Prior Authorization (PA) and Referral Requirements for Covered Services for BMC HealthNet Plan Accountable Care Organization Plan (ACO Plan) Members with Family Assistance Coverage

This is a list of Prior Authorization and/or Referral requirements for all covered services and benefits for MassHealth Family Assistance Members enrolled in all BMC HealthNet Plan ACO Plans (ACO Plan).

We will coordinate all covered services listed below. It is your responsibility to always carry your ACO Plan Member ID Card and your MassHealth identification cards and show them to your providers at all appointments.

You can call **BMC HealthNet Plan's** Member Service Department for more information about services and benefits. Please see the telephone number and hours of operation for our Member Service Department at the bottom of every page of this document.

If you have questions about	Please call
Medical Services	BMC HealthNet Plan**'s Member Services Department** at 1-800-566-0010 (English/other languages), 888-566-0012 (Spanish) or TTY: 711for people with partial or total hearing loss. See below for hours of operation.
Behavioral Health Services	Beacon Health Strategies (Beacon) at 1-888-217-3501 or TTY: 866-727-9441 for people with partial or total hearing loss.
Pharmacy Services	BMC HealthNet Plan**'s** Member Services Department at 1-800-566-0010 or TTY: 711for people with partial or total hearing loss. Also, you may go to BMC **HealthNet Plan ACO's Drug List at** www.bmchp.org.
Dental Services	DentaQuest Customer Service at 1-800-207-5019 or TTY at 1-800-466-7566 or Translation Line at 1-800-207-5019. Hours: 8 a.m. to 6 p.m., Monday–Friday.

In the chart below, if the column under "Prior Authorization Required for Some or All of the Services**" is marked "**Yes**,"** some or all of these services need Prior Authorization (PA) before you receive these **services. Your provider will work with us to request a PA. If the column under "**Primary Care Provider (PCP) Referral Required for Some or All of the Services?**"** is marked **"**Yes**,"** then some or all of these services require a referral from your PCP before you receive these services.

Please keep in mind that services and benefits change from time to time. This Prior Authorization (PA) and/or Referral Requirements for Covered Services listing is for your general information only. Please call our Member Services Department for the most up-to-date information. MassHealth regulations control the services and benefits available to you. To access MassHealth regulations:

- G**o to MassHealth's Web site** www.mass.gov/masshealth; or
- Call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss) Monday through Friday from 8:00 a.m.–5:00 p.m.

*The services in the grid below that are marked with an asterisk (*) are covered directly by MassHealth and may require prior authorization by them. However, we will assist in the coordination of these services.

MassHealth Family Assistance Covered Services for ACO Members	Prior Authorization (PA) Required for Some or All of the Services? Yes or No	Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes or No
Emergency Services – Medical and Behavioral Health		
Emergency Transportation Services Ambulance (air and land) transport that generally is not scheduled, but is needed on an Emergency basis, including Specialty Care Transport that is an ambulance transport of a critically injured or ill Enrollee from one facility to another, requiring care beyond the scope of a paramedic.	No	No
Emergency Inpatient and Outpatient Services	No	No
Emergency Services Programs Medically Necessary services that are available seven days per week, 24 hours per day, to provide assessment, or treatment, or stabilization, or any combination of these services to any Member who is experiencing a mental health or substance use disorder.	No	No
Youth Mobile Crisis Intervention Youth (under the age of 21)-serving component of an Emergency Services Program (ESP) provider.	No	No
Medical Services		
Abortion Services	No	No
Acute Inpatient Hospital Services Includes all inpatient services such as daily physician intervention, surgery, obstetrics, radiology, laboratory, and other diagnostic and treatment procedures and includes Administratively Necessary Days (AND).	Yes	No
Adult Dentures Full and partial dentures, and repairs to said dentures, for adults ages 21 and over.	*	*
Ambulatory Surgery Services Outpatient surgical-related diagnostic, medical, and dental services.	Yes	No
Audiologist (Hearing) Services	Yes	No
Breast Pumps One per birth or as medically necessary, including double electric pumps, are provided to expectant and new mothers as specifically prescribed by their attending physicians and consistent with state and federal law.	Yes	No

MassHealth Family Assistance Covered Services for ACO Members	Prior Authorization (PA) Required for Some or All of the Services? Yes or No	Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes or No
Chiropractic Chiropractic manipulative treatment, office visits, and radiology services. We may establish a limit of 20 visits during a benefit year (January 1–December 31).	No	No
Chronic Disease and Rehabilitation Hospital Services, for all levels of care, including for eligible members under the age of 22, when provided at either a chronic or rehabilitation hospital (or a combination of the 2 facility services). The first 100 days are covered by us and covered by MassHealth thereafter.	Yes	No
Dental Services • Emergency-related dental care.	No	No
• Oral surgery performed in an outpatient hospital or ambulatory surgery setting which is medically necessary to treat an underlying medical condition.	Yes	Yes
• Preventive and basic services for the prevention and control of dental diseases and the maintenance of oral health for children and adults.	*	*
Dialysis Services	No	No
Durable Medical Equipment • Including but not limited to the purchase or rental of medical equipment, replacement parts, and repair for such items. • Enteral Nutritional Supplements (formula) may be covered under your Durable Medical Equipment (DME) Benefit.	Yes	Yes
Early Intervention Services	No	No
Family Planning Services	No	No
Hearing Aid Services	No, except for surgically implanted aids	No
Home Health Services	Yes	No
Hospice Services	Yes	No
Infertility Diagnosis of infertility and treatment of underlying medical condition.	Yes	No
Intensive Early Intervention Services Provided to eligible children under three years of age who have a diagnosis of autism spectrum disorder.	*	*
Laboratory Services All services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of health.	Yes, for select lab services	No

MassHealth Family Assistance Covered Services for ACO Members	Prior Authorization (PA) Required for Some or All of the Services? Yes or No	Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes or No
Orthotic Services Braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body. For individuals over age 21, certain limitations apply.	Yes	No
Outpatient Hospital Services Services provided at an outpatient hospital, for example: • Outpatient surgical and related diagnostic, medical, and dental services. • Therapy services (physical, occupational, and speech). • Diabetes self-management training. • Medical nutritional therapy.	Yes	No
• Office visits for primary care and specialists. • OB/GYN and prenatal care. • Tobacco cessation services. • Fluoride varnish to prevent tooth decay in children and teens.	No	No
Oxygen & Respiratory Therapy Equipment	Yes	No
Physician (primary and specialty), Nurse Practitioners acting as Primary Care Providers, and Nurse Midwife Services For example: • Office visits for primary care OB/GYN and prenatal care. • Diabetes self-management training. • Tobacco cessation services. • Fluoride varnish to prevent tooth decay in children and teens.	No	No
• Office visits for specialty care. • Medical nutritional therapy.	Yes	No
Podiatrist Services (Foot Care)	No	No
Preventive Pediatric Health Screening and Diagnostic Services Children, adolescents, and young adults who are under 21 years old and are enrolled in Family Assistance Plan are entitled to Preventive Pediatric Healthcare Screening and Diagnosis Services.	No	No
Prosthetic Services	Yes	No
Radiology and Diagnostic Services For example: • X-Rays. • Radiation oncology services performed at radiation oncology centers (ROCs) that are independent of an acute outpatient hospital or physician service.	No, except for select radiation oncology services	No
• Magnetic resonance imagery (MRI) and other imaging studies.	Yes	No

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Therapy Services For example: • Occupational therapy. • Physical therapy. • Speech/language therapy.	Yes	No
Vision Care For example: • Comprehensive eye exams once every year for Members under age 21 and once every 24 months for Members age 21 and over, and whenever medically necessary.	No	No
• Vision training. • Ocular prosthesis. • Contacts, when medically necessary, as a medical treatment for a medical condition such as keratoconus. • Bandage lenses.	Yes	No
• Prescription and dispensing of ophthalmic materials, including eye glasses and other visual aids, excluding contacts.	*	*
Wigs As prescribed by a physician related to a medical condition.	Yes	No
Pharmacy Services (See Copayment information in Section 6.5 of your Member Handbook)		
Prescription Medicines	Yes	No
Over-the-Counter Medicines	Yes	No
Behavioral Health (Mental Health and Substance Use Disorder) Services		
Inpatient Services 24-hour services that provide clinical intervention for mental health or substance use diagnoses. Types:		
Inpatient Mental Health Services Hospital services to evaluate and treat an acute psychiatric condition.	Yes	No
Inpatient Substance Use Disorder Services (Level 4) Hospital services that provide detoxification regime of medically directed care and treatment.	No	No
Observation/Holding beds Hospital services for a period of up to 24 hours in order to assess, stabilize, and identify appropriate resources for Members.	Yes	No

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Administratively Necessary Day (AND) Services Day(s) of inpatient hospitalization for Members who are ready for discharge, but an appropriate setting is not available.	Yes	No
Residential Rehabilitation Services (Level 3.1)		
Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) 24-hour residential environment that provides a structured and comprehensive rehabilitation environment.	Yes	No
Family Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) 24-hour residential environment for families in which a Member has a substance use disorder and is pregnant, has custody of a child, or has a physical reunification plan.	Yes	No
Transitional Age Youth and Young Adult Residential Rehabilitation Services for Substance Use Disorder (Level 3.1) 24-hour developmentally appropriate residential environment with enhanced staffing support designed for either Transitional Age Youth or Young Adults.	Yes	No
Youth Residential Rehabilitation Services for Substance Use Disorder (Level 3.1) 24-hour developmentally appropriate residential environment with enhanced staffing support designed specifically designed for youth, ages 13-17.	Yes	No
Co-Occurring Enhanced Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) 24-hour, safe, structured environment, located in the community, **which supports a patient's recovery from addiction and moderate to** severe mental health conditions while helping him/her return to the community, job, or educational roles. These services are scheduled, goal-oriented clinical services that are provided along with psychiatry and medication management to support the patient and keep them stable. They also include teaching the patient the skills necessary to achieve recovery.	Yes	No

MassHealth Family Assistance Covered Services for ACO Members	Prior Authorization (PA) Required for Some or All of the Services? Yes or No	Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes or No
Diversionary Services Those mental health or substance use disorder services that are provided as an alternative to inpatient services or provided to support a Member returning to the community after a 24-hour acute placement or to provide intensive support to maintain functioning in the community. These services are provided in a 24-hour facility or a non-24 hour setting.		
24-hour Diversionary Services		
Community Crisis Stabilization Services provided as an alternative to hospitalization, providing 24-hour observation and supervision.	Yes	No
Community-Based Acute Treatment for Children and Adolescents (CBAT) Mental health services provided on a 24-hour basis with sufficient clinical safe to ensure safety for children or adolescents.	Yes	No
Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7) 24-hour medically monitored addition treatment services that provide evaluation and withdrawal management.	No	No
Clinical Support Services for Substance Use Disorders (Level 3.5) 24-hour treatment services that can be used independently or following an Acute Treatment Services for SUDs.	No	No
Transitional Care Unit (TCU) Community-based therapeutic programs offering high levels of supervision, support, and intensity of service.	Yes	No
Non-24-hour Diversionary Services		
Community Support Program (CSP) An array of services delivered by a community-based, mobile multidisciplinary team.	Yes	No
Partial Hospitalization (PHP) An alternative to inpatient services, PHP offers short-term day mental health programming available 5 to 7 days a week.	No	No
Psychiatric Day Treatment A program of a combination of diagnostic, treatment, and rehabilitative services.	Yes	No
Structured Outpatient Addiction Program (SOAP) Clinically intensive, structured day and/or evening SUD services.	No	No

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Intensive Outpatient Program (IOP) A clinically-intensive service designed to improve functional status, provide stabilization in the community, or divert an admission to Inpatient Service	No	No
Recovery Coaching A non-clinical service provided by peers who have SUD experience and are certified Recovery Coaches.	No	No
Recovery Support Navigators Specialized care coordination services intended to engage Members with SUD in accessing and continuing SUD treatment.	No	No
Outpatient Behavioral Health Services		
Family Consultation Meeting with Member's family to identify and plan for services, coordinate a treatment plan, and review progress or revise the treatment plan.	No	No
Case Consultation A meeting with the treating provider, PCP, and other BH professionals to identify and plans for services, coordinate a treatment plan, review progress, and revise the treatment plan.	No	No
Diagnostic Evaluation An assessment of a Member's level of functioning to diagnose and design a treatment plan.	12 visits per year without Authorization. Prior Authorization required for additional visits.	No
Dialectical Behavioral Therapy (DBT) An outpatient treatment that combines strategies from behavioral cognitive and supportive psychotherapies.	12 visits per year without Authorization. Prior Authorization required for additional visits.	No
Psychiatric Consultation on an Inpatient Medical Unit Meeting between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and a Member at the request of the medical unit to assess the Member's mental status and consult on a behavioral health or psychopharmacological plan.	No	No

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Medication Visit An individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or R.N. Clinical Specialist.	No	No
Couples/Family Treatment Psychotherapeutic and counseling techniques in the treatment of a Member and his/her partner and/or family simultaneously in the same session.	12 visits per year without authorization. Prior Authorization required for additional visits.	No
Group Treatment Psychotherapeutic or counseling techniques in the treatment of a group.	12 visits per year without authorization. Prior Authorization required for additional visits.	No
Individual Treatment Psychotherapeutic or counseling techniques in the treatment of an individual.	12 visits per year without authorization. Prior Authorization required for additional visits.	No
Medication for Addiction Treatment (MAT) Services MAT is the use of medications in combination with counseling and behavioral therapies. This service is effective in the treatment of opioid use disorders (OUD) or people trying to stay on the path to recovery. This service may be provided by a physician*, physician assistant, nurse practitioner, community health center, clinical nurse specialist, or psychiatric clinical nurse specialist. *PCPs who also provide MAT services may provide MAT services to members enrolled in any plan type. There are no PCP restrictions because you are in an ACO or MCO.	No	No
Inpatient-Outpatient Bridge visit Consultation conducted by an outpatient provider while a Member remains on an Inpatient psychiatric unit.	No	No

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Assessment for Safe and Appropriate Placement (ASAP) An assessment, required by MGL 119 Sec. 33B, conducted by a diagnostician with specialized training and experience in the evaluation and treatment of sexually abusive youth or arsonists.	Yes	No
Collateral Contact A communication between a Provider and individuals who are involved in the care or treatment of a Member under 21 years of age.	No	No
Acupuncture Treatment The insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, or heat to the needles or skin, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.	No	No
Opioid Replacement Therapy Medically monitored administration of methadone, Buprenorphine, or other U.S. Food and Drug Administration (FDA)-approved medications to opiate-addicted individuals, in conformance with FDA and Drug Enforcement Administration (DEA) regulations.	No	No
Ambulatory Detoxification (Level 2.d) Outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications.	No	No
Psychological testing The use of standardized test instruments to assess a Covered **Individual's cognitive, emotional, neuropsychological,** verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.	Yes	No
Special Education Psychological Testing Psychological, emotional, or neuropsychological testing that is requested by school personnel responsible for initiating referrals for diagnosis and evaluation of children who qualify for special education programs pursuant to Mass Gen. Law 71B.	Yes	No
Applied Behavioral Analysis Service that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior.	Yes	No
Intensive Home and Community-Based Services for Youth		

MassHealth Family Assistance Covered Services for ACO Members	Prior Authorization (PA) Required for Some or All of the Services? Yes or No	Primary Care Provider (PCP) Referral Required for Some or All of the Services? Yes or No
In-home Therapy Services A service provided to the parent /caregiver of a youth (under the age of 21), in any setting where the youth resides, such as the home and other community settings.	Yes	No
Other Behavioral Health Services		
Electro-Convulsive Therapy (ECT) A therapeutic service that initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by DMH.	Yes	No
Repetitive Transcranial Magnetic Stimulation (rTMS) A noninvasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression.	Yes	No
Specialing Therapeutic services provided to a Member in a variety of 24-hour settings, on a one-to-one basis, to **maintain the individual's safety**.	Yes	No

EXCLUDED AND LIMITED SERVICES LIST

Except as otherwise noted or determined Medically Necessary, the following services are not covered under MassHealth or by BMC HealthNet Plan:

1. Cosmetic surgery, except as determined by BMC HealthNet Plan to be necessary for:
   a. correction or repair of damage following an injury or illness; b. mammoplasty following a mastectomy; or c. any other Medical Necessity as determined by BMC HealthNet Plan. All such services determined by BMC HealthNet Plan to be Medically Necessary shall constitute a BMC HealthNet Plan Covered Service. Specific cosmetic exclusions include:
   - Dermabrasion (procedures used to improve scarred facial skin or smooth facial wrinkles); acne related services, such as the removal of acne cysts or injections to raise acne scars; treatment of vitiligo (white patches) or melasma (brown spots); or removal of skin tags.
   - Hair removal (using electrolysis or other methods); wigs (except as covered for members with cancer); or hair restoration.
   - Laser Surgery of the eye for the purposes of correcting vision when conditions such as myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurred vision) can be corrected by means other than surgery. These procedures are referred to as refractive eye surgery (and include laser surgery, radial keratotomy, and orthokeratology).
2. Treatment for infertility, including but not limited to in-vitro fertilization and gamete intrafallopian tube (GIFT) procedures.
   - Services performed solely to diagnose or treat people who are unable to get pregnant through natural methods. Examples are: diagnostic procedures and tests; oral and injectable drug therapies; artificial insemination of any type; in-vitro fertilization; gamete intra-fallopian transfer; zygote intra-fallopian transfer; intracytoplasmic sperm injection; and banking, obtaining and processing of sperm, egg, or embryos—whether associated with active or future infertility treatment. Also excluded: reversal of voluntary sterilization; and costs related to achieving pregnancy through a surrogate.
3. Experimental treatments.
4. Personal comfort items including air conditioners, radios, telephones, and televisions.
5. Services provided for any of the following reasons: only for your convenience, personal, or environmental comfort; to support your religious preference; to improve performance in sports or exercise activities; to promote a desired lifestyle; or to improve your appearance or your feelings about your appearance.
6. A service or supply which is not provided by a Network Provider, except for:
   - Emergency Services;
   - Family Planning Services; and
   - **Services provided to newborns during the period prior to notification of the newborn's** enrollment by the Executive Office of Health and Human Services
7. Non-covered laboratory services.
   - Maternity or paternity testing for any reason.
   - Tests performed only for purposes of civil, criminal, administrative, or social service agency investigations, proceedings, or monitoring activities. Examples include: forensic exams, autopsy (services performed after death) services, and related labs.
8. Services provided outside the United States and its territories.
9. Services not otherwise covered by MassHealth, except as determined by BMC HealthNet Plan to be Medically Necessary for MassHealth Standard and CommonHealth Members under age 21.

10. Health care services, supplies, equipment, or drugs related to or provided in support of a non-covered service. Note: an exception applies for covered clinical trials.
11. Services that are not Medically Necessary. Services that do not meet our Medical Necessity definition or our clinical criteria.
    - Safety Items: Safety items that are NOT a Medically Necessary component of a BMC HealthNet Plan Authorized corrective or restorative treatment program, or safety items not needed to treat a disease or medical condition. Examples are: door alarms, protective beds or bedding, medical bracelets, and weighted blankets.
    - Devices: Devices that are NOT a Medically Necessary component of a BMC HealthNet Plan Authorized corrective or restorative treatment program. Examples of devices not covered include reaching/grabbing devices not a component of an Authorized treatment plan, arch supports (for non-diabetic or vascular condition), computers, computer communication devices, computer software, telephones, radios, televisions, and personal care items/services such as elevators, room humidifiers, air conditioners, or purifiers.
12. Services you are not legally required to pay for, or services for which you would not be charged if **you didn't have health coverage.** (Example: State-funded vaccines)
13. Services required by a third party (such as an employer, insurance company, licensing organization/agency, school, or court) that are not otherwise Medically Necessary. Examples are: exams and tests required for recreational activities, employment, or college; court-ordered exams; evaluations for job purposes; vocational rehabilitation services; job placement services; or therapy to restore function for a specific occupation.
14. Non-medical services. Examples are: athletic training evaluations; community work integration training; education in patient self-management; court testimony; and educational supplies (such as books, tapes, and pamphlets).
15. Blood and blood products, storage, blood bank services, blood processing and storage, frozen plasma, plasma thawing services, and irradiation of blood.
16. Services for Non-Members: Services for non-members. Example: Harvesting of a human organ **transplant donor's organ or stem cells when the recipient is not a Member. ("Harvesting" means** removing tissue, organs, or specimens from a donor for re-use in transplant surgery.)

    Note: BMC HealthNet Plan covers services given to a non-member: when related directly to a covered human organ transplant when the organ recipient is a Member; and for covered Hospice (care for the terminally ill) counseling services related to mourning the death of a family member.
17. Services for which there is a less intensive level of service, or more cost-effective alternative that can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting. Example: services in an acute Inpatient setting when your condition could be safely and effectively provided in a skilled nursing facility.
18. Special Clothing, except for the following special clothing, which is covered when Medically Necessary: gradient pressure support aids for lymphedema or venous disease (support stockings); clothing needed to wear a covered device (for example, mastectomy bras and stump socks); and therapeutic/molded shoes and shoe inserts for Members with severe diabetic foot disease.
19. Some alternative or complementary medicine services: Examples include:
    - Whole Medicine Systems: Medicine based on theory and practice. Examples are: homeopathic and naturopathic medicine, and traditional Chinese medicine such as acupuncture and Ayurveda. (Note: acupuncture is covered for Members who have it listed in their Covered Services List; and for all Members as part of Medically Necessary covered substance abuse treatment.)

- Mind Body Medicine: Methods designed to improve the mind's ability to affect bodily function and symptoms. Examples are: biofeedback (except for treatment of urinary incontinence), hypnotherapy/hypnosis; meditation; prayer; mental healing; and therapies that use creative outlets such as art, music, or dance.
- Substances that are found in nature. Examples are: herbal products, vitamins, and dietary supplements. Note: prenatal vitamins are covered when prescribed by a Network Provider.
- Manipulative and Body Based Practices: Methods involving manipulating or moving one or more parts of the body. Examples are: massage, myotherapy, craniosacral therapy, osteopathic manipulation, hippotherapy (water therapy), yoga, and reflexology.
- Energy Medicine: Methods involving use of energy fields. Examples are: Reiki, therapeutic touch, pulsed fields, magnetic fields (with the exception of Repetitive Transcranial Magnetic Stimulation (rTMS) as noted above), electromagnetic, or alternating-current or direct-current fields.

20. Relaxation therapies; massage therapies; holistic treatments; treatment at sports medicine clinics; and any related diagnostic services.
21. Chiropractic treatments beyond the 20 visits allowed during a Benefit Year.
22. Weight-Related Services/Equipment: Commercial diet plans, weight loss or weight control programs and clinics, food programs, or the purchase or rental of exercise equipment, personal trainer services, and any services related to any of these.
23. Provider and Facility charges, including:
    - Observation Services: Observation services, including but not limited to: a. services that are not reasonable or necessary for the diagnosis or treatment of the Member; and b. routine preparation and recovery services associated with diagnostic testing or outpatient surgery.
    - Private Room Charges: Charges greater than the rate for a semi-private room (except when a private room is Medically Necessary)
    - Leave of absence charges while an Inpatient in an acute care facility. These are charges incurred because the patient is not present at the midnight census/attendance taking time.
24. The following mental health/substance abuse-related services are excluded:
    - Job-related rehabilitation services. These are services to help people with disabilities prepare and look for a job.
    - Sheltered workshops. These are vocational counseling and training programs in which participants receive paid work experience or other supervised employment.
    - Recreational services.

      Note: play therapy, which is the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is covered.
    - Life-enrichment services. These are ego-enhancing services such as workshops or educational courses provided to functioning persons in need of self-esteem improvement.
    - Non-medical services, such as social, educational, and job related services.
    - Alcohol or drug drop-in centers.
25. Pharmacy Exclusions. The following drugs are not Covered Service:
    - <u>Drugs used primarily for cosmetic purposes.</u> Examples are: all topical hydroquinone products, Benoquin®, and Solage®. MassHealth does not pay for any drug used for cosmetic purposes or for hair growth. Examples include: Rogaine®, Avage®, Propecia®, Renova®, Vaniqa®, and TriLuma®.
    - <u>Cough and Cold.</u> MassHealth does not pay for any drugs used solely for the symptomatic relief of cough or colds, including but not limited to, those that contain an antitussive or expectorant

as a major ingredient, unless dispensed to a Member who is a resident in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR).

- Drugs for the treatment of infertility (to help a person become pregnant). MassHealth does not pay for any drug used to promote male or female fertility.
- Weight loss medications. Any drug used to treat obesity. MassHealth does not pay for any drug used for the treatment of obesity.
- Less-Than-Effective Drugs. MassHealth does not pay for any drug products (including identical, similar, or related drug products) that have been deemed less-than-effective by the U.S. Food and Drug Administration. These are sometimes called DESI drugs. Examples include: Midrin®, Duradrin®, Estratest®, and hydrocortisone rectal suppositories. For a complete list of DESI drugs please visit: http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp.
- Experimental and Investigational Drugs. MassHealth does not pay for any drug that is experimental, medically unproven, or investigational in nature or has not been approved by the U.S. Food and Drug Administration. Examples are: herbal and/or alternative medications and medical foods that require a prescription; Atopiclair®; Udamin®/Udamin SP®, and Foltx®.
- Drugs for Sexual Dysfunction. MassHealth does not pay for any drug when used for the treatment of male or female sexual dysfunction. Examples are: Viagra®, Cialis®, Levitra®, Yohimbine, Caverject®, Edex®, or Muse®.
- Drugs that are not prescribed to treat an illness, injury, or pregnancy, or for preventive care purposes.
- Prescriptions filled at non-Network pharmacies, except in cases of Emergency care, or Urgent Care when you are temporarily traveling within the U.S. or its territories.

- All over-the-counter drugs that are not **listed on BMC HealthNet Plan's over**-the-counter Drug List.
- All over-the-**counter drugs listed on BMC HealthNet Plan's over**-the-counter Drug List for which your Provider has not given you a prescription that meets all legal requirements for a prescription.