4. PROGRAM REGULATIONS

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432.401: Introduction

All therapists participating in MassHealth must comply with MassHealth regulations, including but not limited to 130 CMR 432.000 and in 130 CMR 450.000: *Administrative and Billing Regulations*.

432.402: Definitions

The following terms used in 130 CMR 432.000 have the meanings given in 130 CMR 432.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 432.000 is not determined by these definitions, but by application of regulations elsewhere in 101 CMR 339.00: *Restorative Services*, 130 CMR 432.000, and in 130 CMR 450.000: *Administrative and Billing Regulations*.

Accountable Care Organization (ACO) – an entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans, Primary Care ACOs, and MCO-administered ACOs.

Capitated Program – an ICO, SCO, ACO, or PACE organization, or any other entity that, according to a contract with EOHHS, covers home health and other medical services for members on a capitated basis.

Co-treatment – therapy performed by two therapy providers, who work together as a team to treat one member, when appropriate. The providers may only bill for a maximum of four units per member treatment session.

Group Therapy – simultaneous therapy services provided to two to six patients who may or may not be doing the same activities.

Integrated Care Organization (ICO) – an organization with a comprehensive network of medical, behavioral health care, and long-term services and supports (LTSS) providers that integrates all components of care, either directly or through subcontracts, and has contracted with EOHHS and the Centers for Medicare and Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrolled members with the full continuum of Medicare- and MassHealth-covered services.

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

Managed Care Organization (MCO) – any entity with which the MassHealth agency contracts under its MCO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), and is organized primarily for the purpose of providing health care services.

Marketing – any communication from a therapy provider, or its agent, to a member, or their family or caregivers, that can reasonably be interpreted as intended to influence the member's choice of therapy provider, whether by inducing that member

(1) to retain that therapy provider to provide therapy services to the member;
(2) not to retain therapy services from another therapy provider; or
(3) to cease receiving therapy services from another therapy provider.

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.

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.

Prescribing Provider – the member's physician, nurse practitioner, or physician assistant who prescribes and writes the prescription for therapy services in accordance with 130 CMR 432.415.

Programs of All-inclusive Care for the Elderly (PACE) – the Programs of All-inclusive Care for the Elderly (PACE), as described in 42 CFR 460 and 130 CMR 519.007(C): *Program of All-inclusive Care for the Elderly (PACE).*

Provider Portal – the online site by which LTSS providers, as applicable, submit all MassHealth LTSS prior authorization requests to a MassHealth designated vendor.

Senior Care Organization (SCO) – a managed care organization that participates in MassHealth under a contract with the MassHealth agency to provide coordinated care and medical services through a comprehensive network to eligible members 65 years of age or older. SCOs are responsible for providing enrolled members with the full continuum of MassHealth-covered services, and for dual eligible members, the full continuum of MassHealth and Medicare-covered 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 functions 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.

Therapy Provider (Therapist) – a MassHealth enrolled provider of physical therapy, occupational therapy, or speech/language therapy. Therapy Provider may refer to an individual practitioner or a group practice consisting of therapy providers.

Therapy Visit – a personal contact with a member provided by a licensed physical therapist, licensed physical therapy assistant, licensed occupational therapist, licensed occupational therapy assistant, licensed speech/language pathologist, or licensed speech/language pathologist assistant for the purpose of providing a covered service.

Unfair or Deceptive Acts or Practices – any unfair or deceptive acts or practices, as that term is referred to in M.G.L. c. 93A, § 2 and in the regulations promulgated thereunder by the Massachusetts Attorney General.

432.403 Eligible Members

(A) (1) MassHealth Members. MassHealth covers therapist services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the MassHealth regulations. 130 CMR 450.105: *Coverage Types* 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: *Emergency Aid to the Elderly, Disabled and Children Program*.

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

432.404: Provider Eligibility: In State

Payment for the services described in 130 CMR 432.000 will be made only to therapists who are participating in MassHealth on the date of service, for services personally rendered by therapists or for services rendered by licensed therapy assistants, subject to the supervision requirements of 130 CMR 432.404(D). To participate in MassHealth as an in-state MassHealth provider, the provider must:

(A) obtain a MassHealth Provider number before providing therapy services;

(B) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract*, including, but not limited to, change of ownership, change of address, and addition or deletion of a branch office;

(C) meet all applicable state and federal regulatory requirements, including but not limited to 101 CMR 339.00: *Restorative Services*, 130 CMR 432.000, and 130 CMR 450.000: *Administrative and Billing Regulations*;

(D) meet the applicable requirements below.

(1) Physical Therapist. A physical therapist must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as a physical therapist.

(2) Physical Therapist Assistant (PTA). A PTA must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as a PTA. PTAs must work under the supervision of a licensed physical therapist. Supervision of PTAs must be performed following state regulatory guidance. For physical therapy, *see* 259 CMR 5.00: *Physical Therapist*.

(3) Occupational Therapist. An occupational therapist must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as an occupational therapist.

4) Occupational Therapy Assistant ("OTA"). An OTA must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as an OTA. OTAs must work under the supervision of a licensed occupational therapist Supervision of OTAs must be performed following state regulatory guidance. For occupational therapy, *see* 259 CMR 3.00: *Occupational Therapists.*

(5) Speech/Language Therapist (Speech/Language Pathologist). A speech/language pathologist must be currently licensed by and in good standing with the Massachusetts Board of Registration in Speech-Language Pathology and Audiology as a speech/language therapist or speech/language pathologist.

(6) Speech/Language Therapist Assistant (Speech/Language Pathologist Assistant (SLPA)). An SLPA must be currently licensed by and in good standing with the Massachusetts Board of Registration in Speech-Language Pathology and Audiology as an SLPA. An SLPA must work under the supervision of a licensed Speech/Language pathologist. Supervision of SLPAs must be performed following state regulatory guidance. For speech/language pathologist, *see* 260 CMR 10.00: *Use and Supervision of Speech-Language Pathology and Audiology Assistant*.

(E) Therapy Group Practice. To participate in MassHealth as a Therapy Group Practice, a group practice

(1) must have a MassHealth provider number;

(2) must be composed of physical, occupational, or speech/language therapists (or any combination of the three), each of whom has an individual provider number;

(3) must have a physical location that meets the requirements of 130 CMR 432.406(B);

(4) must be financially viable and must at all times be able to have adequate resources to finance the provision of services; and

(5) may include PTAs, OTAs, and SLPAs who provide services subject to the supervision requirements of 130 CMR 432.404(D).

432.405: Provider Eligibility: Out of State

To participate in MassHealth, an out-of-state therapy provider must

(A) participate in the Medicaid program in the state in which it is located;

(B) be licensed by and be in good standing with their state's licensing authority;

(C) provide therapy services consistent with the provisions of 130 CMR 450.109: *Out-of-state Services*;

(D) obtain a MassHealth provider number before providing therapy services;

(E) provide services in accordance with 130 CMR 432.411: *Payable Services*; and

(F) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract*, including, but not limited to, change of ownership, change of address, and addition or deletion of a branch office.

(G) As set forth at 130 CMR 432.411(E) and (F), the MassHealth agency pays for services provided by out of state therapists or, by out of state PTAs, OTAs, and SLPAs when consistent with Medicaid requirements regarding therapy assistants in the state in which they are located, subject to the supervision requirements of 130 CMR 432.000.

432.406: Provider Responsibilities

(A) Therapy Provider Service Location Site Visits. An unscheduled therapy service location site visit may be conducted by MassHealth or its designee, to assess compliance with MassHealth rules and regulations, including but not limited to those described in 130 CMR 432.406(B) and (C), under the following circumstances:
(1) for a physical therapy services group practice or individual physical therapist that is not a Medicare provider and is newly enrolled in MassHealth; or
(2) for any MassHealth enrolled therapy provider at the sole discretion of the MassHealth agency or its designee. *See* 130 CMR 450.212: *Provider Eligibility: Eligibility Criteria*.

(B) Therapy Provider Service Location Requirements. A therapy provider service location must meet all of the following requirements:
(1) there must be a sign posted identifying the business name and hours that the service location is open;
(2) the location must be staffed with an employee during posted business hours;
(3) the location must be available to members during regular, posted business hours;
(4) all licenses, certifications, accreditations, and permits are active and visible in areas accessible to members at each provider service location;

(5) the therapy provider service location must be physically accessible to all members that are receiving therapy services at the service location;
(6) there must be a business telephone line with a voice message system that members are able to call;
(7) there must be written procedures and policies for maintaining and ensuring that equipment is inspected annually and is in a safe operating condition;
(8) the therapy provider service location must provide privacy to members during any therapy visit, as requested, and also offer a private space for a member and therapy provider to discuss the member's needs; and
(9) the therapy provider service location must be in compliance with applicable federal, local and state regulations.

(C) Policy and Procedure Manual. Each therapy provider must develop, maintain, review, and comply with a comprehensive policies and procedures manual governing the delivery of therapy services, which at a minimum must address the following:
(1) human resources and personnel;
(2) a plan for ascertaining that all therapy assistants and group therapy practice health care providers have current, valid licenses;
(3) therapy group practice staff and staffing requirements;
(4) the methods for providing initial and ongoing training of personnel regarding the group therapy practice's standards, procedures, and policies, including but not limited to standard hazardous waste disposal, emergency procedures, proper documentation, members' rights, and proper billing;
(5) staff evaluation and supervision;
(6) the mechanisms used to report and respond to violations, incident reporting, accident reports, or complaints in an appropriate manner;
(7) recognizing and reporting abuse (physical, sexual, emotional, psychological), neglect, self-neglect, and financial exploitation;
(8) Health Insurance Portability and Accountability Act (HIPAA);
(9) privacy and confidentiality;
(10) infection control and communicable disease control; and
(11) first aid and cardiopulmonary resuscitation requirements.

(D) Financial Viability Documentation. A therapy provider must, upon request, submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the therapy provider, supported by documentation to demonstrate that the therapy provider has adequate resources to finance the provision of services in accordance with 130 CMR 432.000.

(130 CMR 432.407 through 432.410 Reserved)

432.411: Payable Services

The MassHealth agency pays for the following therapist services subject to the conditions and limitations of 130 CMR 432.000 and 130 CMR 450.000: *Administrative and Billing Regulations*:

(A) individual treatment;

(B) initial therapy evaluation and reevaluations;

(C) co-treatment;

(D) group therapy.

(E) The MassHealth agency pays for services set forth at 130 CMR 432.411 (A) through (D) when provided by therapists or by PTAs, OTAs, and SLPAs subject to the supervision requirements of 130 CMR 432.000.

(F) Service provided by supervised PTAs, OTAs, or SLPAs must be billed using the MassHealth provider ID of the supervising MassHealth-enrolled therapist.

432.412: Nonpayable Services

The MassHealth agency does not pay a therapy provider for any of the following services:

(A) indirect services such as staff meetings, staff supervision, member screening, and development or use of instructional texts and reusable treatment materials;

(B) nonmedical services such as vocational, social, and recreational services;

(C) unproven or experimental treatment, as described in 130 CMR 450.204(E);

(D) mental health services; and

(E) services provided by unlicensed persons including, but not limited to aides and students, even if under the supervision of a licensed therapy provider.

432.413: Nonpayable Circumstances

The MassHealth agency does not pay a therapist for services provided under any of the following circumstances.

(A) The therapist provided the service in an inpatient or long-term care facility and is paid by the inpatient or long-term care facility to provide that service, whether or not the cost of the service is included in the MassHealth agency’s or other payer’s rate of payment for that facility.

(B) The therapist receives compensation from the state, county, or municipality, unless they are supplementing their income by providing services during off-duty hours.

(C) Under comparable circumstances, the therapist does not customarily bill private patients who do not have health insurance.

432.414: Service Limitations

(A) The MassHealth agency pays a therapist for no more than one individual treatment and one group therapy session per member per day. For a further description of payable service codes and modifiers, *see* Subchapter 6 - Service Codes and Descriptions of the *Therapist Manual.*

(B) The MassHealth agency does not pay for a treatment claimed for the same date of service as an evaluation or reevaluation, since the evaluation or reevaluation fee includes payment both for a written report and for any treatment provided at the time of the evaluation or reevaluation.

(C) The MassHealth agency pays a therapist for providing services in a Medicare-certified long-term-care facility subject to 130 CMR 432.413 (A) and only in the following circumstances:

(1) the member is not covered for therapy services under Medicare Part A or B; or

(2) (a) the member is covered for therapy services under Medicare, but the facility or the therapist has submitted the claim to Medicare, and Medicare has denied payment; and

(b) the therapist has obtained prior authorization as necessary in accordance with 130 CMR 432.417.

(D) 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.

(1) The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 432.414(D)(2).

(2) 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.

432.415: Prescription Requirements

(A) The MassHealth agency pays for only those treatments and evaluations for which the therapist has obtained written prescriptions from the member's prescribing provider. Electronic prescriptions (escripts) are allowable if they comply with state and federal requirements and are transmitted by the member's prescribing provider in accordance with the MassHealth agency's administrative and billing instructions.

(B) Initial Prescription. The initial prescription must be written on the prescribing provider's letterhead, must be dated prior to the initiation of the prescribed services, and must contain the following information:

(1) the member's name;
(2) the member's diagnosis that requires therapy services;
(3) the reason for the prescription;
(4) the date of prescription; and
(5) the prescribing provider's signature and contact information, including name, NPI, and telephone number.

(C) Prescription Renewal. The MassHealth agency pays for continuing physical, occupational, or speech/language therapy only when the prescription or plan of care is signed by the member's prescribing provider every 60 days, and the therapist has obtained prior authorization from the MassHealth agency, as applicable, in accordance with 130 CMR 432.417.

(D) A prescription from the prescribing provider does not authorize payment. The therapy performed by a therapist pursuant to the evaluation described in 130 CMR 432.416 must constitute medically necessary and appropriate and effective treatment, within accepted medical standards for the member's condition.

432.416: Evaluations and Plan of Care Requirements

(A) Initial Evaluation. An initial evaluation is an in-depth assessment of a member's medical condition or disability, or both, and level of functioning to determine the need for therapy. When therapy is indicated, it is used to develop a plan of care. The evaluation is conducted by a licensed therapist in response to the prescribing provider's initial prescription for therapy services and must occur prior to the start of therapy care. The MassHealth agency will only pay for one initial evaluation relative to an initial prescription. Documentation of the therapy initial evaluation must include 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 member's diagnosis (specific and relevant to the medical condition requiring therapy services);
(3) list of precautions, if applicable, relevant to the member's illness, injury or disability requiring therapy services;
(4) a medication list;
(5) a detailed treatment plan describing the type, amount, frequency, and duration of therapy and indicating the diagnosis, prognosis, anticipated goals, and location where therapy will take place, or the reason treatment is not indicated;
(6) additional health care evaluations, as indicated;
(7) a description of the member's psychosocial and health status that includes:
(a) the present effects of the member's current condition, disability or injury/illness requiring therapy services;
(b) a brief history, the date of onset, and any past treatment of the condition, disability, or injury/illness;
(c) the member's level of functioning, including physical and functional limitations, both current and before onset of the current condition, disability or illness/injury, if applicable;

(d) any other significant physical or mental disability that may affect therapy;
(e) sensory and cognitive status, if applicable; and
(f) social supports, if applicable.
(8) identification of any current durable medical equipment (DME) used by the member;
(9) identification of any other medical/health services concurrently being provided to the member;
(10) a description of any conferences with the member, member's family, member's clinician, or other interested persons;
(11) a detailed plan of care, which must meet the conditions at 130 CMR 432.416(C);
(12) the therapist's signature and the date of the evaluation; and
(13) for speech/language therapy only:
(a) assessments of speech production skills, stimulability, receptive and expressive language skills, augmentative and alternative communication skills, fluency, voice or swallowing;
(b) documentation of the member's cognitive linguistic functioning; and
(c) a description of the member's communication needs and motivation for therapy.

(B) Reevaluation. A reevaluation is an evaluation conducted by a licensed therapist focused on determining the member's progress toward goals identified in the plan of care, as well as making a professional judgment about continuing care, modifying goals and/or treatment, or terminating therapy services. A reevaluation is needed when there are new clinical findings, a rapid change in the individual's status, or a member's inability to respond to therapy interventions. Routine, ongoing progress notes that are part of each therapy visit are not considered reevaluations.

(C) Plan of Care. All therapy services must be provided under a plan of care established individually for the member. The plan of care must include the following:
(1) a description of the type of therapy, location where therapy will take place, anticipated frequency, length of each visit, and an estimate of the duration of the therapy services;
(2) documentation of the diagnosis, prognosis, anticipated goals, functional and measurable short- and long-term goals, and the reason therapy is needed; and
(3) dated signature of the licensed therapist who developed the plan of care.
(4) The plan of care must be reviewed and updated at least every 60 days with the renewal of the prescription for therapy services, and more frequently as the member's condition or needs require, including any significant change that may alter the type, frequency, or duration of therapy services.

432.417: Prior Authorization

(A) General Terms.
(1) Prior authorization (PA) must be obtained from the MassHealth agency or its designee as a prerequisite to payment for visits in excess of the number of visits described in 130 CMR 432.417(B). Without such prior authorization, the MassHealth agency will not pay therapy providers for services in excess of the number of visits described in 130 CMR 432.417(B).
(2) 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 third-party health insurance payment, including Medicare. *See* 130 CMR 450.303: *Prior Authorization* for additional information about prior authorization.

(3) Approvals for prior authorization specify the number of hours, visits, or units for each service that are medically necessary and payable each calendar week and the duration of the prior authorization period. The authorization is issued in the member's name and specifies frequency and duration of care for each service approved per calendar week.
(4) The therapy provider must submit all prior authorization requests in accordance with 130 CMR 450.303: *Prior Authorization* and any relevant MassHealth agency instructions.
(5) In conducting prior authorization review, the MassHealth agency or its designee will apply any applicable MassHealth medical necessity guidelines and may refer the member for an independent clinical assessment to inform the determination of medical necessity for therapy services.
(6) If the number of prior-authorized services need to be adjusted because the member's medical needs have changed, the therapy provider must request a prior authorization adjustment from the MassHealth agency or its designee.

(B) Services that Require Prior Authorization. The MassHealth agency requires that the therapist obtain prior authorization as a prerequisite to payment for the following services to eligible MassHealth members:
(1) more than 20 occupational-therapy visits or 20 physical-therapy visits, including group-therapy visits but not including evaluations, for a member in a 12-month period;
(2) more than 35 speech/language therapy visits, including group-therapy visits but not including evaluations, for a member in a 12-month period;
(3) more than two evaluations in a 12-month period.

(C) Submission Requirement. For all prior-authorization requests, the therapist must include the prescription for services that identifies the member's diagnosis, frequency, and duration of therapy services, and a description of the intended therapy intervention, as well as all forms and documentation as designated by the MassHealth agency. The therapy provider should complete a prior authorization request for prior authorization requests for therapy services through the LTSS Provider Portal in accordance with 130 CMR 432.417(B), as applicable.

(D) Members in Capitated Programs. For those members who are enrolled in MassHealth capitated programs, the therapy provider must follow the capitated program's specific prior authorization procedures, where applicable, for therapy services.

(E) Notice of Approval, Deferral, or Denial of Prior Authorization.
(1) Notice of Approval. For all approved prior-authorization requests for therapy services, the MassHealth agency or its designee sends written notice to the member and the therapist about the frequency, duration, and intensity of care authorized, and the effective date of authorization.
(2) Notice of Denial or Modification and Right of Appeal.
(a) For all denied or modified prior-authorization requests, the MassHealth agency or its designee notifies both the member and the therapy provider of the denial or modification and the reason. In addition, the member will receive information about the member's right to appeal and the appeal procedure.

(b) A member may request a fair hearing if the MassHealth agency or its designee denies or modifies a prior-authorization request. The member must request a fair hearing in writing within 30 days after the date of receipt of the notice of denial or modification. The Office of Medicaid Board of Hearings will conduct the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(3) Notice of Deferral. If the MassHealth agency or its designee defers a prior authorization request due to an incomplete submission or lack of documentation to support medical necessity, the MassHealth agency or its designee will notify the member and therapy provider of the deferral, the reason for the deferral, and provide an opportunity for the provider to submit the incomplete or missing documentation.

If the provider does not submit the required information within 21 calendar days of the date of deferral, the MassHealth agency or its designee will make a decision on the prior authorization request using all documentation and forms submitted to the MassHealth agency and will send notice of its decision to the provider and the member in accordance with 130 CMR 432.417(E).

432.418: Recordkeeping Requirements

Payment for any service listed in 130 CMR 432.000 is conditioned upon its full and complete documentation by the provider in the member's medical record. Records must be retained by the provider in accordance with 130 CMR 450.205(G) and any other guidance provided by the MassHealth agency. The therapist is responsible for the complete documentation of therapy services provided, including therapy services provided under the therapist’s supervision. The record must include the following:

(A) the prescribing provider’s initial written prescription, and, if applicable, prescription renewals every 60 days (*see* 130 CMR 432.415);

(B) the written initial evaluation report and, if applicable, any subsequent reevaluation (*see* 130 CMR 432.416);

(C) the name, NPI, and telephone number of the member’s prescribing provider;

(D) the written documentation for each date on which therapy was provided, including the following:

(1) the date on which therapy was provided;
(2) the amount of time spent in therapy;
(3) the specific therapeutic procedures and methods used;
(4) the teaching tools provided to the member, their family, or other persons;
(5) the member's response to treatment;
(6) any changes in the member's condition;
(7) the problems encountered or changes in the plan of care or goals, if any;
(8) the location where the service was provided, if different from that in the evaluation or reevaluation report;

(9) the therapist's signature and, if applicable, the signature of the licensed physical therapy assistant, the licensed occupational therapy assistant, or licensed speech/language therapy assistant; and;
(10) written documentation demonstrating measurable, objective, and functional progress as a direct result of treatment, excluding those who meet criteria in 130 CMR 432.414(D).

(E) as applicable, a copy of the prior authorization request(s), including a copy of any prior authorization forms, as designated by the MassHealth agency, and the MassHealth agency's response;

(F) documentation on the teaching provided to the member, member's family, or caregiver by the therapist on how to manage the member's treatment regimen, any ongoing teaching required due to a change in the treatment or the member's condition, and the response to the teaching; or as applicable, documentation indicating that teaching was unsuccessful or unnecessary and why further teaching is not reasonable.

432.419: Payment for Therapy Services.

The Executive Office of Health and Human Services establishes the rates payable for therapy services. *See* 101 CMR 339.00: *Restorative Services*. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 432.000 and 130 CMR 450.000: *Administrative and Billing Regulations.*

432.420: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

The MassHealth agency pays for all medically necessary therapy services for EPSDT-eligible members in accordance with 130 CMR 450.140 through 130 CMR 450.150, without regard to service limitations described in 130 CMR 432.000, and with prior authorization.

432.421: Quality Management and Utilization Review

(A) A therapy provider must participate in any quality management and program integrity processes as required by the MassHealth agency including making any necessary data available and providing access to visit the therapy provider's place of business upon request by MassHealth or its designee.

(B) A therapy provider must submit requested documentation to the MassHealth agency or its designee for purposes of utilization review and provider review and audit, within the MassHealth agency's or its designee's time specifications. The MassHealth agency or its designee may periodically review a member's plan of care and other records to determine if services are medically necessary in accordance with 130 CMR 450.204: *Medical Necessity*. The therapy provider must provide the MassHealth agency or its designee with any supporting documentation the MassHealth agency or its designee requests, in accordance with M.G.L. c. 118E, § 38 and 130 CMR 450.000: *Administrative and Billing Regulations*.

432.422: Prohibited Marketing Activities

A therapy provider must not

(A) with the knowledge that a member is enrolled in a MassHealth capitated program, engage in any practice that would reasonably be expected to have the effect of steering or encouraging the member to disenroll from the MassHealth capitated program in order to retain the therapy provider to provide therapy services on a fee-for-service basis; or

(B) offer to a member, or their family or caregivers, in person or through marketing, any inducement to retain the therapy provider to provide therapy services, such as a financial incentive, reward, gift, meal, discount, rebate, giveaway, or special opportunity;

(C) pay a "finder's fee" to any third party in exchange for referring a member to the therapy provider; or

(D) engage in any unfair or deceptive acts or practices in connection with any marketing.

REGULATORY AUTHORITY

130 CMR 432.000: M.G.L. c. 118E, §§ 7 and 12.