

# MassHealth LTSS Provider Information: Updates Related to the Coronavirus Disease 2019 (COVID-19)

*Updated as of July 14, 2020*

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## Disclaimer

*To mitigate the spread of COVID-19, MassHealth is committed to enabling Members to remain in their homes to reduce exposure and transmission, to the extent possible, and to preserve health system capacity for the duration of this public health emergency. In addition to the allowable flexibilities described in this document, MassHealth is working to determine if there are any additional flexibilities necessary. If so, MassHealth will provide further guidance describing any such additional flexibilities. Please refer to the MassHealth website for additional information and updates: <https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers>.*

*Unless otherwise stated, information provided in this document is effective for the duration of the state of emergency declared via Executive Order No 591.*

For guidance on how to request Provider Protective Equipment (PPE) in Massachusetts during the COVID-19 response refer to <https://www.mass.gov/info-details/guidance-for-requesting-personal-protective-equipment-ppe>.

## **For Adult Day Health Providers**

*MassHealth is aware that the Department of Public Health issued an order on March 24, 2020 instructing Adult Day Health programs to close their day sites due to the COVID-19 public health emergency. While Adult Day Health program day sites are closed pursuant to that order, Adult Day Health programs may be eligible to receive retainer payments pursuant to Administrative Bulletin 20-33. Please refer to Administrative Bulletin 20-33 for information on Adult Day Health retainer payments.*

- **Member Engagements Conducted During Day Program Site Closure**

During the period in which day sites are closed pursuant to DPH's COVID-19 order requiring the closure of day sites, all documentation of member engagement should reflect the nature of engagement provided and the status of the member, including but not limited to the overall health status of the member and any care coordination that occurred relative to the engagement.

- The type and nature of each member engagement must be clearly documented in the member's record.
- In addition to documentation in the member's record, providers are also required to develop or amend individual care plans to meet the members' needs while they remain home. The care plans may identify the type of engagements being provided by ADH staff to the member during the COVID-19 public health emergency. Individual care plan development or the amendment of already existing care plans may be completed by any member of the interdisciplinary team as long as there is oversight by the program nurse.
- Member engagements may include, but are not limited to the following:
  - Checking for COVID-19 symptoms and triaging, as needed;
  - Identifying and addressing any nutritional needs or deficiencies,
  - Appropriately monitoring, managing and refilling member medications;
  - Coordinating care and activities of daily living (ADL), as well as instrumental activities of daily living (IADL) for members without formal supports at home;
  - Providing members and their families with language and interpretation supports;
  - Conducting mental and emotional wellness checks and supports;
  - Employing interventions to promote member orientation of person, place and time;
  - Providing caregiver support, especially for informal caregivers supporting members with dementia.

- **Member Engagement by Nursing Staff**

Clinical oversight and care coordination of Adult Day Health members must be overseen by nursing staff. Nurses should be outreaching to member's PCPs as needed and making other appropriate medical/clinical referrals, in consultation other clinical

staff. Adult Day Health Nursing staff must coordinate follow up to the extent possible, including but not limited to onsite delivery of nursing services to the member's home.

- **Member Engagement by Social Service/Behavioral/Activity Professionals**  
Social/Behavioral/Activity Professional may engage with members to review any social service needs and screen for any mental health concerns. These member engagement activities may also include providing caregiver support related to behavioral management, dementia specific care, and emotional support to the caregivers. The goal of this outreach is to reduce isolation and mental health decline of the member and maintain highest level of functioning.
- **Member Engagement by Direct Service Staff (language specific)**  
Direct service staff may provide outreach to members in the primary language of the member. The purpose of this outreach is to assess the member's overall wellbeing, provide a familiar check-in to assist in orientation to date and time, provide emotional support and report back to ADH professional staff the need for any additional outreach.
- **Member Engagement Pertaining to Nutrition**  
Adult Day Health staff may provide member engagement activities in order to determine the nutritional needs of the members and access to food. If assessed and warranted, referrals to meals on wheels should be made. If an ADH provider who participates in the Child and Adult Care Food Program (CACFP) meal program for adults has the capability to deliver home delivered meals to a member lacking access to food, the Department of Elementary and Secondary Education (DESE) is providing guidance for reimbursement of those meals.
- **Prior Authorization Extensions**  
All ADH Prior Authorizations with an expiration date that falls between July 1, 2020 and August 31, 2020 be automatically extended for a period of up to 90 days. During this time providers do not need to request the continuations of an existing prior authorization.
- **Claims Submission Update**
  - Adult Day Health Providers who engaged with members and coordinated care for members during the period of March 16<sup>th</sup> through March 31<sup>st</sup> while their programs ceased congregate operations may submit 15-minute unit claims for those engagements. The performance and delivery of care management activities must be clearly documented in the member's record.
  - For dates on or after April 1, 2020 through June 30, 2020 providers may only submit claims in accordance with the standards set forth in the Adult Day Health Services Administrative Bulletin 20-33 located on the MassHealth website (<https://www.mass.gov/doc/administrative-bulletin-20-33-101-cmr-31000-adult-day-health-services-additional-rate-0/download>)
    - If ADH providers have submitted any 15-minute unit claims for the period on or after April 1, 2020 through June 30, 2020 those claims must be voided before entering claims in accordance with ADH Administrative Bulletin 20-33.

- Providers must continue to use the Place of Service Code 02 on all the claims submitted.
- Providers may only bill for members who are in the community. Providers may not bill for any services during periods in which a member is admitted to an inpatient setting.
- In reference to the ADH Administrative Bulletin 20-33, encounter logs submitted to MassHealth must be sent electronically and in Excel. Hand-written or PDF logs will not be accepted.

### **For Day Habilitation Providers**

*MassHealth is aware that the Department of Public Health issued an order on March 24, 2020 instructing Day Habilitation programs to close their day sites due to the COVID-19 public health emergency. While Day Habilitation program day sites are closed pursuant to that order, Day Habilitation programs may be eligible to receive retainer payments pursuant to Administrative Bulletin 20-34. Please refer to Administrative Bulletin 20-34 for information on Day Habilitation retainer payments.*

- **Member Engagements Conducted during Day Program Site Closure**

During the period in which day sites are closed pursuant to DPH's COVID-19 order requiring the closure of day sites, all documentation of member engagement should reflect the nature of engagement provided and the status of the member, including but not limited to the overall health status of the member and any care coordination that occurred relative to the engagement.

- The type and nature of each member engagement must be clearly documented in the member's record.
- In addition to documentation in the member's record, providers are also required to develop or amend the members' current Day Hab Service Plan to meet the members' needs while they remain home. The care plans/amended DHSPs should identify the type of engagements being provided by DH staff to the member during the COVID-19 public health emergency.
- Member engagements may include, but are not limited to the following:
  - Checking for COVID-19 symptoms and triaging, as needed;
  - Coordinating care and activities of daily living (ADL), as well as instrumental activities of daily living (IADL) for members without formal supports at home;
  - Conducting mental and emotional wellness checks and supports;
  - Employing interventions to promote member orientation of person, place and time;
  - Monitoring and encouraging progress towards member's day habilitation service plan goals;
  - Evaluate service need areas, such as self-help, sensory motor skills, communication, independent living, affective development, social and behavior development and wellness;
  - Providing caregiver support, especially for informal caregivers supporting the member
  - Providing caregiver support and supplying positive behavior support strategies.

- **Member Engagement by Nursing Staff**  
Clinical oversight and care coordination of Day Habilitation members must be overseen by nursing staff. Nurses should be outreaching to member's caregivers, residences, and PCPs as needed. If necessary, Day Habilitation nursing staff should also be making other appropriate medical/clinical referrals in consultation with other clinical/Interdisciplinary Team staff. record.
- **Indirect Therapy Member Engagement**  
Any Day Habilitation provider staff with knowledge of the member's Day Habilitation Service Plan (DHSP) may conduct indirect therapies related to a MassHealth member's plan via telehealth (including telephone and live video).
- **Indirect Therapy In-Home Engagement**  
For members without formal supports at home, a Day Habilitation provider may deploy a staff person to the member's residence to assist the member with ADLs and indirect therapies related to the member's Day Habilitation Service Plan.
- **Claims Submission Update**
  - Day Habilitation Providers who engaged with members and coordinated care for members during the period of March 16<sup>th</sup> through March 31<sup>st</sup> while their programs ceased congregate operations may submit 15-minute unit claims for those engagements. The performance and delivery of care management activities must be clearly documented in the member's record.
  - For dates on or after April 1, 2020 through June 30, 2020 providers may only submit claims in accordance with the standards set forth in the Day Habilitation Services Administrative Bulletin 20-34 located on the MassHealth website (<https://www.mass.gov/doc/administrative-bulletin-20-34-101-cmr-34800-day-habilitation-program-services-additional-rate-0/download>)
    - If Day Habilitation providers have submitted any 15-minute unit claims for the period on or after April 1, 2020 through June 30, 2020 those claims must be voided before entering claims in accordance with Administrative Bulletin 20-34.
    - Providers must continue to use the Place of Service Code 02 on all the claims submitted.
  - Providers may only bill for members who are in the community. Providers may not bill for any services during periods in which a member is admitted to an inpatient setting.
  - In reference to the DH Administrative Bulletin 20-34, encounter logs submitted to MassHealth must be sent electronically and in Excel. Hand-written or PDF logs will not be accepted.

## **For Adult Foster Care Provider Agencies**

- **Initial Evaluations**

Prior to conducting an initial evaluation of a Member for Adult Foster Care services, an Adult Foster Care Provider Agency should administer screening questions by telephone in order to assess the Member for symptoms of COVID-19.

- If the Member is determined to be asymptomatic, the Adult Foster Care Provider Agency should administer the initial evaluation for Adult Foster Care services according to normal procedure. If the Adult Foster Care Provider Agency is unable to perform the evaluation face to face, then the provider agency may conduct the evaluation through video conferencing.
  - If the Member is determined to be symptomatic (i.e. has a fever higher than 100.3 degrees, or new respiratory symptoms such as cough, shortness of breath, or sore throat, or has been diagnosed with COVID-19) or the Adult Foster Care Provider Agency is unable to perform the evaluation either face to face or through video conferencing, they should refer the Member to their PCP who will determine the most appropriate action.
  - **Required signatures on Physician Summary Forms and PCP Order Forms** may be waived. Providers are still responsible for completing these forms and submitting them for Prior Authorization purposes.
  - **Member signature requirements** may be waived as long as the Provider documents the date, time, and verbal attestation from the Member, and includes the note 'Covid-19' on required documents for record keeping purposes.
- **Reassessments and Significant Changes**

An Adult Foster Care Provider Agency may conduct a reassessment to an existing prior authorization for Adult Foster Care services via telehealth (including telephone or live video), in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers#provider-bulletins->), and as determined necessary by the Adult Foster Care Provider Agency. Required signatures on Physician Summary Forms and PCP Order Forms, and Member signature requirements are waived until further notice. However, all other required information for prior authorization requests must be submitted to MassHealth Long Term Services and Supports (LTSS) Provider Portal (<https://www.masshealthltss.com>). Providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.
  - **Physical Exams**

If a Member has not had a primary care provider (PCP) visit within the last 90 days to meet program requirements for either initial or reassessment, MassHealth will accept documentation of a PCP visit and physical exams within the last 18 months which must be clearly documented in the member record. Providers must also clearly document if a caregiver, or the Adult Foster Care Provider Agency's employee is unable to secure a physical examination prior to the start of service or in accordance with regulations requiring physical examinations. Tuberculosis screening requirements are waived for the member, caregiver, and AFC staff.

- **Prior Authorizations**

- **Extensions**

- Adult Foster Care Provider Agencies may request the continuation of an existing prior authorization. That provider must submit an extension request to MassHealth Long Term Services and Supports (LTSS) Provider Portal (<https://www.masshealthltss.com>) prior to the end date of the existing prior authorization. Such extension requests must have the following note in the comments field: “COVID-19”. Extension requests will be approved for periods up to 90 days.

- **Signature Requirements**

- If a Provider’s clinical staff is unable to sign a PA request electronically or via wet signature, the comment section should include the phrase ‘COVID-19 clinical sign-off’ in the LTSS Provider Portal.

- **Caregiver Logs**

- Member and Caregiver signature requirements may be waived. Providers should document the date, time, and verbal attestation from the Caregiver on Caregiver logs and include the note ‘Covid-19’ on required documents for record keeping purposes.

- **Care Management Activities**

- An Adult Foster Care Provider Agency may conduct any required in-person care management activities, via telehealth (including telephone or live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers#provider-bulletins->), as determined necessary by the Adult Foster Care Provider Agency. The performance and delivery of care management activities via telehealth must be clearly documented in the Member’s record.

- **Leave of Absence Days**

- As a reminder, an Adult Foster Care Provider Agency may bill up to 15 Non-Medical Leave of Absence Days (NMLOA) per member per calendar year, and up to 40 Medical Leave of Absence Days (MLOA) per member per calendar year. A NMLOA is defined as a short-term absence from an AFC-qualified setting during which a member does not receive AFC services for non-medical reasons. MLOA is defined as a short-term absence from an AFC-qualified setting during which a member does not receive AFC services from the AFC caregiver because the member is temporarily admitted to a hospital, nursing facility, or other medical setting. Providers may bill MLOA days in situations in which the member is quarantined from their AFC caregiver due to COVID-19 and the AFC caregiver is unable to provide AFC services to the member as a result. When using MLOA designated days for COVID-19 related purposes, the AFC provider should update the member’s record to note COVID-19 for such days.

## **For Group Adult Foster Care Provider Agencies**

- **Initial Evaluations**

Prior to conducting an initial evaluation of a Member for Group Adult Foster Care services, a Group Adult Foster Care Provider Agency should administer screening questions by telephone in order to assess the Member for symptoms of COVID-19.

- If the Member is determined to be asymptomatic, the Group Adult Foster Care Provider Agency should administer the initial evaluation for Group Adult Foster Care services according to normal procedure. If the Group Adult Foster Care Provider Agency is unable to perform the evaluation face to face, then the provider agency may conduct the evaluation through video conferencing.
- If the Member is determined to be symptomatic (i.e. has a fever higher than 100.3 degrees, or new respiratory symptoms such as cough, shortness of breath, or sore throat, or has been diagnosed with COVID-19) or the Group Adult Foster Care Provider Agency is unable to perform the evaluation either face to face or through video conferencing, they should refer the Member to their PCP who will determine the most appropriate action.
- **Required signatures on Physician Summary Forms and Member signature requirements** may be waived. Providers should document the date, time, and verbal attestation from the Member, and include the note 'Covid-19' on required documents for record keeping purposes.

- **Reassessments**

A Group Adult Foster Care Provider Agency may conduct a reassessment to an existing authorization for Group Adult Foster Care services via telehealth (including telephone or live video), in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers#provider-bulletins->), and as determined necessary by the Group Adult Foster Care Provider Agency. Member signature requirements are waived. Providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.

- **Care Management Activities**

A Group Adult Foster Care Provider Agency may conduct any required in-person care management activities, via telehealth (including telephone or live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers#provider-bulletins->), as determined necessary by the Group Adult Foster Care Provider Agency. The performance and delivery of care management activities via telehealth must be clearly documented in the Member's record. Providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.

- **Direct Care Aide Activities**

Prior to providing Direct Care Aide Services, the Group Adult Foster Care Provider Agency should administer screening questions via telephone in order to assess the Member for symptoms of COVID-19.



- If the Member is determined to be asymptomatic, Direct Care Aides should continue to provide care to Members in the home. The Group Adult Foster Care Provider Agency should evaluate the needs of each Member in order to determine the daily need and frequency of visits.
  - If a Member becomes symptomatic, the Agency should refer the Member to their PCP for the most appropriate course of action.
- **Leave of Absence Days**  
As a reminder, a Group Adult Foster Care Provider may bill up to 15 Non-Medical Leave of Absence Days (NMLOA) per member per calendar year, and up to 30 Medical Leave of Absence Days (MLOA) per member per calendar year. A NMLOA is defined as a short-term absence from a GAFC-qualified setting during which a member does not receive GAFC services for non-medical reasons. A MLOA is defined as a short-term absence from a GAFC-qualified setting during which a member does not receive GAFC services because the member is temporarily admitted to a hospital, nursing facility, or other medical setting. Additionally, providers may bill MLOA days in situations in which the member is quarantined from their GAFC Direct Care Aide due to COVID-19 and the GAFC Direct Care Aide is unable to provide GAFC services to the member as a result. When using MLOA days for COVID-19 related purposes, the GAFC provider should update the member's record to note COVID-19 for such days.

## **For PCA Program: Personal Care Management Agencies**

- **Initial Evaluations**  
Prior to conducting an initial evaluation for Personal Care Attendant Services, a Personal Care Management Agency should administer screening questions via telephone in order to assess the Member for symptoms of COVID-19.
  - If the Member is determined to be asymptomatic, the Personal Care Management Agency may administer the initial evaluation for Personal Care Attendant Services according to normal procedure.
  - If the Member is determined to be symptomatic (i.e. has a fever higher than 100.3 degrees, or new respiratory symptoms such as cough, shortness of breath, or sore throat, or has been diagnosed with COVID-19) or the Personal Care Management Agency is unable to perform the evaluation either face to face or through video conferencing, they should refer the Member to their PCP who will determine the most appropriate action.
- **Reassessments and Adjustments**  
A Personal Care Management Agency may conduct a reassessment and/or an adjustment to an existing prior authorization for Personal Care Attendant Services via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers#provider-bulletins->), and as determined necessary by the Personal Care Management Agency. Requests for adjustments to Member Pas must be submitted to

MassHealth Long Term Services and Supports (LTSS) Provider Portal (<https://www.masshealthltss.com>), however Member signature requirements are waived until further notice. Such requests must have the following note in the comments field: “COVID-19”. Providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.

- ***School Hours***

A Personal Care Management Agency should not request an adjustment for Consumers whose PA reflects time spent in school to accommodate additional time needed while Consumers are out of school. MassHealth will be adjusting all affected PAs with school time using already approved vacation time to calculate the number of units required. The adjustment time will be effective from March 16, 2020 through June 26, 2020. Once the adjustments are completed, notification to Consumers and PCM Agencies will be sent following usual processes, including written notifications and information available on the MassHealth Long Term Services and Supports (LTSS) Provider Portal (<https://www.masshealthltss.com>). In addition, once all PA adjustments are completed for each PCM agency, Optum will provide the PCM Agency through secure email a spreadsheet of all impacted PAs to assist with PCM Agency tracking.

- ***Day Programs***

For Consumers whose PA reflects time spent in Adult Day Health centers or for Day Habilitation services that are now closed, Personal Care Management Agencies have worked with MassHealth to determine the number of additional units to add to each PA to reflect the needs of Consumers while they are home. The additional time is based on the number of units a Consumer has been approved on their non-attendance days. The adjustment time will be effective from March 16, 2020 through June 30, 2020. Once the adjustments are completed, notification to Consumers and PCM Agencies will be sent following usual processes, including written notifications and information available on the MassHealth Long Term Services and Supports (LTSS) Provider Portal (<https://www.masshealthltss.com>). In addition, once all PA adjustments are completed for each PCM agency, Optum will provide the PCM Agency through secure email a spreadsheet of all impacted PAs to help with PCM Agency tracking.

- **Prior Authorization Extensions**

Personal Care Management Agency may request the continuation of an existing prior authorization. That provider must submit an extension request to MassHealth Long Term Services and Supports (LTSS) Provider Portal (<https://www.masshealthltss.com>) prior to the end date of the existing prior authorization. Such extension requests must have the following note in the comments field: “COVID-19”. Extension requests will be approved for periods up to 90 days.

- **Signature Requirements**

- Required physician/nurse practitioner/physician assistant signatures for the purpose of approving Prior Authorization requests are waived until further notice.
  - Clinical staff signatures for the purpose of signing Evaluations and Prior Authorization requests may be waived. The staff member should document the date, time, attestation, and ‘Covid-19’ in the PA request.
  - Consumer, Surrogate, and Legal Guardian signatures may be waived.
    - For the purpose of PA submission, Consumer, Surrogate, or Legal Guardian must provide verbal agreement to the PCA evaluation. The PCM agency should document the date, time, attestation of agreement, and ‘Covid-19’ in the PA request.
    - For the purpose of all other required paperwork; documentation should support the discussion of such paperwork and the date, time, and verbal attestation from the Consumer, Surrogate, or Legal Guardian, and include the note ‘Covid-19’ on required documents for record keeping purposes.
- **Standard Documentation to Include with a Prior Authorization Request for Personal Care Attendant (PCA) Services**
    - MassHealth is waiving the requirement to submit the additional documents listed on the PCA-SD form when requesting a Prior Authorization. The Personal Care Management Agency, however, remains obligated to determine other services the member is receiving to ensure there is no duplication of personal care services. The Personal Care Management agency must list the other services a member is receiving in the comments section of the PA request, including schedules of those other services and any pertinent information. The comment section should also indicate that the additional documents listed in the PCA-SD form were not submitted pursuant to this Covid-19 guidance.
    - MassHealth is waiving the requirement to submit the Consumer Assessment to Manage PCA Services form with a Prior Authorization request.
- **Intake and Orientation and Functional Skills Training**

A Personal Care Management Agency may conduct Intake and Orientation and all forms of Functional Skills Training via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers#provider-bulletins->), and as determined necessary by the Personal Care Management Agency. The performance of these functions shall be billed per usual protocols and their performance and delivery via telehealth must be clearly documented in the Member’s record. Providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.
- **Consumer Communications of Temporary Suspension of Overtime Policy**

Personal Care Management Agencies should inform Consumers of the temporary suspension of the overtime policy described in this guidance document. Personal Care Management Agencies should also inform Consumers that suspension of the

overtime policy does not permit Consumers to utilize more PCA hours than have been authorized by MassHealth.

- **Consumer Communications of the Use of Electronic Timesheet**  
Personal Care Management agencies should inform Consumers of the value of adopting the electronic timesheet at their respective Fiscal Intermediary for the purpose of ensuring timely payroll. Personal Care Management agencies should direct Consumers to their Fiscal Intermediary for assistance in accessing the electronic timesheet.
- **Consumer Communications around the Completion of New Hire Paperwork**  
Personal Care Management agencies should inform Consumers and PCAs, to the extent possible, to reach out to their Fiscal Intermediaries to utilize available technologies in expediting and simplifying the completion of New Hire Paperwork.

### **For PCA Program: Consumers who Employ PCAs**

- **Overtime Policy**  
MassHealth is temporarily suspending the overtime limits (weekly hour limits) listed under 130 CMR 422.418(A) for the PCA program. Pursuant to this change, until further notice, a Consumer may schedule a PCA to work overtime hours without requiring prior authorization from MassHealth. Consumers should schedule their PCAs with the health and well-being of both Consumer and PCA in mind. Suspension of the overtime policy does not permit Consumers to utilize more PCA hours than have been authorized by MassHealth.

### **For PCA Program: Fiscal Intermediaries working on behalf of Consumers**

- New Hire Orientation in-person classes are temporarily suspended. During this period of suspension, the following applies:
  - New Hire Orientation sanctions will be suspended for a period of 30 days for all PCAs currently sanctioned.
  - During this 30 day period, all PCAs may satisfy the new hire orientation training requirement by taking the online training, including PCAs who are no longer within the first three months of employment and PCAs who are currently receiving a sanction due to having not previously taken the New Hire Orientation within the required time frame.
  - The 9-month grace period for taking the New Orientation will be paused for a period of 30 days.
  - MassHealth will update this information if it determines that the temporary 30-day suspension needs to be extended.
- **Overtime Non-Compliance**  
Fiscal Intermediaries will cease sending letters to Consumers and PCAs for overtime non-compliance. Consumers, however, will continue to receive notices of overbilling for the purpose of record keeping and self-adjustment as needed. Consumers must

still schedule their PCAs according to their PA approval.

## **For Durable Medical Equipment (DME) and Oxygen and Respiratory Equipment Providers**

- **Prescription and Letters of Medical Necessity**

MassHealth is accepting prescriptions and letters of medical necessity signed by the members Prescribing Provider. A Prescribing Provider can be the members physician, nurse practitioner, physician assistant, or clinical nurse specialist who prescribes and writes the prescription and/or letter of medical necessity in accordance with 130 CMR 409.416 and 130 CMR 427.408.

- **Prior Authorization Extensions**

Durable Medical Equipment Providers or Oxygen and Respiratory Equipment Providers may request a continuation of an existing prior authorization. The provider must submit an extension request via email to [support@masshealthtss.com](mailto:support@masshealthtss.com) prior to the end date of the existing prior authorization. Such extension requests must have the following document in the comments field: “COVID-19”. Extension requests will be approved for up to 90 days.

- **Continued Delivery of Rental Items and Supplies That Are Not Subject to Prior Authorization with Prescriptions That Would Otherwise Expire During the COVID-19 Emergency**

For continuity of care, MassHealth is allowing continued delivery of equipment and supplies that are not subject to prior authorization but have prescriptions that expire during the COVID-19 emergency. Specifically, DME and Oxygen and Respiratory Equipment providers may continue delivery of rental equipment and supplies for 90 days from the expiration of the prescription or until the end of the COVID-19 emergency, whichever is later. For items and supplies delivered under otherwise expired prescriptions, providers must clearly document COVID-19 extensions of prescriptions in the member’s record and when submitting claims; and must obtain and document a new oral prescription. Additionally, as described below, during the COVID-19 emergency, providers may deliver up to a 90-day supply in one delivery and must follow the billing guidelines in the following paragraph.

- **Delivery of Durable Medical Equipment (DME) and Oxygen and Respiratory monthly supplies**

Notwithstanding those sections of the DME & Oxygen Payment and Coverage Guideline Tool that prohibit DME and Oxygen and Respiratory Therapy providers from delivering more than a 30-day supply of covered medical supplies to a MassHealth Member, those providers may deliver up to a 90-day supply of those medical supplies upon the Member’s request. Providers must clearly document in the Member’s chart and when submitting claims that the provider delivered an increased supply due to “COVID-19”. Providers must also include, in the Member’s chart and with the claims, the dates of service (DOS) and time period the delivery will encompass.

- **Billing Guidelines for delivery of supplies provided up to a 90-day Period:**
  - Providers are requested to submit one claim per delivery.
  - The first line of the claim should coincide with the delivery date.
  - Providers should submit separate line items identifying the specific months the delivery encompasses and include the allowed monthly limit on each claim line.
  - Providers are requested to pay close attention to any prior approvals that might be expiring and request an extension if needed. Any months that you are billing should have an active prior approval in place, if PA is required.
  - Do not bill a three-month delivery on one line item with one date of service to avoid your claim being denied.

**Example of submitting a claim for T4521:** *Adult sized disposable incontinence product brief/diaper, Small, each 1 unit = each, 248 per month.*

|  |           |                     |
|--|-----------|---------------------|
| Line item 1: Date of delivery 04/01/2020 | units 248 | add price: \$213.60 |
| Line item 2: Date 05/01/2020             | units 248 | add price: \$213.60 |
| Line item 3: Date 06/01/2020             | units 248 | add price: \$213.60 |
|  |           | <i>Total 640.80</i> |

- **Sample list of supplies that can be delivered and billed for up to a 90-day supply (but not limited to):**
  - Diabetic Supplies
  - Absorbent supplies
  - Enteral Supplies
  - Wound Care supplies.
- **Member or Member’s designee signature on delivery ticket**  
 Notwithstanding the requirements of 130 CMR 409.419(A) and 130 CMR 427.430(C), DME and Oxygen and Respiratory Therapy providers should not ask the Member or the Member’s designee to sign a delivery slip at the time that the provider delivers DME and Oxygen and Respiratory Therapy supplies or equipment to the Member’s home. Providers must document the date and the following on the delivery slip, “Signature not required related to COVID-19”.
- **Face-to-Face requirement**  
 In accordance with 42 CFR 440.70(f)(6), MassHealth will permit physicians and other qualified non-physician practitioners, as appropriate, to conduct any face-to-face encounter required by 42 CFR 440.70 via telehealth using 2-way audio-video telecommunications technology that allows for real-time interaction between the physician/allowed practitioner and the patient, and in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download> ). DME and Oxygen and Respiratory Therapy providers must (1) verify that the physician or qualified non-

physician practitioner performed the encounter and (2) include documentation of that encounter in the member's records

- **Streamlined Prior Authorization Requirements for Durable Medical Equipment and Supplies, and Oxygen/Respiratory Equipment and Supplies**

MassHealth is lifting the requirement that providers obtain prior authorization prior to delivering DME, Oxygen/Respiratory equipment, and supplies. While PA is not required prior to delivery, Providers must continue to submit required documentation for PA requests and obtain PA for all services identified as subject to PA under MassHealth provider regulations at 130 CMR 409.000, 130 CMR 427.000, and 130 CMR 450.000, and as specified in the MassHealth DME and Oxygen Payment and Coverage Guideline Tool at <https://www.mass.gov/info-details/masshealth-payment-and-coverage-guideline-tools>. MassHealth will conduct a streamlined review for documentation required for processing PA's (e.g., manufacturer invoices) and issue PA approval notices based on provided documentation.

- **Instructions for Billing:**

Providers must submit for and obtain PA for all items subject to PA prior to submitting a claim for payment, otherwise the claim will be denied. The requested start date on the PA should be on or before the date of delivery. This change is effective for dates of delivery on or after 03/31/20.

- **The Streamlined Prior Authorization Requirements DO NOT apply to the following:**

- Mobility devices (including but not limited to, manual wheelchairs, power wheelchairs and accessories)
- Chest Wall Oscillation/Vest
- Alternative Augmentative Communication devices

## **For Home Health Agencies providing Intermittent Home Health Services and Continuous Skilled Nursing (CSN) Services**

- **Providers Qualified to Order Home Health Services and Establish a Plan of Care**

MassHealth is expanding the medical practitioners that may order home health services and establish a member's plan of care as described in 130 CMR 403.420.

Pursuant to this change, in addition to physicians, a nurse practitioner, clinical nurse specialist, or a physician assistant may: (1) order home health services; (2) establish and periodically review a member's plan of care for home health services (e.g., sign the plan of care), and (3) certify and re-certify the member's plan of care.

- **12-Hour Annual In-Service Training Requirement for Home Health Aides**

Home Health Agencies may postpone the 12-hour annual in-service training requirement for home health aides described in 42 CFR 484.80(d) for the duration of the Commonwealth's state of emergency. Home Health agencies must complete all postponed 12-hour in-service trainings within three months after the state of emergency is lifted.

- Availability of Caregivers**

If, as determined by a Home Health Agency, that a member's family member or primary caregiver who is providing care to a member pursuant to 130 CMR 403.409(D), is unable to continue to provide care due to COVID-19, the Home Health Agency may request from the MassHealth agency additional home health and/or Continuous Skilled Nursing services, as applicable, to ensure the member's medical needs continue to be met. These additional home health services and/or Continuous Skilled Nursing services may be authorized for periods of up to 90 days.
- Provision of Intermittent Home Health Services via Telehealth**

A Home Health Agency Provider may provide appropriate home health services via telehealth (including telephone and/or live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>), as determined necessary by the Home Health Agency Provider. Telehealth visits may be used for any service visit the home health agency determines appropriate for telehealth, including visits to recertify the member's medical necessity for continuing home health services. The provision of home health services via telehealth should be billed per usual protocols and the performance and delivery via telehealth must be clearly documented in the Member's record. Telehealth visits should be billed using the same procedure codes for services delivered face-to-face.
- Provision of CSN Services via Telehealth**

A Home Health Agency Provider may provide member/family consultative CSN services via telehealth (including telephone and/or live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>) as determined necessary by the Home Health Agency Provider. The provision of CSN services via Telehealth is limited to consultative services and recertification visits to determine the member's continued medical necessity for CSN services. Telehealth visits should be billed using the same procedure codes for services delivered face-to-face. The number of units billed per CSN consultative visit or recertification visit should correspond to the length of time the home health agency provided via Telehealth (i.e. a 30 minute consultative or recertification visit would equate to two units of CSN services).
- Performance of Face-to-Face Encounter Requirements via Telehealth**

In accordance with 42 CFR 440.70(f)(6), MassHealth will permit physicians and other qualified non-physician practitioners, as appropriate, to conduct any face-to-face encounter required by 42 CFR 440.70 via telehealth using 2-way audio-video telecommunications technology that allows for real-time interaction between the physician/allowed practitioner and the patient, and in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download> ). The home health agency must



ensure documentation of the face-to-face encounter in the Member's record as specified in 130 CMR 403.420(E)(3)

- **Timeframe to Acquire Signatures on Plans of Care**  
MassHealth will allow home health agency providers additional time to obtain the signed plan of care. The home health agency may obtain the signed plan of care either before the first claims submission or within 90 days from the first claims submission as long as the requirements outlined in 130 CMR 403.420 are met, effectively extending the physician signature or allowable non-physician signature, from 45 days to 90 days.
- **Prior Authorization Extensions**  
Home Health Agency Providers may request the continuation of an existing prior authorization. The provider must submit an extension request via email to [support@masshealthtss.com](mailto:support@masshealthtss.com) prior to the end date of the existing prior authorization. Such extension requests must have the following note in the comments field: "COVID-19". Extension requests may be approved for periods up to 90 days depending on the home health agency's ability to assess the member's continuing need for home health services. All approved extensions will be based off of the member's most recently authorized frequency for home health services. PA extensions will not be approved for requests to increase the frequency of services.
- **Home Health Aide Supervision Requirements**  
Home Health Agencies may provide home health aide supervisory visits conducted by a nurse or therapist via Telehealth (including telephone and/or live video)) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>). Additionally, supervisory visits shall be conducted no less than every 30 days. This is an expansion of the requirements established under 42 CFR 484.80(h), which require a supervisory visit no less than every 14 days.
- **Temporary Expansion of Home Health Aide Services**  
As described further in MassHealth Home Health Agency Bulletin 56, for the duration of the state of emergency declared via Executive Order No. 591, MassHealth will permit Home Health Agency Providers to provide home health aide services to MassHealth members with an existing prior authorization for PCA services when a member is experiencing a disruption in receipt of PCA services due to COVID-19. Refer to Home Health Agency Bulletin 56 for further information.

## **For Community Case Management Program (CCM)**

- **Acquiring Signatures on PCA Surrogate Forms**  
CCM may waive Consumer, Surrogate, and Legal Guardian signatures. CCM should document the date, time, and verbal attestation from the Consumer, Surrogate, or Legal Guardian, and include the note 'Covid-19' on required documents for record keeping purposes.

- **Telehealth**  
CCM may conduct an Initial Evaluation, Care Management Activities, Comprehensive Needs Assessment, and Reassessment for all services CCM provides and authorizes for MassHealth Members via telehealth (including telephone and/or live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>) as determined necessary by the Community Care Management Program.

## **For Independent Nurse Providers**

- **Temporary Change to Overtime Requirements**  
MassHealth is temporarily suspending the requirement of Independent Nurses to contact a minimum of two other CSN providers in attempts to find other nurses to fill CSN hours that exceed 40 hours for a CCM member, as established under 130 CMR 414.416(A)(3). If an Independent Nurse meets the other conditions listed under 130 CMR 414.416, MassHealth may also provide an Independent Nurse a prior authorization for the overtime rate for up to 90 consecutive calendar days following review and approval by MassHealth.
- **Providers Qualified to Establish a Plan of Care**  
MassHealth is expanding the providers that may order CSN services, as well as establish a member's initial plan of care and any recertifying plans of care as described in 130 CMR 414.412(A) to include a nurse practitioner, clinical nurse specialist, or a physician assistant.
- **Timeframe to Acquire Signatures on Plans of Care**  
MassHealth will allow Independent Nurse providers additional time to obtain the signed plan of care. The Independent Nurse may obtain the signed plan of care either before the first claims submission or within 60 days from the first claims submission as long as the requirements outlined in 130 CMR 414.420 are met, effectively extending the physician signature or allowable non-physician signature timeframe from 30 days to 60 days, as temporarily allowed by MassHealth.
- **Temporary Change to Limit of Hours**  
MassHealth is temporarily expanding the maximum limit of hours described in 130 CMR 414.409(C) from 60 hours provided in a consecutive 7-day period to 80 hours in a consecutive 7-day period; and from 12 hours in a consecutive 24-hour period to 16 hours in a consecutive 24-hour period. All requests to temporarily increase the frequency of continuous skilled nursing service delivery must be authorized by the Community Case Management Program.
- **Availability of Caregivers**

If, as determined by the Independent Nurse, that a Member's family member or primary caregiver who is providing care to the Member pursuant to 130 CMR 403.414(I), is unable to continue to provide care due to COVID-19, the Independent Nurse may request from the MassHealth agency additional Continuous Skilled Nursing services, as applicable, to ensure the Member's medical needs continue to be met. These additional Continuous Skilled Nursing services may be authorized for periods of up to 90 days.

- **Provision of CSN Services via Telehealth**

An Independent Nurse Provider may provide member/family consultative CSN services via telehealth (including telephone and/or live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>), as determined necessary by the Independent Nurse. The provision of CSN services via telehealth is limited to consultative services and recertification visits to determine the member's continued medical necessity for CSN services. Telehealth visits should be billed using the same procedure codes for services delivered face-to-face. The number of units billed per CSN consultative visit or recertification visit should correspond to the length of time the home health agency provided via Telehealth (i.e. a 30 minute consultative or recertification visit would equate to two units of CSN services).

## **For Hospice Agency Providers**

- **Waiver of Non-Core Hospice Service Delivery**

In accordance with a CMS waiver of this requirement under Medicare, MassHealth is temporarily suspending the requirement for hospice agencies to directly provide certain non-core hospice services as described under 42 CFR 418.70, including physical therapy, occupational therapy, and speech-language pathology, and homemaker services, as long as a hospice provider's suspension of directly providing non-core hospice services does not inhibit the hospice provider's ability to effectively provide palliation of the member's terminal illness. All non-core hospice services not delivered directly by the hospice provider must still be paid for by the hospice provider and cannot be billed to the MassHealth agency by another provider.

- **12-Hour Annual In-Service Training Requirement for Hospice Aides**

Hospice Agencies may postpone the 12-hour annual in-service training requirement for hospice aides described in 42 CFR 418.76(d). Hospice agencies must complete all postponed 12-hour in-service trainings within 90 days of the termination of the state of emergency declared via Executive Order No 591.

- **Timeframe on Certification of Terminal Illness**

If a Member's physician is unable to complete and submit to the Hospice Agency Provider written certification of terminal illness for a Member's initial 90-day certification period, or any subsequent recertification periods, the Hospice Agency

Provider may acquire an oral certification within 2 calendar days and the written certification before the Hospice Agency Provider submits a claim for payment to the MassHealth agency in accordance with CFR 418.22(3).

- **Telehealth**

A Hospice Agency Provider may conduct required in-person activities as described at 130 CMR 437.423 via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>), and as determined necessary by the Hospice Agency Provider. The performance of these functions shall be billed per usual protocols and the performance and delivery via telehealth must be clearly documented in the Member's record. Providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.

- **Volunteer Services**

MassHealth is permitting hospice agencies to suspend the use of volunteers required under 130 CMR 437.421(E)(1).

- **Expanded Timeframe to Review a Member's Plan of Care**

Hospice agencies may extend the timeframe for when a member's hospice plan of care is reviewed by the Hospice Interdisciplinary Team, as described in 130 CMR 437.422(C), from every 15 days to every 21 days.

- **Hospice Aide Supervision Requirements**

Hospice Agencies may provide hospice aide supervisory visits conducted by a nurse via Telehealth (including telephone and/or live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>). Additionally, hospice aide supervisory visits shall be conducted no less than every 30 days. This is an expansion of the requirements established under 42 CFR 418.76(h), which require a supervisory visit no less than every 14 days.

- **Contracted Staff**

Per 42 CFR 418.64, a Hospice Agency Provider may use contracted staff for core services only under extraordinary circumstances (i.e., to supplement hospice employees in order to meet patients' needs during periods of peak patient load.) If contracting is used, the hospice must continue to maintain professional, financial, and administrative responsibility for the services in accordance with current regulations and policy.

## **For Therapy Providers (Physical, Occupational, Speech)**

- **Medical Referral Requirements**

If a therapy provider is unable to acquire a written medical referral from a licensed physician or nurse practitioner prior to initiation of therapy services, or for any subsequent 60-day period, as described in 130 CMR 432.415, the therapy provider may obtain a verbal medical referral from a licensed physician approving the provision of therapy services. The verbal medical referral for therapy services must include the date and time acquired, as well as the signature of the licensed therapist obtaining the verbal medical referral, and must be maintained in the member's record. The therapist provider must acquire the written medical referral for therapy services prior to billing the MassHealth agency.

- **Prior Authorization Extensions**

Therapy Providers may request the continuation of an existing prior authorization. The provider must submit an extension request via email to [support@masshealthtss.com](mailto:support@masshealthtss.com) prior to the end date of the existing prior authorization. Such extension requests must have the following note in the comments field: "COVID-19". Extension requests may be approved for periods up to 30 days depending on the therapy provider's ability to assess the member's continuing need for therapy services. PA extensions will not be approved for requests to increase the frequency of services.

- **Telehealth**

A Therapy Provider may conduct required in-person activities via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>). as determined necessary by the Therapy Provider. The performance of these functions shall be billed per usual protocols and the performance and delivery via telehealth must be clearly documented in the Member's record. Providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.

## **For HCBS Waiver Providers**

- HCBS Waiver service providers should reference the MassHealth guidance for Agency In-Home Care, Non-Agency In-Home Care, and Community Day Program COVID-19 Guidance, as applicable, as well as guidance throughout this document that pertains to providers of LTSS services most similar to the waiver services they provide. If it is unclear which set of guidance is most applicable, providers may contact the University of Massachusetts Medical School Disability and Community Services HCBS Provider Network Administration Unit as follows:
  - Phone: toll free (855) 300-7058
  - Email: [ProviderNetwork@umassmed.edu](mailto:ProviderNetwork@umassmed.edu)
- If, as determined by an HCBS Waiver Provider, that a Member's family member or primary caregiver who is providing care to a Member, is unable to continue to provide care due to COVID-19, the HCBS Waiver Provider may request from the

waiver case manager additional HCBS Waiver services, as applicable, to ensure the Member's needs continue to be met. These additional HCBS services may be either additional hours of the current services authorized or may include authorization of new service types.

- An HCBS Waiver Provider may conduct required in-person activities (e.g., Adult Companion and Individual Support and Community Habilitation) as described at 130 CMR 630.00 via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers#provider-bulletins>), and as determined necessary by the HCBS Waiver Provider. The performance of these functions shall be billed per usual protocols and the performance and delivery via telehealth must be clearly documented in the Member's record. For 15-minute and per-visit services, waiver service providers should bill the same procedure codes for services delivered via telehealth as appropriate for those services delivered face-to-face, adding a second position modifier, UC.
- In addition, all HCBS Waiver services identified in Appendix K Addendum: COVID-19 Pandemic Response, Section 2(a)(v): COVID-19 Pandemic Response (see Massachusetts' approved Appendix K available at <https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers>) may be delivered via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers#provider-bulletins>), and as determined necessary by the HCBS Waiver Provider. For 15-minute and per-visit services, waiver service providers should bill the same procedure codes for services delivered via telehealth as appropriate for those services delivered face-to-face, adding a second position modifier, UC. The delivery via telehealth of all services must be clearly documented in the Member's record.
- For waiver Day Services delivered via telehealth, providers should bill as usual, using the regular waiver day services code on days when a full 6 hours of services are delivered to the participant. On days when fewer than 6 hours of waiver day services are delivered to a participant, providers should bill using the CBDS service code in 15-minute increments for the number of units that corresponds to the duration of service delivery that day. See table below for details. Providers are expected to maintain documentation in member records that clearly demonstrates the nature and duration of services delivered, in connection with the units billed.

| Waiver Service  | HCBS Waiver | Code  | Modifiers | Unit     | Rate     |
|---|-------------|-------|-----------|----------|----------|
| <b>Day Services (per diem)</b><br>NOTE: Bill at per diem rate on days when provider delivers six (6) hours of service to participant.               | ABI-N       | S5108 | U4,UC     | per diem | \$102.90 |
|   | ABI-RH      |       | U5,UC     |          |          |
|   | MFP-CL      |       | U8,UC     |          |          |
|   | MFP-RS      |       | U9,UC     |          |          |
| <b>Day Services (15-minute)</b><br>NOTE: Bill at 15-minute unit rate on days when fewer than six (6) hours of service are delivered to participant. | ABI-N       | S5100 | U4,UC     | 15 min   | \$4.40   |
|   | ABI-RH      |       | U5,UC     |          |          |
|   | MFP-CL      |       | U8,UC     |          |          |
|   | MFP-RS      |       | U9,UC     |          |          |

- Member signature requirements may be waived as long as the Provider documents the date, time, and verbal attestation from the Member, and includes the note ‘Covid-19’ on required documents for record keeping purposes.
- HCBS Waiver service providers should reference the standards set forth in Administrative Bulletin 20-35 located on the MassHealth website (<https://www.mass.gov/doc/administrative-bulletin-20-35-101-cmr-35900-rates-for-home-and-community-based-services-0/download>).

## For Nursing Facilities

- **Coverage of COVID-19 Quarantine in a Nursing Facility**  
There may be instances in which Nursing Facilities will need to quarantine Members infected with COVID-19 for public health reasons or otherwise cannot safely discharge a Member due to COVID-19 exposure or risk, even though these Members may no longer require a Nursing Facility level of care. MassHealth will pay Nursing Facilities for Members no longer requiring a Nursing Facility level of care but who must be quarantined in the facility or otherwise cannot be safely discharged due to COVID-19. Nursing Facilities should complete the following steps in order to be paid by MassHealth:
  - For any Member to whom the above circumstances apply, Nursing Facilities must email [Meera.Ramamoorthy@mass.gov](mailto:Meera.Ramamoorthy@mass.gov) and [Jacqueline.Fratus@mass.gov](mailto:Jacqueline.Fratus@mass.gov), with subject line **LTC COVID-19** and in the body of the email include:
    - Provider number
    - Member name
    - Member MassHealth ID
    - Date of confirmed or suspected COVID-19 diagnosis of member or caregiver
    - *Nursing facilities must use a **state secure email** to send such requests. If a provider has not used a state secure email before, the provider must email [Meera.Ramamoorthy@mass.gov](mailto:Meera.Ramamoorthy@mass.gov) and [Jacqueline.Fratus@mass.gov](mailto:Jacqueline.Fratus@mass.gov) for further instructions.*
  - MassHealth will extend eligibility for the duration the Member is quarantined and/or until the Member can be safely discharged to the community, to allow the Nursing Facility to bill MassHealth for Members who no longer require a

Nursing Facility level of care. If the Member has a PPA, their PPA will be \$0 beginning the month of notification, and for the duration the Member is quarantined and/or until the Member can be safely discharged to the community.

- **When the Member is ready for safe discharge**, nursing facilities must email [Meera.Ramamoorthy@MassMail.State.MA.US](mailto:Meera.Ramamoorthy@MassMail.State.MA.US) and [Jacqueline.Fratus@mass.gov](mailto:Jacqueline.Fratus@mass.gov), at MassHealth with subject line **LTC COVID-19 Discharge** that includes a Discharge SC-1 indicating when the member has been discharged.
  - *Nursing facilities must use a **state secure email** to send such requests. If a provider has not used a state secure email before, the provider must email [Meera.Ramamoorthy@mass.gov](mailto:Meera.Ramamoorthy@mass.gov) and [Jacqueline.Fratus@mass.gov](mailto:Jacqueline.Fratus@mass.gov) for further instructions.*

- **Medical Leave of Absence Bed-Hold Days**

Notwithstanding the limits described in MassHealth Nursing Facility Bulletins 138 and 139, MassHealth is temporarily lifting the 20-day limit for paid Medical Leave of Absence bed-hold days in cases where Members may not be safely discharged back to the Nursing Facility or must be safely quarantined due to COVID-19. All such instances must be clearly documented in the Member’s record.

## **For Chronic Disease and Rehabilitation Hospitals (CDRHs)**

- **Suspension of the 45-day nonpayment Administrative Day (AD) policy**

- Pursuant to [All Provider Bulletin 289](#) (March 2020), chronic disease and rehabilitation inpatient hospitals may bill MassHealth for members no longer requiring an inpatient level of care but who must be quarantined in the hospital or otherwise cannot be safely discharged due to COVID-19 by switching the members to administrative day (AD) status. Notwithstanding any contrary requirements in 130 CMR 435.412, MassHealth will consider all administrative days **directly related to COVID-19** as reimbursable.
  - Chronic disease and rehabilitation inpatient hospitals rendering COVID-19-related services to MassHealth members will be paid in accordance with the administrative day rate specified in their Chronic Disease and Rehabilitation Hospital Contract.
  - Chronic disease and rehabilitation hospitals must document in the patient record the specific COVID-19 related reason requiring administrative days.
- For dates of service on or after March 10, 2020, CDRH providers should bill using the short-stay Administrative Day occurrence code 21 for MassHealth members meeting the criteria listed above, **who are currently in or entering the 45-day AD window only:**

| <i><b>Occurrence code:</b></i> | <i><b>Rate:</b></i>  |
|--------------------------------|--|
| 21                             | <i>CDRH-specific short-stay Administrative Day (AD) per diem</i> |



- **Pre-Admission Screenings**

Pursuant to All Provider Bulletin 291, notwithstanding 130 CMR 435.408: *Screening Program for Chronic-Disease and Rehabilitation Hospitals*, MassHealth will not require pre-admission screening of members seeking admission to Chronic Disease and Rehabilitation Hospitals (CDRH). Instead, a CDRH may admit a member after submitting a notification of admission packet to MassHealth, with the below documentation. The admission will be subject to concurrent and retrospective review as clinically indicated.

- A CDRH seeking to admit a member may admit the member after submitting a notification of admission packet to MassHealth Office of Clinical Affairs (OCA), with the following documentation:
  - Admission notes
  - Clinical notes over the last 3 days in the acute hospital (documenting clinical and functional status)
  - CDRH attestation of patient needs
- Upon receipt of an admission packet with the above required information, OCA will assign a “PAS number” to the admission for payment purposes.