedures 4-23
433.433: Nurse Practitioner Services 4-23
433.434: Physician Assistant Services 4-24
(130 CMR 433.435 Reserved)
433.436: Radiology Services: Introduction 4-26
433.437: Radiology Services: Service Limitations 4-26
433.438: Clinical Laboratory Services: Introduction 4-27
433.439: Clinical Laboratory Services: Service Limitations 4-28
(130 CMR 433.440 Reserved)

Institutionalized Individual – a member who is either:

(1) involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or

(2) confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

Intensive Care Services – the services of a physician other than the attending physician, provided for a continuous period of hours (rather than days), required for the treatment of an unusual aspect or complication of an illness, injury, or pregnancy.

Interchangeable Drug Product – a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A-rated") by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

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 physician or 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 433.443(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 433.000.

Mentally Incompetent Individual – a member 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.

Not Otherwise Classified – a term used for service codes that should be used when no other service code is appropriate for the service provided.

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.

Oxygen – gaseous or liquid medical-grade oxygen that conforms to United States Pharmacopoeia Standards.

Pediatric Office Visit – a medical visit by a member under 21 years of age to a physician's office or to a hospital outpatient department.

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 – 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.

Prolonged Detention – constant attendance to a member in critical condition by the attending physician.

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

Referral – the transfer of the total or specific care of a member from one physician to another. For the purposes of 130 CMR 433.000, a referral is not a consultation.

Respiratory Therapy Equipment – a product that:

(1) is fabricated primarily and customarily for use in the domiciliary treatment of pulmonary insufficiencies for its therapeutic and remedial effect;
(2) is of proven quality and dependability; and
(3) conforms to all applicable federal and state product standards.

Routine Study – a set of X rays of an extremity that includes two or more views taken at one sitting.

Separate Procedure – a procedure that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but commands a separate fee when performed as a separate entity not immediately related to other services.

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.

Therapeutic Radiology Service – a radiology service used to treat an injury or illness.

Therapy Visit – a personal contact provided as an office visit or outpatient visit for the purpose of providing a covered physical or occupational therapy service by a physician or licensed physical or occupational therapist employed by the physician. Additionally, speech therapy services provided by a physician as an office or outpatient visit is considered a therapy visit.

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.

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.

433.402: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency pays for physician services provided to MassHealth members, subject to the restrictions and limitations described in the MassHealth regulations. 130 CMR 450.105 describes the services covered and the members covered under each coverage type.
(2) Recipients of 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) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

433.403: Provider Eligibility

(A) Participating Providers
(1) 130 CMR 433.000 applies to medical, radiology, laboratory, anesthesia, and surgery services provided to members by physicians participating in MassHealth as of the date of service.
(2) To be eligible for payment, a physician must be physically present and actively involved in the treatment of the member. Time periods specified in the service descriptions refer to the amount of time the physician personally spends with the member, except in the instances noted where the service can be performed under the direct supervision of the physician. For surgery, the physician must be scrubbed and present in the operating room during the major portion of an operation.

(B) In State. An in-state physician is a physician who is licensed by the Massachusetts Board of Registration in Medicine.

(C) Out of State. An out-of-state physician must be licensed to practice in his or her state. The MassHealth agency pays an out-of-state physician for providing covered services to a MassHealth member only under the following circumstances.
(1) The physician practices in a community of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont that is within 50 miles of the Massachusetts border and provides services to a member who resides in a Massachusetts community near the border of that physician's state.

(2) The physician provides services to a member who is authorized to reside out of state by the Massachusetts Department of Social Services.
(3) The physician practices outside a 50-mile radius of the Massachusetts border and provides emergency services to a member.
(4) The physician practices outside a 50-mile radius of the Massachusetts border and obtains prior authorization from the MassHealth agency before providing a nonemergency service. Prior authorization will be granted only for services that are not available from comparable resources in Massachusetts, that are generally accepted medical practice, and that can be expected to benefit the member significantly. To request prior authorization, the out-of-state physician or the referring physician must send the MassHealth agency a written request detailing the proposed treatment and naming the treatment facility (see the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*). The MassHealth agency will notify the member, the physician, and the proposed treatment facility of its decision. If the request is approved, the MassHealth agency will assist in any arrangements needed for transportation.

433.404: Nonpayable Circumstances

(A) The MassHealth agency does not pay a physician for services provided under any of the following circumstances.
(1) The services were provided by a physician who individually or through a group practice has contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution that involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to member care.
(2) The services were provided by a physician who is an attending, visiting, or supervising physician in an acute, chronic, or rehabilitation hospital but who is not legally responsible for the management of the member's case with respect to medical, surgery, anesthesia, laboratory, or radiology services.
(3) The services were provided by a physician who is a salaried intern, resident, fellow, or house officer. 130 CMR 433.404 does not apply to a salaried physician when the physician supplements his or her income by providing services during off-duty hours on premises other than those of the institution that pays the physician a salary, or through which the physician rotates as part of his or her training.
(4) The services were provided in a state institution by a state-employed physician or physician consultant.
(5) Under comparable circumstances, the physician does not customarily bill private patients who do not have health insurance.

(B) The MassHealth agency does not pay a physician for performing, administering, or dispensing any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, 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.

(C) The MassHealth agency does not pay a physician for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).

(D) The MassHealth agency does not pay a physician for otherwise payable service codes when those codes are used to bill for circumstances that are not payable pursuant to 130 CMR 433.404.

433.405: Maximum Allowable Fees

(A) The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for physician services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 433.000, and is made at the lowest of the following:
(1) the physician's usual and customary fee;
(2) the physician's actual charge submitted; or
(3) the maximum allowable fee listed in the applicable DHCFP fee schedule, subject to any fee reductions enacted into law.
(B) The DHCFP fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations:
(1) 114.3 CMR 16.00: Surgery and Related Anesthesia Care
(2) 114.3 CMR 17.00: Medical and Related Anesthesia Care
(3) 114.3 CMR 18.00: Radiology
(4) 114.3 CMR 20.00: Clinical Laboratory Services

433.406: Individual Consideration

(A) The MassHealth agency has designated certain services in Subchapter 6 of the *Physician Manual* as requiring individual consideration. This means that the MassHealth agency will establish the appropriate rate for these services based on the standards and criteria set forth in 130 CMR 433.406(B). Providers claiming payment for any service requiring individual consideration must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that may include, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The MassHealth agency does not pay claims for services requiring individual consideration unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim. See 130 CMR 433.410 for report requirements.

(B) The MassHealth agency determines the appropriate payment for a service requiring individual consideration in accordance with the following standards and criteria:
(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the member's disease, disorder, or disability;
(4) any applicable relative-value studies;
(5) any complications or other circumstances that the MassHealth agency deems relevant;
(6) the policies, procedures, and practices of other third-party insurers;
(7) the payment rate for drugs as set forth in the MassHealth pharmacy regulations at 130 CMR 406.000; and
(8) for drugs or supplies, a copy of the invoice from the supplier showing the actual acquisition cost.

433.407: Service Limitations: Professional and Technical Components of Services and Procedures

Additional limitations are set forth in 130 CMR 433.413 and 433.437.

(A) Definitions.
(1) Mobile Site – any site other than the physician's office, but not including community health centers, hospital outpatient departments, or hospital-licensed health centers.
(2) Professional Component – the component of a service or procedure representing the physician’s work interpreting or performing the service or procedure.

(3) Technical Component – the component of a service or procedure representing the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses of the service or procedure, excluding the physician's professional component.

(B) Payment. A physician may bill for the professional component of a service or procedure or, subject to the conditions of payment set forth in 130 CMR 433.407(C), both the professional and technical components of the service or procedure. The MassHealth agency does not pay a physician for providing the technical component only of a service or procedure.

(C) Conditions of Payment for the Provision of Both the Professional and Technical Components of a Service or Procedure. Only the physician providing the professional component of the service or procedure may bill for both the professional and technical components. This constitutes a limited exception to 130 CMR 450.301. A physician may bill for providing both the professional and technical components of a service or procedure in the physician's office only when one of the following conditions is met:

(1) the physician owns or leases the equipment used to perform the service or procedure, provides the technical component (either directly or by employing a technician), and provides the professional component; or

(2) the physician subcontracts with a licensed Medicare-certified entity to provide the technical component of the service or procedure either in the physician's office or at a mobile site, and provides the professional component.

433.408: Prior Authorization

(A) Introduction.

(1) Subchapter 6 of the *Physician Manual* lists codes that require prior authorization as a prerequisite for payment. The MassHealth agency does not pay for services if billed under any of these codes, unless the provider has obtained prior authorization from the MassHealth agency before providing the service.

(2) A 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.

(B) Requesting Prior Authorization. All prior-authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Physician Manual*.

(C) Physician Services Requiring Prior Authorization. Services requiring prior authorization include, but are not limited to, the following:

(1) certain surgery services, including reconstructive surgery;

(2) nonemergency services provided to a member by an out-of-state physician who practices outside a 50-mile radius of the Massachusetts border;

(3) certain vision care services; and

(4) certain psychiatry services.

(D) Mental Health and Substance Abuse Services Requiring Prior Authorization. Members enrolled with the MassHealth agency's behavioral health contractor require service authorization before certain mental health and substance abuse services are provided. For more information, see 130 CMR 450.124.

(E) Therapy Services Requiring Prior Authorization. Prior authorization is required for the following therapy services provided by any MassHealth provider to eligible MassHealth members.

(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.

(F) Nonphysician Services Requiring Prior Authorization. Many nonphysician services require prior authorization, and must first be ordered, or have their need substantiated, by a physician before the MassHealth agency grants such authorization. These services include, but are not limited to, the following:

(1) transportation;
(2) selected drugs;
(3) home health services;
(4) nursing facility services;
(5) durable medical equipment; and
(6) therapy services.

433.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any service listed in 130 CMR 433.000 is conditioned upon its full and complete documentation in the member's medical record. Payment for maintaining the member's medical record is included in the fee for the service.

(B) In order for a medical record to document completely a service or services to a member, that record must set forth the nature, extent, quality, and necessity of care provided to the member. When the information contained in a member's medical record is not sufficient to document the service for which payment is claimed by the provider, the MassHealth agency will disallow payment for the claimed service.

(C) The MassHealth agency may at its discretion request, and upon such request the physician must provide, any and all medical records of members corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, §38, and 130 CMR 450.205. The MassHealth agency may produce, or at its option may require the physician to produce, photocopies of medical records instead of actual records when compliance with 130 CMR 433.409(C) would otherwise result in removal of medical records from the physician's office or other place of practice.

(D) (1) Medical records corresponding to office, home, nursing facility, hospital outpatient department, and emergency department services provided to members must include the reason for the visit and the data upon which the diagnostic impression or statement of the member's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, these medical records must include, but may not be limited to, the following:

(a) the member's name and date of birth;
(b) the date of each service;
(c) the name and title of the person performing the service, if the service is performed by someone other than the physician claiming payment for the service;
(d) the member's medical history;

(e) the diagnosis or chief complaint;
(f) clear indication of all findings, whether positive or negative, on examination;
(g) any medications administered or prescribed, including strength, dosage, and regimen;
(h) a description of any treatment given;
(i) recommendations for additional treatments or consultations, when applicable;
(j) any medical goods or supplies dispensed or prescribed; and
(k) any tests administered and their results.

(2) When additional information is necessary to document the reason for the visit, the basis for diagnosis, or the justification for future diagnostic procedures, treatments, or recommendations for return visits or materials, such information must also be contained in the medical record. Basic data collected during previous visits (for example, identifying data, chief complaint, or history) need not be repeated in the member's medical record for subsequent visits. However, data that fully document the nature, extent, quality, and necessity of care provided to a member must be included for each date of service or service code claimed for payment, along with any data that update the member's medical course.

(E) For inpatient visit services provided in acute, chronic, or rehabilitation hospitals, there must be an entry in the hospital medical record corresponding to and substantiating each hospital visit claimed for payment. An inpatient medical record will be deemed to document services provided to members and billed to the MassHealth agency if it conforms to and satisfies the medical record requirements set forth in 105 CMR 130.000. The physician claiming payment for any hospital inpatient visit service is responsible for the adequacy of the medical record documenting such service. The physician claiming payment for an initial hospital visit must sign the entry in the hospital medical record that documents the findings of the comprehensive history and physical examination.

(F) Additional medical record requirements for radiology, psychiatry, and other services can be found in the applicable sections of 130 CMR 433.000.

(G) Compliance with the medical record requirements set forth in, referred to in, or deemed applicable to 130 CMR 433.000 will be determined by a peer-review group designated by the MassHealth agency as set forth in 130 CMR 450.206. The MassHealth agency will refuse to pay or, if payment has been made, will consider such payment to be an overpayment as defined in 130 CMR 450.234 subject to recovery, for any claim that does not comply with the medical record requirements established or referred to in 130 CMR 433.000. Such medical record requirements constitute the standard against which the adequacy of records will be measured for physician services, as set forth in 130 CMR 450.205(B).

433.410: Report Requirements

(A) General Report. A general written report or a discharge summary must accompany the physician's claim for payment for any service that is listed in Subchapter 6 of the *Physician Manual* as requiring a report or individual consideration (I.C.), or if the code is for an unlisted service. This report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of the service.

(J) Family Consultation. The MassHealth agency pays for a preplanned meeting of at least one-half hour with the parent or parents or legal guardian of a child who is being treated by the physician, when the parent or parents or legal guardian are not clients of the physician.

(K) Crisis Intervention/Emergency Services. The MassHealth agency pays for an immediate mental health evaluation, diagnosis, hospital prescreening, treatment, and arrangements for further care and assistance as required, provided during all hours to members showing sudden, incapacitating emotional stress. The MassHealth agency pays only for face-to-face contact; telephone contacts are not payable. The MassHealth agency pays for no more than two hours of emergency services per member on a single date of service.

(L) Electroconvulsive Therapy. The MassHealth agency pays for electroconvulsive therapy only when it is provided in a hospital setting by a physician and only when both the physician and the facility meet the standards set by the Massachusetts Department of Mental Health, including those relative to informed consent.

(M) After-Hours Telephone Service. The physician must provide telephone coverage during the hours when the physician is unavailable, for members who are in a crisis state.

(N) Hospital Inpatient Visit. A visit to a hospitalized member is payable only as a hospital visit (see 130 CMR 433.415) unless at least 15 minutes of psychotherapy is provided. Payment will be made for only one visit per member per day.

(O) Routine Inpatient Care. The MassHealth agency pays for a maximum of three weeks of routine inpatient care without prior authorization if the admission has received a preadmission screening number from the MassHealth agency or its agent in accordance with 130 CMR 433.415(A). Routine inpatient care includes the following services. The amounts of services listed are the maximum payable; fewer services may be provided.

(1) During the first week of hospitalization, the MassHealth agency pays for the following:

(a) for an initial evaluation:

(i) up to three hours for a member under 19 years of age; and

(ii) up to two hours for a member aged 19 or older;

(b) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:

(i) up to five hours for a member under 19 years of age; and

(ii) up to three hours for a member aged 19 or older; and

(c) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:

(i) up to one day for a member under 19 years of age; and

(ii) up to three days for a member aged 19 or older.

(2) During each of the second and third weeks of hospitalization, the MassHealth agency pays a psychiatrist for the following:

(a) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:

(i) up to five hours for a member under 19 years of age; and

(ii) up to three hours for a member aged 19 or older; and

(b) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:

(i) up to two days for a member under 19 years of age; and

(ii) up to four days for a member aged 19 years or older.

(3) The MassHealth agency pays for only one type of service a day.
(4) In order to be payable, individual psychotherapy, regulation of medication, and daily medical care must involve face-to-face contact between the psychiatrist and the member.
(5) For extended hospitalization, if the hospital has complied with the MassHealth agency's concurrent review process, the MassHealth agency pays a psychiatrist for the services described in 130 CMR 433.429(O)(2), that is, for the same amount of services payable in the second and third weeks.

433.430: Dialysis: Service Limitations

(A) Medicare Coverage. Medicare is the primary source of payment for medical care to persons of any age who have chronic renal disease and who require hemodialysis or a kidney transplant. Members being treated for chronic renal disease must be referred to a MassHealth Enrollment Center or their Social Security Administration office to determine Medicare eligibility.

(B) Service Limitations. The MassHealth agency pays for hemodialysis only to hospitalized members who are:
(1) being dialyzed for acute renal failure;
(2) receiving initial dialysis for chronic renal failure prior to continuing chronic maintenance dialysis; or
(3) receiving dialysis for complications of chronic maintenance dialysis.

433.431: Physical Medicine: Service Limitations

(A) The services listed in 130 CMR 433.431 are payable only when the physician prescribes the needed therapy, and the services are provided by the physician or by a licensed physical or occupational therapist employed by the physician, subject to all general conditions of payment, including the requirement to obtain prior authorization as described in 130 CMR 433.408.

(B) Physical medicine services include, but are not limited to, superficial or deep-heat modalities, therapeutic exercise, traction, hydrotherapy, prosthetics and orthotics training, activities of daily living and ambulation training, range of motion, and manual muscle strength assessment. Other restorative services are covered by MassHealth upon referral by a physician (see 130 CMR 433.471).

(C) (1) 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 433.431(C)(2).
(2) In certain instances, the specialized knowledge and judgment of a licensed physician or 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 physician or a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed physician or licensed therapist, rather than a nonphysician or non-therapist, must be documented in the medical record.

433.432: Other Medical Procedures

(A) Cardiovascular and Other Vascular Studies. Fees for cardiovascular services and other vascular studies include payment for laboratory procedures, interpretations, and physician services (except surgery and anesthesia services), unless otherwise stated. These services may be billed in addition to an office visit.

(B) Cardiac Catheterization. Fees for cardiac catheterization are for the physician's services only and include payment for the usual preassessment of the cardiac problem and the recording of intracardiac pressure.

(C) Pulmonary Procedures. Fees for pulmonary procedures include payment for laboratory procedures, interpretations, and physician's services. These services may be billed in addition to an office visit.

(D) Dermatological Special Procedures. These services may be billed in addition to an office visit.

(E) Unlisted Procedures. Providers may bill for unlisted procedures only if there is no "Not otherwise classified" code.

433.433: Nurse Practitioner Services

(A) General. 130 CMR 433.433 applies specifically to nurse practitioners. In general, however, subject to the limitations of state law, the requirements elsewhere in 130 CMR 433.000 that apply to physicians also apply to nurse practitioners, such as service limitations, recordkeeping, report requirements, and prior-authorization requirements.

(B) Conditions of Payment. The MassHealth agency pays either an independent nurse practitioner (in accordance with 130 CMR 433.433(C)) or the physician employer of a nonindependent nurse practitioner (in accordance with 130 CMR 433.433(D)) for nurse practitioner services provided by a nurse practitioner when:

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR 4.00);

(2) the nurse practitioner has a current license to practice as a nurse practitioner in Massachusetts from the Massachusetts Board of Registration in Nursing; and

(3) the nurse practitioner has a current collaborative arrangement with a physician or group of physicians, as required by state law or regulation (including but not limited to 244 CMR 4.00 and 130 CMR 433.433(C)(2)). The MassHealth agency deems this requirement to be met for nonindependent nurse practitioners employed by a physician.

(C) Independent Nurse Practitioner Provider Eligibility.

(1) Submission Requirements. Only an independent nurse practitioner may enroll as a MassHealth provider. Any nurse practitioner applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she is:

(a) a member of a group practice comprising physicians and other practitioners and is compensated by the group practice in the same manner as the physicians and other practitioners in the group practice;

(b) a member of a group practice that solely comprises nurse practitioners; or

(c) in a solo private practice.

(2) Collaborative Arrangement Requirements. The independent nurse practitioner's collaborating physician must be a MassHealth provider who engages in the same type of clinical practice as the nurse practitioner. The nurse practitioner must practice in accordance with written guidelines developed in conjunction with the collaborating physician as set forth in 244 CMR 4.00. The nurse practitioner must submit to the MassHealth agency thorough documentation of the collaborative arrangement, including guidelines and any written agreement signed by the nurse practitioner and the collaborating physician or physicians. The guidelines must specify:

(a) the services the nurse practitioner is authorized to perform under the collaborative arrangement; and

(b) the established procedures for common medical problems.

(3) Consultation Between Independent Nurse Practitioner and Collaborating Physician. The MassHealth agency does not pay for a consultation between an independent nurse practitioner and a collaborating physician as a separate service.

(D) Submitting Claims for Nonindependent Nurse Practitioners. Any nurse practitioner who does not meet the requirements of 130 CMR 433.433(C) is a nonindependent nurse practitioner and is not eligible to enroll as a MassHealth provider. As an exception to 130 CMR 450.301, an individual physician (who is neither practicing as a professional corporation nor a member of a group practice) who employs a nonindependent nurse practitioner may submit claims for services provided by a nonindependent nurse practitioner employee, but only if such services are provided in accordance with 130 CMR 433.433(B), and payment is claimed in accordance with 130 CMR 450.301(B).

433.434: Physician Assistant Services

(A) General. 130 CMR 433.434 applies specifically to physician assistants. In general, however, subject to the limitations of state law, the requirements elsewhere in 130 CMR 433.000 that apply to physicians also apply to physician assistants, such as service limitations, recordkeeping, report requirements, and prior-authorization requirements. Services provided by a physician assistant must be limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR 5.00).

(B) Conditions of Payment. The MassHealth agency pays the physician employer of a physician assistant (in accordance with 130 CMR 433.434(E)) for services provided by a physician assistant when the:

(1) services are limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR 5.05);

(2) physician assistant has a current license or certificate of registration from the Massachusetts Board of Registration of Physician Assistants. Services provided by a physician assistant who possesses only a temporary license to practice, who has failed the certifying examination, or whose license has expired or is suspended are not payable; and

(3) services are provided pursuant to a formal supervisory arrangement with a physician, as further described under 130 CMR 433.434(C).

(C) Supervisory Arrangement Requirements

(1) The services of a physician assistant must be performed under the supervision of a physician. For purposes of 130 CMR 433.434, "supervision" or "supervise" means that the supervising physician is principally responsible for all medical decisions relating to physician assistant services and is either:

(a) immediately available to the physician assistant in person or by means of a communication device; or

(b) in actual physical attendance at and during the provision of those physician assistant services identified in written guidelines as requiring the physician's physical presence. (See 130 CMR 433.434(C)(3).)

(2) The physician assistant's supervising physician must be a MassHealth provider who engages in the same type of clinical practice as the physician assistant. Such supervising physician must be the physician assistant's employer or a physician member of the physician assistant's employer group. (See 130 CMR 433.434(E).)

(3) The physician assistant must practice in accordance with written guidelines developed in conjunction with the supervising physician as set forth in 263 CMR 5.04. The guidelines must specify:

(a) what services the physician assistant can perform;

(b) the established procedures for common medical problems; and

(c) those services for which the supervising physician must be physically present.

(4) The physician assistant’s supervising physician must designate another licensed physician to provide temporary supervision in circumstances where the supervising physician is unavailable. Such designated physician must be a MassHealth provider who engages in the same type of clinical practice as the supervising physician. The name of such physician must be documented in the member’s records.

(5) The physician assistant's supervising physician is, in all cases, responsible for ensuring that each task performed by a physician assistant is properly supervised, even under circumstances involving temporary supervision by another physician pursuant to 130 CMR 433.434(C)(2).

(6) A supervising physician may not supervise more than the number of physician assistants allowed in 263 CMR 5.00.

(D) Nonpayable Services

(1) Physician supervision of or consultation with a physician assistant is not payable as a separate service.

(2) The MassHealth agency does not pay for surgical assistance provided by a physician assistant.

(E) Submitting Claims for Physician Assistants. A physician assistant is not eligible to enroll as a MassHealth provider. As an exception to 130 CMR 450.301(A), a physician or group practice who is an employer of a physician assistant may submit claims for services provided by a physician assistant employee but only if such services are provided in accordance with 130 CMR 433.434, and payment is claimed in accordance with 130 CMR 450.301(B).

(130 CMR 433.435 Reserved)

433.436: Radiology Services: Introduction

The MassHealth agency pays for radiology services only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Provider Eligibility. A provider of portable X-ray services is eligible to participate in MassHealth only if the provider is certified by Medicare.

(B) Request for Portable X-Ray Services. Portable X-ray services may be provided to a member at a mobile site (see 130 CMR 433.407(A)) at the written request of a licensed physician. This written request must specify the reason the X ray is required, the area of the body to be exposed, the number of X rays to be obtained, the views needed, and a statement of the member's condition that necessitates portable X-ray services. If the member resides in a long-term care facility, a copy of this written request must be kept in the member's medical record in the facility as well as in the member's record maintained by the physician.

(C) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (see 130 CMR 433.409), the physician must keep suitable records of radiology services performed. All X rays must be labeled adequately with the following:
(1) the member's name;
(2) the date of the examination;
(3) the nature of the examination; and
(4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

See also the general limitations described at 130 CMR 433.407.

(A) Portable X-Ray Services. In addition to radiology services provided to a member at a mobile site, the MassHealth agency pays for one physician visit to the mobile site, regardless of the number of members receiving portable X-ray services at that mobile site.

(B) Computerized Axial Tomography (CT Scans). The MassHealth agency pays for CT scan services (head and body scans) only when they are performed in a facility having a Determination of Need for a CT scanner by the Massachusetts Department of Public Health. The MassHealth agency pays physicians directly only for the professional component (interpretation) of a CT scan. All CT scan services must meet current Medicare standards.

(C) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays physicians in accordance with the DHCFP fee schedule. The MassHealth agency does not pay for the interpretation of an X ray that was previously read and taken in the same hospital. However, the MassHealth agency does pay a physician for interpreting an X ray that was previously read and taken in a different hospital.

(D) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays the physician in accordance with the DHCFP fee schedule.

(C) Authorization.

(1) Taxi and Dial-a-Ride Transportation. Taxi and dial-a-ride transportation requires a Prescription for Taxi or Dial-a-Ride Transportation (PT-1) form, pursuant to 130 CMR 407.421(C).

(2) Ambulance and Wheelchair Van Transportation. Nonemergency ambulance and wheelchair van transportation requires that a Medicare/Medicaid Medical Necessity Form be completed, pursuant to 130 CMR 407.421(D). The Medical Necessity Form may be signed by a physician, physician's designee, physician assistant, nurse midwife, nurse practitioner, or managed-care representative. Information given on the medical necessity form must be supported by the member's medical record. Emergency ambulance trips do not require a prescription. However, the nature of the emergency must be supported by medical records at the hospital to which the member was transported.

(3) Multiple Trips. When a member must travel more than once per 30-day period to the same destination, all trips may be authorized for the 30-day period on one medical necessity form. The anticipated dates of each trip and the anticipated total number of trips must be entered on the form.

(4) Other Forms of Transportation. Other forms of transportation (for example, train, boat, and plane) are payable only if the member obtains prior authorization from the MassHealth agency.

(D) Member Reimbursement. The MassHealth agency reimburses a member directly for expenses incurred in traveling to medical services covered by MassHealth when documented in accordance with 130 CMR 407.431.

433.471: Therapy, Speech and Hearing Clinic, and Amputee Clinic Services

(A) Payable and Nonpayable Services. The MassHealth agency pays for (therapy, speech and hearing clinic, and amputee clinic services that require the skill and training of a licensed physician or a licensed therapist to reduce physical disability and to restore the member to a satisfactory functional level, or to prevent the worsening of the member's condition. The MassHealth agency does not pay for medically unnecessary or experimental services.

(B) Physical, Occupational, and Speech Therapy.

(1) Physician Authorization.

(a) Physical and occupational therapy require a written referral from a licensed physician or licensed nurse practitioner before the member's evaluation or treatment, and prior authorization after 20 visits, including group-therapy visits. The orders for physical therapy and occupational therapy must be renewed in writing every 60 days as long as the member is undergoing treatment.

(b) Speech therapy requires the written recommendation of a licensed physician, nurse practitioner, or dentist before the member's evaluation or treatment, and prior authorization after 35 visits, including group-therapy visits.

(2) Service Restrictions.

(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 433.471(B)(2)(b).

(b) In certain instances, the specialized knowledge and judgment of a licensed physician or 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 physician or a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed physician or licensed therapist, rather than a nonphysician or non-therapist, must be documented in the medical record.

(C) Speech and Hearing Clinic Services. The member must be examined by an ear specialist (an otologist or an otolaryngologist) before referral is made to a speech and hearing clinic approved by the MassHealth agency. If a hearing aid is indicated, a medical clearance stating that the member has no medical conditions to contraindicate the use of a hearing aid must accompany the referral.

(D) Amputee Clinic Services. An amputee clinic provides the following services: complete medical evaluation of the member's need for an artificial limb (prosthetic device); counseling concerning the use of the device; prescription of the device; referral to a certified prosthetic company; and follow-up evaluation. The MassHealth agency pays for a prosthetic device only when it is prescribed by an amputee clinic approved by the MassHealth agency.

433.472: Mental Health Services

130 CMR 433.472 describes the range of mental health services payable by the MassHealth agency.

(A) Mental Health Center Services. It is appropriate to refer members to a mental health center when the they are no longer able to maintain their level of functioning and must seek professional help. Referral for treatment in a clinic setting is appropriate when the individuals are not harmful to themselves or to others and can maintain themselves in the community even if at a diminished level of functioning.

(1) The MassHealth agency pays for mental health center services provided by freestanding mental health centers, community health centers, hospital-licensed health centers, or hospital outpatient departments only when the MassHealth agency has certified the provider to perform mental health center services.

(2) Mental health center services are payable only when provided by psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, counselors (with a master's or doctoral degree in counseling education or rehabilitation counseling), or occupational therapists.

(3) Mental health center services include diagnosis and evaluation, case consultation, medication, psychological testing if done by a licensed psychologist, and individual, couple, family, and group psychotherapy.

(B) Mental Health Practitioner Services. A member may be referred to a private mental health practitioner (a licensed physician or a licensed psychologist) for the same reason that the member may be referred to a mental health center. Mental health practitioners provide services that are more specialized and less comprehensive than the treatment and support services provided in mental health centers.

(1) The only mental health practitioners who can receive direct payment by the MassHealth agency for diagnostic and treatment services are licensed physicians (see 130 CMR 433.428 and 433.429).

(2) The MassHealth agency pays licensed psychologists only for providing psychological testing. The MassHealth agency does not pay psychologists for providing psychotherapy, even under the supervision of a psychiatrist.

(C) Psychiatric Hospital Services. When psychiatric individuals require 24-hour management because they may be harmful to themselves or to others, or if they are unable to maintain themselves in the community, inpatient psychiatric services may be appropriate.

(1) The MassHealth agency pays for inpatient psychiatric hospitalization only when provided to:

(a) a member aged 65 years or older in a psychiatric hospital participating in MassHealth; or

(b) a member of any age in a licensed and certified general hospital with or without an inpatient psychiatric unit.

(2) The services of an inpatient psychiatric unit include medication, individual and group therapy, milieu activities, and 24-hour observation provided by an interdisciplinary team.