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4. Program Regulations:

130 CMR 455.000: *Urgent Care Clinic Services*

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455.401: Introduction

All urgent care clinics participating in MassHealth must comply with all MassHealth regulations including, but not limited to, 130 CMR 455.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

455.402: Definitions

The following terms used in 130 CMR 455.000 have the meanings given in 130 CMR 455.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 455.000 is not determined by these definitions, but by application of 130 CMR 455.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

Primary or Elective Care — medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. Primary or elective care includes, but is not limited to, physical examination, diagnosis and management of illness, ongoing health maintenance, accident prevention, and referral when necessary.

Urgent Care – a term defined in 105 CMR 140.000: *Licensure of Clinics*.

Urgent Care Clinic (UCC) – an entity licensed as a clinic by the Massachusetts Department of Public Health (DPH) pursuant to M.G.L. c. 111, § 51 and 105 CMR 140.000: *Licensure of Clinics*, if in state, or by the licensing authority of its own state, if out of state, that is not part of a hospital and that possesses its own legal identity, maintains its own patient records, administers its own budget and personnel, and is organized primarily for the purpose of rendering urgent care.

Urgent Care Visit – an in-person encounter between an eligible member and a licensed practitioner (such as a physician or nurse practitioner) or other medical professional under the direction of a licensed practitioner for the provision of urgent care as defined in 130 CMR 455.402.

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455.403: Eligible Members

- (A) (1) MassHealth Members. The MassHealth agency covers UCC services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in 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 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*.

455.404: Provider Eligibility

Payment for the services described in 130 CMR 455.000 will be made only to providers of UCC services who are participating in MassHealth on the date of service.

- (A) In State. To participate in MassHealth, a UCC located in Massachusetts must
- (1) operate under a clinic license issued by the Massachusetts Department of Public Health pursuant to 105 CMR 140.100 *et seq.*; and
  - (2) have a signed provider contract with the MassHealth agency.
- (B) Out of State. To participate in MassHealth, an out-of-state UCC must obtain a MassHealth provider number and meet the following criteria:
- (1) if the clinic is required by its own state's law to be licensed, the clinic must be licensed by the appropriate state agency under whose jurisdiction it operates;
  - (2) the clinic must participate in its state's Medicaid program (or the equivalent); and
  - (3) meet the conditions set forth in 130 CMR 450.109: *Out-of-state Services*.

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455.405: Maximum Allowable Fees

(A) The Executive Office of Health and Human Services (EOHHS) determines the payment rate for UCC services in accordance with 101 CMR 317.00: *Rates for Medicine Services*, 101 CMR 318.00: *Rates for Radiology Services*, and 101 CMR 320.00: *Clinical Laboratory Services*.

(B) Payment is subject to the conditions, exclusions, and limitations set forth in 130 CMR 455.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

455.406: Individual Consideration

(A) The MassHealth agency has designated certain services in Subchapter 6 of the *Urgent Care Clinic 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 455.406(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 or pathology report. 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 455.407 for report requirements.

(B) The MassHealth agency considers the following factors when determining the appropriate payment for an individual consideration service:

- (1) the amount of time required to perform the service;
- (2) the degree of skill required to perform the service;
- (3) the policies, procedures, and practices of other third-party insurers, both governmental and private;
- (4) other standards and criteria as may be adopted by EOHHS or the MassHealth agency.

455.407: Report Requirements

A general written report or a discharge summary must accompany the claim for payment for any service that is listed in Subchapter 6 of the *Urgent Care Clinic 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.

Each urgent care clinic must provide a copy of the medical record of each urgent care visit to the MassHealth member at the end of the urgent care visit or as soon as available and, with the member's consent, provide a facsimile or electronically transmitted copy of the medical record of the urgent care visit to the member's primary care provider, if any. Such copies or transmission must be provided at no charge to the member. In the event that the member has a primary care provider, the urgent care clinic shall provide the member with the name and contact information of such primary care provider, in a manner to be prescribed by the MassHealth agency. In the event that the member does not have a primary care provider, the urgent care clinic shall

- (1) notify the MassHealth agency that the member does not have a primary care provider, using a form that will be prescribed by the MassHealth agency; and

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(2) provide the member with the names of primary care providers who participate in MassHealth and practice in the member’s municipality of residence or an adjacent municipality, in a manner to be prescribed by the MassHealth agency.

(455.408 through 455.412 Reserved)

455.413: Covered Services

The MassHealth agency pays for medically necessary urgent care identified in Subchapter 6 of the *Urgent Care Clinic Manual*.

455.414: Noncovered Services

The MassHealth agency does not pay for the following services:

- (A) services performed for experimental, unproven, cosmetic or otherwise medically unnecessary procedure or treatment;
- (B) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment);
- (C) services otherwise identified in the MassHealth regulations at 130 CMR 455.000 or 130 CMR 450.000: *Administrative and Billing Regulations* as not payable; or
- (D) otherwise payable service codes when those codes are used to bill for circumstances that are not payable pursuant to 130 CMR 455.414.

455.415: Urgent Care Visits: Service Limitations

The following restrictions and limitations apply to urgent care visits as defined in 130 CMR 455.402.

Treatments or Procedures. The UCC may bill for an urgent care visit, a treatment, or a procedure, but may not bill for more than one of these services provided to the same member on the same date when the services are performed in the same location. X-rays, laboratory tests, and certain diagnostic tests identified in Subchapter 6 of the *Urgent Care Clinic Manual* may be billed in addition to an urgent care visit.

455.416: Laboratory Services: Introduction

The MassHealth agency only pays UCCs for those laboratory services listed in Subchapter 6 of the *Urgent Care Clinic Manual*. The MassHealth agency pays a UCC for laboratory services that are medically necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of MassHealth members, subject to all the restrictions and limitations described in 130 CMR 455.000 and 130 CMR 450.000: *Administrative and Billing Regulations*. In order for a UCC to be paid for any laboratory service, a written request for that service from an authorized prescriber must be present in the member’s medical record.

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455.417: Laboratory Services: Eligibility to Provide Services

A UCC may claim payment for the laboratory services listed in Subchapter 6 of the *Urgent Care Clinic Manual* only when all of the following conditions are met.

(A) The laboratory services are performed in the UCC.

(B) The laboratory tests are performed on properly and regularly calibrated equipment, and daily controls are carried out.

(C) The UCC has been certified by the Centers for Medicare & Medicaid Services (CMS) for performing in-house clinical laboratory services, based on the criteria set forth in the Clinical Laboratory Improvement Amendments (CLIA) of 1988, as it may be amended. In addition, the UCC's laboratory must maintain its own quality-control program and successfully participate in one or more proficiency testing programs that cover all Medicare-certified specialties and subspecialties of the laboratory. The UCC must make the results of the proficiency testing programs available to the MassHealth agency and the Attorney General's Medicaid Fraud Division upon request or during an on-site visit.

(D) If the UCC is located in-state, the UCC has been approved by the Massachusetts Department of Public Health to perform in-house clinical laboratory services. If the UCC is located out-of-state, in addition to meeting the requirements of 130 CMR 455.404(B), 455.417(A) through (C), and 130 CMR 450.109: *Out-of-state Services*, the UCC must also meet its own state's requirements for performing in-house clinical laboratory services.

455.418: Laboratory Services: Service Limitations

(A) The MassHealth agency does not pay a UCC for services listed as non-covered services or for which payment limits apply in accordance with the MassHealth *Independent Clinical Laboratory Manual* at 130 CMR 401.000: *Independent Clinical Laboratory*.

(B) The MassHealth agency does not pay a UCC for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue).

(C) The MassHealth agency does not pay a UCC for the professional component of a clinical laboratory service. The MassHealth agency will pay a UCC for the professional component of an anatomical service, as provided in Subchapter 6 of the *Urgent Care Clinic Manual* (for example, bone marrow analysis or analysis of a surgical specimen).

(D) In no event may a UCC bill or be paid separately for each of the tests included in a profile or panel test (as defined herein) when a profile or panel test has either been performed by that UCC or requested by an authorized person. A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics.

(1) The group of tests is designated as a profile or panel by the UCC performing the tests.

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(2) The group of tests is performed by the UCC at a usual and customary fee that is lower than the sum of that UCC's usual and customary fees for the individual tests in that group.

(E) The MassHealth agency does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438: *Clinical Laboratory Services: Introduction*, including but not limited to

- (1) tests performed to establish paternity;
- (2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and
- (3) post-mortem examinations.

(F) Some services listed in Subchapter 6 of the *Urgent Care Clinic Manual* are designated "I.C.," an abbreviation for individual consideration. This means that a specific fee could not be established. The payment for an I.C. service will be determined by the MassHealth agency based on the designation of the test as entered on the claim form.

(G) A UCC may not bill for a visit when a member is being seen for laboratory services only.

#### 455.419: Laboratory Services: Services Performed by Outside Laboratories

(A) A UCC may not bill the MassHealth agency for laboratory services provided outside the UCC. In this case, the testing laboratory should bill the MassHealth agency directly for those services.

(B) When sending a specimen to an outside laboratory, the UCC must include the member's MassHealth identification number and the UCC's MassHealth provider number.

#### 455.420: Radiology Services: Introduction

The MassHealth agency will pay for the radiology services in Subchapter 6 of the *Urgent Care Clinic Manual* only when the services are provided at the written request of a licensed physician or dentist. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

#### 455.421: Radiology Services: Service Limitations

(A) Definitions.

Global Fee – the rate of payment for the two components of a radiology service: the professional component and the technical component.

Professional Component – the component of a radiology service for interpreting a diagnostic test or image.

Technical Component – the component of a radiology service for the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses.

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(B) Payment of the Global Fee. The MassHealth agency will pay a UCC the global fee for performing a radiology service at the UCC when one of the following conditions is met.

- (1) The UCC owns or leases the equipment for providing the technical component of the service, employs a technician to provide the technical component of the service, and employs a board-certified or board-eligible radiologist to provide the professional component of the service.
- (2) The UCC employs a board-certified or board-eligible radiologist to provide the professional component of the service and the UCC subcontracts with a licensed Medicare-certified entity to provide the technical component of the service.
- (3) The UCC subcontracts with a licensed Medicare-certified entity to provide the professional and technical component of the service.

(C) Subcontracting for Radiology Services.

- (1) All subcontracts between the UCC and the licensed Medicare-certified entity must be in writing, ensure continuity of care, and be consistent with all applicable provisions of 130 CMR 455.000.
- (2) The UCC is legally responsible to the MassHealth agency for the performance of any subcontractor. The UCC must ensure that every subcontractor is licensed and Medicare certified, and that services are furnished in accordance with the MassHealth agency's regulations, including, but not limited to, those set forth in 130 CMR 450.000: *Administrative and Billing Regulations*. The UCC must submit claims for payment for radiology services provided hereunder in accordance with the MassHealth agency's regulations and applicable fee schedules.

(D) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (*see* 130 CMR 455.422), the UCC must keep records of radiology services performed. All X-rays must be labeled 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.

#### 455.422: Recordkeeping Requirements

(A) The urgent care clinic is responsible for ensuring the medical necessity of the services and maintaining test results in the member's health record. Payment for any service listed in 130 CMR 455.000 is conditioned upon its full and complete documentation in the member's medical record and must be maintained for at least six years. 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.

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(C) The MassHealth agency may at its discretion request, and upon such request the UCC 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: *Recordkeeping and Disclosure*. The MassHealth agency may produce, or at its option may require the UCC to produce, photocopies of medical records instead of actual records when compliance with 130 CMR 455.422(C) would otherwise result in removal of medical records from the UCC's office.

(D) The medical record must include, but is not limited to

- (1) the date of each service;
- (2) the member's name, address, telephone number, date of birth, and MassHealth identification number;
- (3) the name, title, and signature of the person performing the service;
- (4) the member's medical history;
- (5) the diagnosis or chief complaint;
- (6) a written order for the tests or treatment to be performed and the respective results;
- (7) the name of the supervising physician;
- (8) clear indication of all findings, whether positive or negative, on examination;
- (9) any medications administered or prescribed, including strength, dosage, and regimen;
- (10) a description of any treatment given;
- (11) recommendations for additional treatments or consultations, when applicable;
- (12) pertinent findings on examination; and
- (13) any medical goods or supplies dispensed or prescribed.

#### REGULATORY AUTHORITY

130 CMR 455.000: M.G.L. c. 118E, §§ 7 and 12.